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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(British Psychological Society, Division of Clinical Psychology).
WELCOME TO THE SOUTH WESTERN edition of the PSIGE Newsletter.

The South Western region is made up of Gloucestershire, Bristol and Avon, Somerset, Devon and Cornwall, including the Scillies – and the Channel Isles. It is thus a large area: the distance from Gloucester at one end of the patch to Penzance at the other is the same as from London to Preston. (This may be of no surprise to you who travel down to the sunny shores of Cornwall, pass Exeter and think ‘nearly there’, only to arrive at your particular patch of heaven three hours later.) The membership of PSIGE is 30-odd (no, we do not have especially odd members), and is scattered but stable; we like living in the South West.

There are three training courses in the area (Bristol, Exeter and Plymouth), and in addition to providing placements and acting as clinical supervisors, local members are actively involved in convening and teaching on the older adult components of these courses.

We have sought to convey a distinctive South Western flavour to this edition of the newsletter. We hope that you especially appreciate the cover photograph, which is of a (now deceased) client of one of our local members together with his wife.* The term ‘silver surfer’ definitely has two meanings down in these parts, and there are certainly also legions of older people making creative use of the web, but we thought that wouldn’t be so visually striking. There is another photograph later in this issue.

We have tried to involve as many local members as possible in producing material, and this is particularly evident in the item in which we asked local psychologists to tell us what they enjoy about working with older people. Respondents ranged from trainees to old hands, but certain themes characterised all the contributions. The most common theme concerned the stories told by older people, either explicitly or implicitly, and the immense range of human experience and human history represented by these stories. The second theme, related to the first, is the personal impact on the contributors, especially concerning reflections on their own possible futures. The third theme was the variety of work involved, the range of knowledge and skills required by clinicians working in the specialty.

Several of the articles in this edition deliberately challenge conventional views, a pattern which is itself contrary to the view that down in these parts we are only interested in an easy life. There is a proposal that we, as psychologists and members of PSIGE, have been fundamentally ineffective in enhancing the lives and well-being of older people. There are reflections and some research findings on the assumptions typically made about the self-awareness of people with dementia, and how this is at least in part socially constructed. A different form of challenge reported is that of managing to eat for a week on the state pension.

Less challenging, perhaps, but hopefully also of interest are accounts of various activities in the region. These include a self-help and support group for people with dementia, a support group for carers, and an in-reach project providing input to residential homes. You will also learn of the experience of one of the convenors associated with the closure of a long-stay hospital.

We hope that you will appreciate this variety, as you may recognise that the region’s cuisine is not limited to cream teas.

P.F. Joyce and Philippa Wilson
Regional Convenors.

*Mrs. Pugsley has kindly given permission to use this photograph of herself and her late husband John.
Letter from the Chair

Steve Boddington

Welcome to the 95th edition of the PSIGE Newsletter, hosted by the South West Geographical Group. This seems strangely appropriate with Summer upon us … the South West feels very appealing!

Much of our recent committee business has been taken up with planning for the AGM, held at the Brighton Conference in early July (more about this in the next Newsletter), and with understanding the impact of the DCP restructuring on the way in which we work as a faculty. I have written a discussion document that has been sent to the DCP Executive, and was presented and discussed at our AGM (available on the PSIGE website). However, the two immediate issues with which we have been asked to comply are that our finances and our membership database should be subsumed within the workings of the Division. The finances issue is a requirement for the Society to conform to the guidelines set out by the charities commission, and is therefore one to which we have a legal obligation to comply. This loss of autonomy is in some way softened by the fact that our outgoing Chair (Nicky Bradbury) now sits on the DCP finance committee and has a role in supporting the DCP treasurer in his unenviable task! The membership database issue is more complex as we undertook to ensure that our database was compliant with the Data Protection Act about three years ago, and you (PSIGE members) have given consent for us (PSIGE committee) to hold your membership details. We would contravene the DPA if we were to hand over this information to the DCP without your consent! We will pick this issue up at our strategy meeting at the end of September.

The DCP restructuring will have many other implications for us as a Faculty over the coming year or so and we would really like to hear from you, if you have views on any of these issues, or if you have any suggestions about how we can move forward with the Division in a constructive manner.

I hope that you find the contents of this edition useful and interesting, and that you have a very enjoyable Summer … what better holiday reading could you want?!

Steve Boddington
PSIGE Chair

Editor's Note

Thanks very much to South West PSIGE for producing such a superb edition. A read through the Editorial indicates the care and thought that has gone into producing this issue.

After five years, this is my last Newsletter. I’ve thoroughly enjoyed the job and wish to thank everyone who has contributed in any way. My successor will be Romola Bucks and in anticipation of her election to the post at the AGM her details replace mine in this edition.

Sinclair Lough

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Supporting residential care homes for older adults and improving the quality of care for people with dementia

Elizabeth Drew

Context and Background

As the trend for older people’s care provision moves from residential care to very sheltered housing schemes those clients left in residential care are likely to have a higher degree of mental health needs. This places different demands on the staff who work in these residential homes, who have often had only limited training to enable them to respond to these demands. The Mental Health In-Reach Team (MHIRT) was set up to provide a support service to these homes in order to address these concerns. The hope was that with extra support these homes would be more equipped to cope with residents with mental health needs and, therefore, help prevent what was seen as unnecessary hospital admissions or transfer to other care environments. These aims are in line with the National Service Framework (NSF) for older people (2001) which states that: ‘specialist mental health services should provide training and advice for other professionals and staff whose responsibilities include providing care and treatment for older people with mental health problems.’ Additionally it specifies that ‘specialist mental health services should provide advice and outreach to those providing residential and nursing homes’ (NSF, 2001). The MHIRT also contributes to standard two of this framework, ‘person-centred care’, by advocating the importance of providing person-centred care and giving staff training centred on Tom Kitwood’s approach to dementia care (Kitwood, 1997).

The MHIRT was originally set up as a year-long project in response to a report from the Nuffield Institute. This Nuffield report was commissioned to look into care facilities for older people across what used to be Avon. It stated that what was needed were: ‘In-reach teams to offer advisory and clinical support in assessment and care planning to homes according to need.’ (Crisis in care or capacity for change?, January, 2003.) Based on the results of an audit of the project, funding for the team has been continued after the initial year. The organisation of the team and the services provided has been maintained. However, the number of homes covered has been expanded and there have been a number of ongoing developments to the service.

Organisation of the team and support offered

The MHIRT is made up of a Community Psychiatric Nurse (CPN) and an Assistant Psychologist. The team is managed by one of the older adult Community Mental Health Team (CMHT) leaders. Both members of the team also receive clinical supervision from members of their own profession and a system of graduated response is in place so that clinical psychologists and other professionals can become directly involved if the MHIRT feels that this is necessary.

Support is offered to homes in a number of ways:

1. **Weekly in-house training sessions** covering a range of issues related to dementia and mental health needs are delivered to staff. Topics covered have included: dementia theory, challenging behaviour, dealing with aggression, depression, anxiety, alcohol use, person-
centred care, activities and stress. Most training visits last for approximately an hour-and-a-half with a 45-minute presentation and time for discussion and questions focusing on particular residents within the particular home.

2. **Staff support sessions** provide a space for staff to talk about any issues that they are finding difficult. On occasions staff have requested to talk to a member of the MHIRT individually and this service has been provided.

3. **One-off presentations** on requested subjects for homes that have specific training needs.

4. **Regular ‘pop-in’ visits** to those homes that are not currently receiving training to make sure that they continue to feel supported by the MHIRT.

A key aspect of the MHIRT is the collaborative nature of its service. The MHIRT works together with homes to identify their specific needs and then tailors its approach to meet these. Some homes want regular training on a variety of topics at a specific time each week whereas other homes feel that staff support sessions are more important and some prefer to just receive pop-in visits. Where staff want training on a topic that is not normally covered, the MHIRT endeavours to either provide this training or refer to another professional who can provide this. An example of this is a home that recently took on a resident who had a history of chronic schizophrenia. Staff were frightened by this as they felt they had no knowledge in this area, so the MHIRT did a training session on schizophrenia and allowed staff the space to talk about their feelings about this condition. The session proved helpful in giving the staff some knowledge and making them feel more comfortable providing care to this individual. So far the placement has been a success and staff report feeling empowered by the experience.

In addition the MHIRT takes individual case referrals from the five older adult CMHTs that cover the Bristol area, the care home management team and care homes themselves as well as other health care providers. These referrals usually indicate that a particular home is having problems managing a particular individual or situation. The vast majority of referrals are about challenging or aggressive behaviour. However, referrals regarding mental health issues such as depression, concerns over medication and questions about the appropriateness of a placement have also been received. In response to these referrals the MHIRT will visit the home in question and help staff think of new ways of working with a resident that might resolve the problems being encountered. Through this approach the MHIRT encourages staff not to think of the particular resident as ‘the problem’ but to gain insight into the reasons behind the residents’ behaviour. We have often found that changing staff’s perception of the resident and their behaviour is all that is needed to resolve the situation.

One of highly valued aspects of the MHIRT is the fast response rate to such referrals. The aim is to respond to referrals on the same or next day; this is almost always achieved. The advantage of this to homes is that they feel that they get an immediate response to a request for help, which helps them to feel listened to. In addition we have noticed that by addressing an issue early, before patterns set in, the outcome is more likely to be successful.

**Promoting person-centred care**

The MHIRT works to promote person-centred care. This is a key message given both through training sessions and consultation sessions. Tom Kitwood’s (1997) model of dementia underpins this work. The aim is to make staff see ‘the PERSON with dementia’ rather than ‘the person with DEMENTIA’ (Kitwood, 1997). This approach to care encourages staff to see things from the resident’s point of view, bringing a new understanding of problems and a focus on individuals. By increasing the person-centred care given in homes the
occurrence of challenging behaviour is likely to reduce as residents’ personhood is maintained. In this way the work of the MHIRT is improving the quality of life of people living in residential care. Evidence from semi-structured questionnaires included in the last audit of the MHIRT clearly demonstrates that staff are more aware of residents’ perspectives after training:

‘It helped us see dementia through the client’s eyes. Seeing how they are feeling helps us to work better with them.’ (A quote from member of care staff working in one of the homes)

A more recent development to the service offered by the MHIRT is to carry out Dementia Care Mapping in homes and provide staff with feedback concerning the well-being of residents. This development aims to further the work on encouraging person-centred care.

**Improving communication**

A key strength of the MHIRT is that it is independent from other services while maintaining strong links with care homes and their management team, CMHTs and inspection bodies. The MHIRT uses this strength to facilitate effective communication between these services. This is an important function of the team, which helps the smooth running of placements. Different bodies within the health and social care system often have different perceptions of risk and, therefore, have different expectations of care homes. This can leave care homes in a difficult position often described by managers as being ‘stuck between a rock and a hard place’. For example, some residents can become aggressive either physically or verbally. The CMHTs, because of their experience of mental health problems, often see this type of behaviour as part of caring for people with dementia or mental health problems and not necessarily a high risk situation. However, the inspectorate has a different view. Their procedures compel homes to report any aggressive incident and often require the home to act on the situation due to the high level of risk that they associate with this type of behaviour. In one incident I was involved with, the inspectorate was insisting on a protection of vulnerable adults (POVA) meeting about a resident who had become aggressive. The inspectorate was concerned for the other residents in the home. The home contacted the CMHT for involvement. However, the CMHT felt that this was not a POVA situation and a meeting would be inappropriate. The MHIRT visited this home and had a meeting with staff and the inspectorate about the incident. We offered some advice about what may have triggered the situation and how staff could avoid it reoccurring. We also helped the home to write and put in place a risk assessment. This satisfied the inspectorate that appropriate action had been taken. In addition we fed back to the CMHT to aid their understanding of the care homes position. In this way the involvement of the MHIRT helps services to understand each other better.

**Reflections on working in the MHIRT**

I have been working as an assistant psychologist in the MHIRT since September, 2005. I have greatly valued working in this position and have gained both professionally and personally from the experience. I have observed the hard work of care staff struggling to provide quality care for older people with low levels of staffing and resources. It is evident that the vast majority of staff in homes really care for the people that they look after. However, their job is often made difficult by high demands, time constraints, and lack of training. Most of the homes I have worked with have been extremely appreciative of the MHIRT and value the knowledge and understanding gained. I have found it to be very rewarding to be enabling staff to give better care and to be providing some support for staff working in difficult conditions. However, I have noticed that where homes have a strong culture of ‘task orientated’ work that prioritises the tidiness of rooms and administration work
and marginalises time spent engaging individual residents in meaningful activity it is a hard uphill climb. Staff in such homes can seem difficult to engage in training and resistant to the person-centred model. This is sometimes not helped by my identity as a relatively young woman; staff see me as inexperienced and, therefore, unable to help them. These problems in engaging staff can be helped by working a couple of shifts with them, showing a willingness to get involved and give ‘hands-on’ care as well as simply talking about ‘theories’. Although progress is often slow when one is trying to help a culture to change I believe that the in-reach model is a good way of doing this and I have had some success during my time in this post. I believe that a psychological way of working has a lot to offer this service and that this type of staff training is an essential part of the clinical psychologists’ role as it encourages a more psychologically informed approach. I hope that this service is continued within Bristol and that the in-reach team model is transferred to other mental health services.

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References

Another photo of Mr. and Mrs. Pugsley with their surfing friends.
IT IS GENERALLY ACCEPTED THAT people are now living longer. Many older people are healthy and independent but a large number also have chronic illnesses and need assistance with everyday activities. Family members are often the first to provide care for older relatives with chronic illnesses and they frequently provide care for the longest period of time.

Caring for someone with chronic illness is associated with negative mental health consequences, especially depression (Gallagher et al., 1989; Schulz et al., 1990; Wright et al., 1993). Rates of depression and other mental health problems are higher among carers of older people with cognitive impairments compared with carers of those who have physical impairments (Birkel, 1987; Tennstedt et al., 1992). About 25 per cent of family carers of people with dementia are affected by depression and up to 73 per cent by some type of mental health problem (Levin et al., 1994; Gilleard, 1992).

Health services have traditionally focused attention on the person with dementia rather than the carer (Hettiaratchy & Manthorpe, 1992). However, the need for services to consider the well-being of carers is now widely acknowledged. Standard seven of the National Service Framework for Older People states that ‘older people who have mental health problems should have access to integrated mental health services provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and for their carers’ (Department of Health, 2001, p.96). In addition, the British Psychological Society (BPS) in its paper ‘Clinical Psychology Services for Older People in Primary Care’ states that clinical psychologists have a role in meeting carers’ needs through providing ‘effective approaches to coping with personal stress as well as practical and problem-solving help’ (BPS, 2002, p.10).

The most popular clinical intervention with carers of people with dementia is support groups. Group interventions have a number of advantages. They reduce isolation, facilitate learning from and modelling on one another, and create a permissive atmosphere for expression of emotions (Yalom, 1975). In addition, group interventions can provide carers with understanding, affirmation and validation of thoughts and feelings about providing care, and universalise and normalise carers’ experiences (Toseland & Rossiter, 1989). Pragmatically, group interventions are less costly in terms of therapist time and resources than individual therapy.

The Clinical Psychology Service in North Bristol has been running support groups for carers of older people with dementia for a number of years. This article looks at the evaluation of one of these groups and reflects on the findings obtained. The key questions the evaluation aimed to consider were whether the group was effective in meeting carers’ needs and if so, what was it that carers found helpful?

Spouse Carers’ Support Group
The group evaluated was for spouse carers of older people with dementia. It was limited to spouse carers as it has been argued that spouses experience certain aspects of caring differently to adult children (Toseland & Rossiter, 1989). One reason for this is that spouses usually live with their partners with dementia. Another factor is that spouses may feel under a social obligation to care for...
their partner. A third issue is that the effects of dementia on the marital relationship will be different from the effects on the parent-child relationship. The Clinical Psychology Service runs alternative groups for adult children who are carers.

The group had seven members; five of whom had partners who lived at home. Two had partners in residential care. The partners of those attending the group had varying degrees of dementia from mild to severe. Referrals to the group came from members of the Older Adults Community Mental Health Team. Team members were able to refer any spouse carers of people with dementia whom they thought might benefit from attending the group.

Group sessions were one-and-a-half hours long and were run weekly, for seven weeks. The group had a psychoeducational format and the programme for the sessions is shown in Table 1 below.

The group was evaluated in a number of ways. Carers were asked to fill in a brief questionnaire at the end of sessions two to six to give feedback about each session. In the final session, group members were asked to indicate one key thing they felt they would take with them from having attended the group. Finally, three weeks after the last session, a more detailed feedback form was posted out to carers for them to complete and return.

**Results from the evaluation**

**a. Feedback from individual sessions**

Questions on the form which concerned whether the group was effective in meeting carers’ needs were ‘How much did you learn?’ and ‘How much of the information was new to you?’ Feedback in relation to these two questions is presented in Figure 1. for each individual session from two to six.

Most group members learned at least something from each session. However, for sessions three, five and six, a small percentage of group members did not feel they learned much from attending the session. Similarly, the majority of group participants thought that at least half of the information presented was new to them.

<table>
<thead>
<tr>
<th>Week</th>
<th>Topic for session</th>
<th>Session run by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introductions – meeting each other, finding out about the group programme.</td>
<td>Psychologists</td>
</tr>
<tr>
<td>2</td>
<td>When mental powers fail (1) – Causes of memory problems/dementia, diagnosis and medication.</td>
<td>Specialist Registrar</td>
</tr>
<tr>
<td>3</td>
<td>When mental powers fail (2) – Understanding unusual behaviour and dealing with problems.</td>
<td>Psychologists</td>
</tr>
<tr>
<td>4</td>
<td>Support outside the home – Day, respite and residential care, financial issues and benefits.</td>
<td>Social Workers</td>
</tr>
<tr>
<td>5</td>
<td>Support at home – The work of social services at home and voluntary agencies.</td>
<td>Community Care Worker and Dementia Care Trust Worker</td>
</tr>
<tr>
<td>6</td>
<td>The experience of caring – The impact of caring, stress and coping.</td>
<td>Psychologists</td>
</tr>
<tr>
<td>7</td>
<td>Final session – Any other business, accessing further support, information leaflets and goodbyes!</td>
<td>Psychologists</td>
</tr>
</tbody>
</table>
Figure 1: Responses to questions relating to effectiveness of group in terms of meeting carers' need, from feedback form given at end of each session. Figures are given as percentages as not all group members attended every session.

Response to question: 'How much did you learn?' for sessions 2 to 6.

Response to question: 'How much of the information was new for you?' for sessions 2 to 6.

s2 – Causes of memory problems/dementia, diagnosis and medication.
s3 – Understanding unusual behaviour and dealing with problems.
s4 – Day, respite and residential care, financial issues and benefits.
s5 – The work of social services at home and voluntary agencies.
s6 – The impact of caring, stress and coping.
However, again, for sessions three, five and six, some group members felt that none or only a bit of the information presented was new to them.

**b. Key thing group members felt they would take away with them from having attended the group**

This question pertains to what carers may have found helpful from having attended the group and the answers are set out in Table 2 below.

Five people indicated that being able to interact with others was the main thing that they gained. Group members felt that this was helpful because it was a chance to unburden themselves, to speak to someone not immediately connected with their situation, to learn from others and to re-evaluate their own difficulties in the light of hearing what others were coping with. For one person, practical information in terms of benefits advice was an important gain from attending the group.

**c. Responses to detailed feedback form**

Five of the seven group members returned the form. One person gave feedback relating to some of the questions asked on the form over the telephone. Table 3 (alongside) shows answers given to questions which have most bearing on whether, and how, the group was effective in meeting the support needs of spouse carers.

Most of those who responded to the detailed feedback form found the group helpful or very helpful, although one person said that they found the group ‘somewhat helpful’.

As in the answers given to the question asked at the end of the final session, a key aspect of attending the group for a number of people was interacting with other carers. In relation to this, responses given echoed those given in the last session, with group members stating that talking to other carers and hearing about their situations was helpful in enabling them to feel less isolated and to re-evaluate their own experiences as less problematic compared with others.

The responses also indicated that for two group members the talks and educational aspect of the group were important and for one group member, attendance at the group had led to her feeling calmer. Two members made changes as a result of attending the group, both of which were concerned with looking after themselves as carers.

<table>
<thead>
<tr>
<th>Group member</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>‘Talking to everyone. Good to get it off your chest.’</td>
</tr>
<tr>
<td>B</td>
<td>‘Putting my mind at rest’ [re: benefit allowance]</td>
</tr>
<tr>
<td>C</td>
<td>‘Talking to people who aren’t in my family, people not in the immediate situation.’</td>
</tr>
<tr>
<td>D</td>
<td>[Agreed with C]</td>
</tr>
<tr>
<td>E</td>
<td>‘I learned a lot that I didn’t know before.’</td>
</tr>
<tr>
<td>F</td>
<td>‘Impressed by people’s courage and coping in a situation no-one could have expected. [It was] helpful to hear others’ situations.’</td>
</tr>
<tr>
<td>G</td>
<td>‘[I feel] privileged to have had help, starting with the doctor. I did know where to go. Some carers have much more to deal with than me.’</td>
</tr>
</tbody>
</table>

Table 2: Answers given by group members in response to being asked to ‘Name one key thing you will take away from the group’.
Discussion

The way in which the group was evaluated had certain limitations. Firstly, in terms of the questionnaire used to evaluate individual sessions, the two questions ‘How much did you learn?’ and ‘How much of the information was new to you?’ tapped overlapping concepts; information would have to be new in order for carers to learn something. Secondly, the evaluation question, ‘Name one thing you will take away from attending the group’, asked at the end of the final session was biased towards eliciting positive gains from group members and it may have been difficult for them to have stated in such a public situation if they felt that they had gained nothing from attending the group. Lastly, the final part of the evaluation was dependent on carers returning the form. One person did not return it and it is a possibility that they did not do so because they felt negatively about the group. In addition, the use of a postal questionnaire meant that questions were open to interpretation and there were instances where carers misunderstood what was being asked. Carers also gave quite brief answers to questions and therefore it is likely that only the very key things

Table 3: Responses given to questions on the detailed feedback form sent to carers three weeks after the end of the group. Numbers in brackets refer to the number of people who gave each type of response.

| (1) Overall, how helpful did you find the group? | • Somewhat helpful (1)  
• Helpful (2)  
• Very helpful (3) |
| (2) What did you find helpful about the group? | • Very helpful  
• I gained comfort in the knowledge I was not alone when dealing with specific areas of caring.  
• We all had the care of a partner and we were all on a learning curve. No two sets of circumstances were the same.  
• Listening to others’ greater problems.  
• I learned a lot. Other people in the same situation as myself, with the same problems. I’m not the only one.  
• Listening to other people’s problems. It helped me with mine. |
| (3) What were the most important aspects of the group for you? | • Talking to others with the same problems.  
• The talks given by visiting professionals including yourself.  
• I felt that through past experiences and associations I had more support than many in the group and I have much to be thankful for – I was humbled!!  
• Listening to others’ greater problems.  
• I’ve calmed down a lot, shouting less.  
• The most important thing was when the doctor came and explained how the brain works. |
| (4) What changes have you made as a result of attending the group? | • None (2)  
• Arranged two periods of respite care.  
• None, but will keep this in mind.  
• Before I start work, after my husband leaves for the day centre, I have a cup of tea or coffee and a nice shower. It’s easy to forget to have a shower if you don’t plan it. Have also booked a perm and a manicure. |
which they found helpful or considered important are highlighted. Finally, the questions ‘what did you find most helpful about the group?’ and ‘what were the most important aspects of the group for you?’ again tapped overlapping concepts. What carers found most helpful was often also the most important aspect of the group for them.

In spite of the limitations to the evaluation, however, some themes emerge which may usefully provide a basis for more thorough evaluation in the future. Looking firstly at whether the group was effective in meeting carers’ needs; overall the group was positively evaluated by most participants, however, a small number of people reported that they did not learn very much and that none or only a little of the information presented was new to them. One group member also rated the group overall as ‘somewhat helpful’. The carers who gave these responses were those who had been caring for some time and whose partners had moved to residential care. This suggests that perhaps the format of the group used here was less effective in meeting the needs of a sub-group of experienced carers.

Caring can be conceptualised as a career with a number of stages (Pearlin, 1993; Aneshensel et al., 1995; Pfeiffer, 1999), including receiving the initial diagnosis of dementia and placement into residential care, and each stage is associated with different stress factors. Carers who have placed a relative in care, therefore, have specific support needs which can be identified. Thus, although such carers may no longer have responsibility for daily care, they often have to interact with staff to ensure their relative receives appropriate care. Learning how to interact with staff in an effective way and to accept differences in how staff provide may be a major challenge and carers may find it difficult to accept loss of control over their relative’s situation. In addition, carers may have to contend with guilt associated with placement as well as issues relating to the cost of care which may place them under considerable economic strain. For spouses, in particular, there is also the issue of being in an ambiguous and undefined role. They may not be widowed but do not have the companionship and other benefits of being married; a situation described by Rosenthal and Dawson (1991) as ‘quasi-widowhood’. None of these issues pertaining more directly to carers who have placed their relatives were directly addressed by the present group.

The evaluation also suggests some possibilities in answer to the second question concerning what it was that carers found helpful about attending the group. Qualitative feedback from two sources indicated that a prominent aspect of attending the group for many of the members was the opportunity to interact with other carers. This was seen as valuable because it allowed carers a chance to unburden themselves, to speak to someone not immediately connected with their situation, to learn from others, to feel less isolated and to re-evaluate their experiences as less problematic compared with others. These comments would seem to fit with the generic aspects of groups, and carers’ support groups in particular, identified as beneficial by Yalom (1975) and Tose-land and Rossiter (1989) respectively.

In addition, at the last session one person mentioned practical advice they had been given as the key thing they would take with them from having attended the group, and responses to the final detailed feedback form also indicated that the educational aspect of the group was the most important feature for two members. These comments suggest that the educational component of the group may also have been valued by participants. Finally, responses to the final feedback form indicating that one carer felt calmer after attending the group and two others felt able to make changes concerned with looking after themselves suggests that the group may also have been helpful in enabling carers to give themselves permission to look after themselves as well as the people they support.

The limited evaluation of a carers’ group for spouse carers of older people with
dementia presented here suggests that groups based on a psychoeducational format may be valued by carers, although perhaps in particular those who are in the early stages of a caring career. It also gives some tentative suggestions as to why carers may find such groups beneficial including being able to interact with other carers, receiving information, and feeling more able to look after themselves as carers. Future, larger scale studies would need to explore these suggestions further.

References

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OFF THE TOP OF YOUR HEAD – what do you spend on food per week?

The Age Concern website (April, 2006) states that ‘in 2002–2003, one adult retired households mainly dependent on state pensions spent £19.60 per week on food compared with £21.30 for single non-retired households’.

This figure always elicits discussion with views ranging from being unable to contemplate anybody being able to survive on such a paltry sum to those harking back to their student days and claiming to have lived on less than £5 per week through necessity.

As I live in a single adult household I elected to try it and did so a couple of years ago. The rules were simple: Only shop for what you could walk with or carry home on a bus.

My total spend was just over £25 and it was very time consuming shopping each evening on the way home from work, weighing up what I fancied and could afford that night. I became slightly obsessional about what I was eating and what I was going to eat in a way which was unusual and perhaps not psychologically healthy.

I thought that this time I could certainly manage to come in under the Age Concern limit that I had set myself.

The rules were the same but this time I had to try and eat the ‘five portions’ of fruit and vegetables, largely stick to my regular eating habits and activities and not be unnaturally organised by cooking up a preparatory storm at the weekend as I reckoned that I would be unlikely to start doing this post-retirement. I would price my eating at the end of the week from the shop in the village.

I am certainly not a ‘foodie’ or a great creative cook but I do need sustenance at the end of the day. I admit to having a weird eating pattern – but that is one of the great pleasures of living solo and even as a trainee I lived for many months on a daily diet of ‘brown rice and veg’.

Day 1

Breakfast
Five teabags + bowl of porridge + three tsps sugar.
Lunch
One bowl Alpen.
Supper
Three potatoes, four carrots, one floret of broccoli.
Three teabags.

Day 2

Four teabags + bowl of porridge + three tsps sugar.
One bowl Alpen.
Three teabags.
Two oranges.
Rich tea biscuits.
One large packet of peanuts.
Three teabags.

Day 3

Five teabags + bowl of porridge + three tsps of sugar.
Juice of three oranges.
One bowl of Alpen.
One bowl of cornflakes.
Two slices of toast and peanut butter.
Three teabags.

Day 4

Five teabags + bowl of porridge + three tsps of sugar.
Juice of three oranges.
One bowl Alpen.
Four potatoes, cauliflower, cheese sauce.
Three teabags.
Weekend

Day 5
Six teabags + bowl of porridge + three tsps sugar.
Four carrots, three potatoes, one parsnip.
One hot chocolate and toasted teacake.
Four teabags.

Day 6
Six teabags.
One bowl cornflakes.
Two slices toast.
One cauliflower, two onions, kidney beans, one pound tomatoes, brown rice.
Six teabags.

Day 7
Five teabags + bowl of porridge + three tsps sugar.
Juice of four oranges.
One bowl Alpen.
Brown rice and vegetable stew from Day 6.
Four teabags.

Each day I drank three pints of semi-skimmed milk. My total spend was £28.42 including my £3.50 hot chocolate and teacake treat in a café.

The week was not unusual for me. On days 2 and 3 I went straight from work to somewhere else and didn’t come home to eat. As a retired person I would presumably have more time and flexibility but I doubt that I am going to really become any more interested in food. There were things that I could have done – made a saucepan full of dhal which would have boosted the protein intake and planned my eating systematically using freezing.

This time round I was more relaxed about my eating, confident that I would come in under budget and it was something of a shock and disappointment that I didn’t. The café visit was an indulgence I could have foregone but it did seem like a week with no treats. As someone who adores chocolate and strawberries in season it would be impossible to include them on such a tight budget. I normally drink and eat as much organic and Fair Trade produce as feasible and have a Riverford ‘mini-box’ delivered. This costs £7.50 and would not be viable on such a tight budget although local farmers markets would be an option. The figure does not include ‘borrows’ from the larder – margarine, a drizzle of honey over roast vegetables, peanut butter, the occasional bowl of cereal – all of which would have to be financed from the weekly spend.

Plymouth is a city with pockets of the worst deprivation indices in Europe and as far as I am aware there are no healthy eating projects or community initiatives. Vegetable and food co-ops that I have been involved with in the past seem to be a more middle class and younger age group activity.

Fletcher and Rake (2001) in a Health Education Authority commissioned review have identified that nutritional interventions may differ from those successful with younger age groups. One study promoted wholemeal bread and whole grains through a ‘community organisation method’ which included ‘social events, favourable bread pricing, media coverage and social marketing, with a primary care leaflet’ and showed increased sales of bread and grains. Another study used garden boxes, gardening and nutrition classes to promote vegetable consumption. Although the study was hampered by the lack of a comparison control group the strategy was felt to warrant more rigorous investigation. Given the fun and friendship a local vegetable co-op provided a group of 20 and 30 somethings in the 80s I can only agree that they may offer an acceptable alternative for those people for whom a ‘day centre’ or group activity does not appeal.

Poor nutrition has been linked with fractured neck of femur (Lumbers et al., 2001) – they compared the nutritional status of a sample of older female patients admitted for emergency surgery with an age matched independent living group attending local day centres. The hip fracture group had a lower body weight and lower intakes of energy, carbohydrate, protein and calcium but the
intakes for both groups were below the estimated average requirement for energy.

Our local city council has recently trimmed its Meals on Wheels service to the extent that a couple in their 90s were not deemed ‘frail enough’ to receive them, requiring them to visit the local community centre every day for a hot meal at lunchtime. Whilst this was a part of their weekly routine twice a week it was now a necessity.

The exercise has been fascinating and revealing. Having lived solo since my children left home three years ago I can identify how easy it is to develop idiosyncratic and unhealthy patterns of eating culminating in the day I realised that all I had eaten since my porridge that morning was 10 Chomp bars. This would not fit any of the three main clusters of diets found amongst women by Cook and Shetty (2001) of whom 33 per cent eat a ‘sweet traditional diet’, 32 per cent a ‘healthy diet’ and 18 per cent a ‘mixed diet’. My dietary intake would fall into the remaining 17 per cent of unspecified whackiness and I would probably be amongst the 28 per cent of women who claim vegetarian status but are not defined as such from their food frequency questionnaire (Cade et al., 2004)

Food, its preparation and its provision remains at the heart of how many women view of themselves and it has taken greater priority on initial assessment visits – helped by my co-visiting nurse colleague who has a background in eating disorders.

A senior cleric in Birmingham has tried something similar by aiming to live on the minimum wage during Lent. He received criticism for the patronising nature of the project and similar brickbats can be thrown about this venture. I would argue that it is not pretending but simply a gentle reminder to explore food, its getting, preparation and eating in a slightly more rigorous way than in the past – and indeed, in my capacity as citizen rather than psychologist to write a strong letter to the council about the parlous state of Meals on Wheels provision.

<table>
<thead>
<tr>
<th>Spend</th>
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<tr>
<td>80 Teabags – 98p</td>
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<tr>
<td>One box porridge – £1.59</td>
</tr>
<tr>
<td>One small bag potatoes – 98p</td>
</tr>
<tr>
<td>One box Alpen – £2.05</td>
</tr>
<tr>
<td>11 oranges @29p – £3.12</td>
</tr>
<tr>
<td>One loaf bread – 70p</td>
</tr>
<tr>
<td>One cauliflower – 99p</td>
</tr>
<tr>
<td>One packet rice – 65p</td>
</tr>
<tr>
<td>21 pints milk@38p – £7.98</td>
</tr>
<tr>
<td>Two onions – 32p</td>
</tr>
<tr>
<td>One kg sugar – 72p</td>
</tr>
<tr>
<td>One floret broccoli – 40p</td>
</tr>
<tr>
<td>Four carrots – 75p</td>
</tr>
<tr>
<td>One parsnip – 42p</td>
</tr>
<tr>
<td>One pound tomatoes – £1.59</td>
</tr>
<tr>
<td>One packet Rich Tea biscuits – 69p</td>
</tr>
<tr>
<td>One large packet peanuts – 99p</td>
</tr>
<tr>
<td>Total – £28.42 (including Hot chocolate and toasted teacake – £3.50).</td>
</tr>
</tbody>
</table>

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References


We are clinical psychologists who are also trained as family therapists and are informed in our practice by ideas drawn from social constructionism and narrative approaches to therapy. Working with older people we talk about many difficult issues with our clients and their families, including death, dying, and the myriad of losses which affect older people. Of all these, perhaps the most difficult is dementia and the loss of memory and cognitive functioning which characterises it. In her book, *Death Talk: Conversations with Children and Families*, Glenda Fredman (1997), talks about her work with children and families affected by death and dying. She reflects on the range of professional and personal stories that people draw on in these conversations and what can be known and talked about in different contexts. Although working with a very different client group, her writing resonated with our clinical and personal experience and helped to focus our own ideas at a time when we were particularly interested in the concepts of awareness, insight and denial as they relate to the onset and progression of dementia.

Fredman describes the way in which professionals are taught to prioritise the knowledge drawn from their professional training over personal experience. Relevant examples of professional theories in her field are the various conceptualisations of process in bereavement and developmental models of children’s understanding of death and dying. She illustrates how in the specific case of death and dying these forms of knowledge do not always fit well with the beliefs people, whether clients or workers, bring with them based on personal experience and cultural, spiritual and religious backgrounds. In order to highlight the range of different sources of knowledge and to disrupt our tendency to privilege the professional at the expense of the personal, she uses the plural term ‘knowledges’.

It is inevitable within the field of older adult psychology that the work has particular personal resonances, as we all hope to live to grow old and can expect to face the losses and frailties of old age. In addition, as we approach midlife, an increasing number of us will be directly confronting such issues as our own parents age. However, although we may discuss concerns about the old people in our own lives with close colleagues, we separate this talk from the realm of professional discourse. Fredman argues that such personal experience does and should inform our professional practice.

In this article, we reflect on the growing literature about awareness in dementia and offer some thoughts about integrating personal experience into our work as we endeavour to create contexts for knowing and telling about dementia.

Marion writes:

‘My simplistic conceptions of awareness and dementia were challenged around the kitchen table by observing my mother’s relationship with her memory problems. I date my first awareness of her memory problems to a family wedding in 1996, when she was disorientated whilst at my sister’s...’
house. Possibly other family members would date their awareness to other events. In the beginning she was aware of her memory problem, which was initially dismissed by the GP she had been persuaded to consult. Two years later she was diagnosed with Alzheimer's disease. Around the time of her diagnosis, she would freely admit that her memory was poor and that she had difficulty remembering what was in each kitchen cupboard. She would recognise the diagnosis of Alzheimer's disease when reminded of it. However, she appeared pleased that her condition had a name rather than being dismayed by the implications attached to the diagnosis. She claimed to still be doing the cooking and other household tasks that my father had by then had to take over and seemed unaware that she was no longer doing the gardening.

These observations aroused my curiosity about the different sorts of self-knowledge implied by the concept of insight and why some things may be harder to know than others.

We were curious about the extent to which the professional literature concerning awareness in dementia would reflect our personal and clinical experience. This is a field that has stimulated a great deal of interest in the last few years and a number of recent articles have comprehensively reviewed the literature and research to date (Clare, 2004a, 2004b; Clare et al., 2005; Aalten et al., 2005; Markova et al., 2005) and identify a number of key explanatory frameworks.

Neuropsychological and psychiatric frameworks

Neuropsychological models typically characterise unawareness as an integral part of the organic impairment associated with the dementing process. There are parallels here with the concept of 'anosagnosia' in other neurological syndromes, which is also seen as a specific deficit (Babinski, 1914). Conceptualising unawareness in this way implies that it is a modular and an 'all or nothing' phenomena. Research in this field has, therefore, tended to adopt a neuroanatomical approach, focussing on localising the regions of the brain that may affect the awareness someone has of their difficulties.

Psychiatric and psychodynamic models develop the concepts of 'insight' and 'denial' and have also traditionally suggested that insight is a unitary phenomenon that can be judged as present, absent or partial. Within the psychiatric literature there is a long history of 'lack of insight' as a clinical feature of mental health problems, particularly in relation to psychosis and dementia. Denial is viewed in a number of different ways, sometimes referring to unawareness and, in other models, conceptualised as a defensive, psychogenic phenomenon. Implicit within this field appears to be the assumption that denial of difficulties in dementia (and other conditions) is generally a bad thing rather than a potentially healthy and functional coping mechanism.

One of the problems with research based on ‘all or nothing’ models of insight is that they fail to address the common clinical observation that people with dementia often exhibit awareness of some aspects of their difficulties and that this may fluctuate. Furthermore, as the review articles cited above indicate, much of the early research exploring awareness in dementia is flawed by virtue of widely varied conceptualisation and definition of terms, lack of clarity and assessment methodologies that make considerable assumptions about what is being measured (Clare et al., 2005).

One response to critiques of current professional knowledge is to develop improved research paradigms. For example, recent neuropsychological research has focussed on ‘metacognition’ – the ability to monitor one’s own thinking and abilities – and the potential disruption to this area of functioning in patients with various conditions including dementia (Moulin et al., 2000; James & Moulin, 2002). Such studies have more clearly defined concepts and employ experimental paradigms that reduce other intervening variables.
Psychosocial and relational models of awareness

The above frameworks assume that awareness in dementia is a property of the individual that can be objectively assessed and tend to ignore its relational nature. Awareness is relational in the sense that there is an object of awareness, something of which we are aware, such as poor memory, hallucinations or a partner’s feelings (Markova & Berrios, 2001). It is also relational in the sense that it can only be assessed within the context of an interaction with another person. As such, the subjectivity of the person attributing insight, unawareness or denial to the other may intrude into supposedly objective judgements. To quote Clare et al. (2005, p.395)

‘For one person to attempt to delineate the nature of another’s subjective experience is a risky and problematic endeavour. For one person to attempt to delineate another’s subjective awareness of aspects of individual subjective experience is doubly so.’

This relational or psychosocial dimension is increasingly recognised in more recent literature which considers the potential impact of other people, cultural norms and beliefs and day-to-day experiences on a person’s level of awareness. This links with the work of Sabat and Harre (1992) on the social construction of dementia, which describes the significance of experiences, interactions and discussion with others in the creation and maintenance of a person’s sense of self.

Qualitative methodologies provide a link between such theoretical expositions and the lived experience of people with dementia and their families. Recent qualitative studies have highlighted the impact of social context on awareness in terms of how people choose to describe their situation (Clare, 2002a, 2002b; MacQuarrie, 2005). Such studies have also demonstrated the way in which people can hold competing and apparently contradictory information about themselves at the same time. For example, in her interviews with people with dementia, MacQuarrie (2005) found a consistent theme of simultaneous acknowledgement (e.g. talking about a diagnosis of Alzheimer’s disease) and resistance (e.g. arguing that all old people have trouble with their memory) when people reflected on their difficulties and experiences.

Such strands of qualitative research are now beginning to offer frameworks for understanding the coping strategies that people use to manage the onset of dementia based on a more nuanced and context specific exploration of awareness. They draw from the personal experience of individuals and families and by extracting themes indicate some common processes. As such they add to our professional knowledge base.

Acknowledging the personal experience of the professional

Our clinical and personal experience is also a rich source of qualitative data that, although less articulated and less structured, is not necessarily less valid than the data we find in published papers. In fact, this is implicitly acknowledged by using discussion with a range of people with personal, clinical and research experience as part of the process of validating qualitative data (Clare, 2002a, p.142).

Our personal knowledge relevant to understanding how people may respond to dementia is drawn from many sources. This may include our own experiences of illness, loss and failure and our empathic responses to the stories of others – our sense of how we might react, our thoughts about what we would want for ourselves or a family member in the same situation and our appreciation of how people’s wishes and needs can change rapidly at times of crisis. It also includes cultural factors that impact on our values, beliefs and ways of making sense of events. We may be less aware of these until we encounter different cultures that throw our own into relief and highlight different possibilities.

Let’s consider the example of personal knowledge about what it might mean to seek
help or an explanation for failing memory. Imagine yourself aged 68 now or 15 years ago. Imagine yourself worried about your memory, then and now and ask yourself ‘Do I want to know what is the matter with my memory? Shall I go to the doctor?’ Are the answers different? Would it be different if you were 78? Would it be different if your mother had had dementia? What if you were living alone? Perhaps your answers would be the same in all these suggested contexts but clinical experience suggests that for many people the answers to these questions depends on the context within which they are asked and the possible consequences of the answers.

One significant contextual difference over the suggested time span is the change in culture relating to diagnosis of dementia. Various factors have contributed to this including the establishment of memory clinics, availability of cholinesterase inhibitors and a change in attitude to sharing diagnosis of dementia with sufferers. Although many of these changes relate to professional practice within specialist settings, they have impacted on the willingness of people to come forward for diagnosis and of GPs to refer to specialists. Wider cultural changes have probably also played a role and are reflected in recent storylines in soap operas (The Archers, Coronation Street). The other aspects of context suggested by our questions are more personal and will interact with other individual variables, such as, for example, personal coping styles.

Our point here is that what we know, or wish to know, about ourselves and are willing to tell others depends not just on the neuropsychology of cognitive deterioration but the social, cultural and personal contexts within which we live. As such, our personal knowledge of what it is to participate in such contexts is as relevant to understanding awareness of dementia as our professional knowledges of neuropsychology and psychological processes.

**Personal knowledge, clinical experience and professional blindspots**

It is easy to focus on the awareness of the person with dementia and fail to consider that of other people involved, including family members and professionals. Perhaps this is because awareness is most often highlighted when its absence becomes problematic. However, lack of awareness is by no means unique to people with dementia. Professionals also have blindspots, we make assumptions and are not always aware of the limitations in our perspective when we encounter people from different backgrounds and cultures. Because our position gives us power to make judgements with significant legal and ethical consequences, it is important that we strive to overcome such barriers to our understanding.

Some typical assumptions can be illustrated by reference to the literature and consideration of some of the ways in which awareness is commonly assessed. For example, insight into mental impairment is often ‘measured’ in terms of a clinician’s judgement about whether the person demonstrates awareness of their difficulties, for example on a three point scale. This assumes that a clinical interview is a context in which people are frank about personal limitations of which they are aware.

Another common measure used in the literature is comparison with a carer’s judgement using scores on activities of daily living scales. Here the assumption is that if there is a discrepancy, it is the person with dementia whose appraisal is inaccurate. Alternative explanations could be that the carer is underestimating their partner’s capabilities as a consequence of being depressed or that they are a couple who have never agreed about who does what in the home!

The assumption common to these approaches is that the person making the judgement is able to more accurately appraise the ‘real’ situation than the person about whom the judgement is being made. Years of working with people with dementia may suggest that this is often a good working
hypothesis but the exceptions are also important. We need to be particularly careful of assumptions that may have more to do with distancing, self protection and the maintenance of professional expertise than accumulated clinical experience.

**The meaning of awareness**

Another aspect, that we need to be sensitive to, is the different meaning that people attach to the presence or absence of awareness and the impact this may have on what they wish to know. Consider family members’ awareness of changes in their relation with dementia. Marion writes:

‘Well meaning friends often ask ‘Does your Mum still recognise you?’ I prefer to hover between acknowledgement and denial in relation to this issue so the question makes me uncomfortable, although I attempt to answer as ‘objectively’ as possible, citing the slimmest evidence as indicating that she may sometimes still do so. I was therefore interested to notice in a group for spouse carers, whose partners were in residential care, that they spontaneously and easily acknowledged that they believed their spouses no longer recognised them. It was clear that this related to the different context and meaning of this change for them, as it had predated placing their loved ones in care and appeared to play a role in alleviating some of the guilt they were still experiencing following this decision.’

This example further highlights the relational nature of awareness and reminds us that our theories about the mind of the other are fundamental to human relationships.

**Implications for practice**

What people with dementia are able to know and tell about their difficulties will vary both from person to person and from context to context. As practitioners we need to be mindful of this and engage in what Fredman calls ‘talking about talking’. Such conversations encourage people to reflect on their attitudes towards and experiences of talking about difficult issues and might, for example, explore who they would normally confide in, who they have already spoken to about their concerns and their anxieties about telling other people. These conversations should also involve sensitivity to non verbal or other cues which might indicate that the person is not able to acknowledge their difficulties in this context. It is important that we respect the range of different ways in which people cope and recognise that apparent unawareness may be part of a self protective strategy that enables a person to maintain self-esteem and resist the impact of dementia on everyday life.

For some people, providing different contexts may enable them to discuss their difficulties. For example, a peer support group for people with similar problems may be a situation in which people can begin to explore the meaning and impact of their memory problems (Watkins et al., 2006). Conversely, some common contexts within services for people with dementia may discourage acknowledgement of limitations and needs. For example, in care planning meetings there is often a lot at stake and a great deal of skill is required to enable people to express themselves, particularly when there is disagreement about the best interests of the person with dementia (Dixon, 2002).

Finally, we suggest continually reflecting on the links between the professional and the personal. Each of these sources of knowledge can be used to critique the other and maintain sensitivity and our awareness. This can help us guard against assumptions based on ‘usual’ clinical practice which may not fit for everyone. Drawing on our personal knowledge may also enable us to balance the need to give accurate information with empathic understanding. For example, when discussing prognosis or feeding back memory test results, considering the different ways in which people cope and appreciating the importance of hope, kindness and everyday politeness.
Conclusion
In emphasising the relational and socially constructed elements of awareness in dementia, we are not denying the relevance of neuropsychological factors. Rather we argue for a ‘both/and’ approach which values the significance of a range of perspectives on this important topic and which is able to incorporate the complexities of knowing and telling about dementia.

By valuing both personal and professional knowledges, we can hopefully build on current understanding to improve our clinical work in individual cases and develop a research agenda which will expand the range of professional knowledge available to us. Topics that might benefit from further exploration include understanding when awareness is helpful and when it is unhelpful; cultural differences in perceptions about self-awareness and the role of awareness of self and other in relationships as couples and families face dementia.

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Clare, L. (2002a). We'll fight it as long as we can: Coping with the onset of Alzheimer’s disease. Ageing and Mental Health, 6(2), 139–148.
This is an impressionistic paper about ourselves and those for whom we have, or should have, some responsibility – the elderly; and about how this group is splitting into two, namely, the Haves, the well-off enjoying their the retirement, the ‘third agers’; and the Have Nots, who, not having occupational pensions or property, face a very dismal future and poor quality of life across many years; about what responsibility PSIGE has in this context; and about how the same fissure between the Haves and the Have Nots will also affect clinical psychology.

I first noticed the ‘new lifers’ when I returned to university. After my retirement from the NHS, I thought it would not be a good idea to go from 60 to 0 in one day. Looking around for a suitable activity, I went on a week’s residential course in creative writing. One thing led to another and I applied for a part-time MA in English Studies at Exeter.

What was immediately noticeable in the seminars was a bimodality of age. This aroused my curiosity. About two-thirds were mid-20s, the rest 40s-plus. The 40-plusses, including myself, were retired people, often retired in their 50s, studying for enjoyment and only secondarily, if at all, for career development. The university was welcoming them because they had the several thousands of pounds needed to study. Once their initial anxiety had been overcome, it rapidly became apparent that this group was really enjoying their newly-acquired freedom and purchasing power.

This group of older people, then, were taking full advantage of the post-modern culture, where almost anything is for sale. They had gained greatly from living through the times of a free education and health service; having final salary occupational pensions; the ability of many to get out at 60; and buying into the housing market. No wonder that, in one exercise we did, when asked our perception of our subjective age, all the over-50s saw themselves as much younger. Or that one such, after working all night on an essay, was still to be seen smiling in the morning. Obviously, bliss was it that dawn to be alive, but to be young-old was very Heaven.

But we should not let this new visibility of young old mislead us as to its frequency. There is a much larger grouping of the elderly, for whom these conditions do not apply, and where things are far grimmer – people having to live, now or in the future, on a State pension. Such poverty and poor quality of life can be seen everywhere, but is especially obvious in tourist/second home areas such as the West Country, where the major, in many places the only, industry is tourism. Here, there is no talk of occupational pensions; salaries are low and by the hour; there is the minimal, State-determined, payment for sick leave. All poorer older people can look forward to is the ever-decreasing State pension many years ahead. They have to pray that their health holds up till then. For them, the future is not one of self-development and self-expression; rather, it is one of continual worry about how poor their quality of life is and is going to be.

The sociologist John Vincent has analysed why the elderly have done so badly in terms of changing their social and economic position (Vincent, 1999). One reason is that the Haves traditionally have different goals from the Have Nots. For example, the Haves want tax relief, while Have Nots want better state pensions. Therefore, especially since we do not have Proportional Representation, this divided political voice of the elderly is a weak one. Successive
governments are happy to exploit this electoral weakness, so that although they talked up and published Mental Health NSFs for older adults, they provided no money for its implementation; and the incentives are all for those helping adults of working age.

It is ironic that the Haves do not see their common cause with the Have Nots, for the Haves are, to a significant extent, a time-specific cohort. Already, the new old will be giving up some of their savings to get their children through education and on the housing ladder. Their medical bills will inexorably rise. The value of their pensions will fall. Many will want to budget to buy decent nursing home care. So, in a few years, there will be fewer Haves and a lot more Have Nots.

Where does all this leave PSIGE? Flicking through the latest Clinical Psychology Forum, I came across Nicky Bradbury’s: ‘Approximately 18 per cent of the population is over 65 years of age, a 2003 census of NHS Clinical Psychologists found that a mere 6.3 per cent of sessions worked in a four-week sample period were with older people.’ One of the motivations behind the creation of PSIGE was to work to decrease this inequality, so that older people had equal access to psychological services. It is, therefore, clear that we have failed.

However, our failure is not just quantitative. It is hard to believe that the quality of life in residential units for older people has improved in PSIGE’s lifetime. Certainly, I know of no research that shows this to be the case. I recently re-visited the Monkey Sanctuary at East Looe, Cornwall. I can thoroughly recommend it as a sobering experience to any PSIGE member. The comparison is not quite as far-fetched as it might seem. The colony was created when woolly-haired monkeys were kept as pets. They no longer are, and the Sanctuary decided that breeding was unethical. So the population is actually of quite elderly monkeys. But in no way does this affect the dedication and individualised care, respect and relationships between staff and monkeys. Perhaps it has increased it, for the death of or even injury to a monkey has clearly been a deeply upsetting experience for the staff. I would challenge readers to visit the Sanctuary and then not to agree that the care is far superior to any you would find in almost any unit for older people.

Perhaps it is unfair to expect that PSIGE could ever affect social attitudes and economic investment. But is this true? Ageism, compared to racism, on the television is manifest. Whereas there clearly has been effort made to promote Asian and Afro-Caribbean newsreaders and presenters, name one person clearly over 65 who fronts a programme of any note? In the time that PSIGE has been going, the position of gay men and lesbian women, of women generally, of physically handicapped people has also become appreciably more positive. Occupational racial discrimination, likewise, is illegal and has probably decreased. In contrast, it is hard to see that the position of old people has improved. The increasing privatisation of services and the decreasing value of pensions would argue against such an assumption. In fact, it is likely that their situation will worsen. Thus, the position and well-being of minorities can change. Political change is achievable. These positive changes have been achieved by pressure groups working for and within the various minorities mentioned above.

This being the case, why has PSIGE, whilst publishing articles on the topic, been so uninterested in helping their client population achieve an improved quality of life?

The sin is not just one of omission. The primary growth area in the last decade in clinical psychology of the older adult has undoubtedly been the assessment of dementia. Even assuming the term has any validity, incidence is five per cent of the over-65s. By our positioning of our profession, and by what our articles in this and other journals are concerned with, by what our conference symposia are concerned with, we are actually supporting and maintaining a very negative stereotype of our client population.

Mike Bender

PSIGE Newsletter, No. 95, July 2006
Our profession is distorting the range of therapeutic inputs that it should be making available to the vast majority of older adults and highlighting probably the most stigmatising aspect of age-related illness.

It is perhaps not difficult to see why, functionally, this should be the case. By maintaining the elderly as sick and dependent, we can justify increased number. If we turn to our profession’s well-being, looking at the growth in PSIGE membership, we can see that clinical psychology has done quite nicely out of the elderly over the last 25 years. So perhaps the energy has gone into seeking new posts. Whatever the reasons, they do not explain the lack of interest in improving the situation of a group that everyone, from Sans Everything – A case to answer, published in 1967, has for years agreed is shame-makingly poor.

There is an interesting piece of research to be done on the strong religious commitment of many of the founding members and early leaders of PSIGE, and it may be that religion and activism don’t mix. The avoidance of ethical commitment – dressed up as the search for objectivity – is true for British psychology and we were all inducted into this attitude. Roberts’ (2006) article on the avoidance of discussion on the Iraq war in Clinical Psychology Forum, in contrast to discussion of its effects in medical journals, is telling.

It is also clear that our best chance of changing the situation is probably past, or at least made very difficult for the next few years. The drastic staff cuts we are seeing in the NHS, and the focus on people in work, or getting them back into work, is implicitly ageist. Even if we all work till we die, the older adult will inevitably have more sickness and disability than younger people, and if the goodies are only available to those in work, this emphasis has to be age-discriminatory.

I have talked of the Haves and the Have Nots among the older population. It seems clear that society, in general, is moving towards a few relatively well-paid jobs, and an awful lot of low-paid ones. Clinical psychologists will be on the well-paid side of the divide. There are two problems here. The price for being on the ‘right’ side of the divide will be high. The professionals’ use of time will be increasingly monitored and the tasks to be done in that time increasingly defined – to the detriment of creativity and job satisfaction. The use of assessment in its negative role of gatekeeping scarce resources will increase; and with it, the pointlessness of those assessments, as demand for services increases due to the ageing population and an ever smaller percentage of the cohort receives the services their needs require. Secondly, the social position of being one of the well-off will become more problematic. The problem with this kind of society is that it is not in equilibrium. As Raymond Williams (1965) has pointed out, societies, if they are to be peaceable, require a consensus across social classes on the fairness of the distribution of resources. Where this is not the case, then, rather like its Victorian predecessor that it increasingly mirrors, the status quo will have to be maintained by force – to use a term of Hechter’s (1975) – by internal colonialism towards the restless natives. The well-being and the wealth of the Haves will have to be increasingly actively monitored and protected from the Have Nots, for example, living with heavy security, till we reach gated estates, with security guards; moving our children to selected schools where the social mix is more restricted; ensuring all members of our families carry mobiles at all times; carefully ensuring that the transport – car, taxi – you use gets you to your door, so that you avoid walking in the open. There are, therefore, real economic and emotional costs to clinical psychologists espousing, implicitly or explicitly, such an unequal distribution of resources.

In Victorian times, there were strong political movements, such as Chartism and Socialism, to channel the Have Nots’ demands for change. Today, we have much less faith in such movements, perhaps because people feel that we are not controlled by our governments but by multi-
nationals. However, without such safety valves, acts expressing discontent about this divide are likely to seem more ‘mindless’ and ‘senseless’ to the Haves. And the situation may be worse now than in Victorian times. Television and advertising implicitly suggest that we have a right to the goodies of life. Except that for an increasing proportion of the population, they’re out of reach, and always will be.

Clearly, this situation has no easy solutions. For those who need our services, the future is increasingly bleak. For ourselves, we surely cannot define our professional achievements in terms of change on scales measuring diagnostic categories. Limiting ourselves to the DSM framework, for example, by giving priority to RCTs using such categories, is to contract into a system that has little research validity, and that is socially and individually toxic (Kirk & Kutchins, 1992; Breggin, 1993; Johnstone, 2000; Bender, 2005). Surely, our professional mandate has to be the improvement of our clients’ quality of life. This quality of life requires the satisfaction of their basic needs and thus clearly has a political and economic underpinning. Therefore, improving our clients’ quality of life involves political change. We in PSIGE have to disown the Society’s deliberately bland ignoring of the economic and political realities underlying well-being. The prime role of PSIGE, I suggest, should be to spell out loudly and clearly to politicians the changes needed to alleviate the psychological needs of their client population; and develop skills in getting such messages across. Such messages, because of the feared cost implications, may be most unwelcome and be received with hostility or indifference but that is no reason for not undertaking our ethical duty. If this line of action were to be pursued, we would need to link with other organisations to create a more powerful momentum than we could achieve by ourselves. I am sure we could find many allies. However, even if that were not the case, I am suggesting that, in terms of discharging our responsibility towards the older members of our society, we certainly should attempt it.

The 25th anniversary of PSIGE gives members the opportunity to look at where the organisation is going, because, at present, it is part of a grossly divisive and unfair distribution of resources, which is damaging the quality of life of those for whom we claim expertise. It can reasonably be asked whether PSIGE represents the best interests of the older population, or only those of its own members. And if that is even partly the case, whether despite the inherent difficulties, we need to seek a newer world. If this article can spark a debate, that would be a small start.

I should like to thank Alison Bender, John Vincent and Tony Wainwright for their comments.

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References
Development in Later Life.
More than Everybody's Business

An East Anglian conference on the 10 October 2006 at Ipswich Town Football Ground

‘When something more than something more is needed’
Anthony Ryle

The NHS is trying to reduce discrimination and increase inclusion, including age-discrimination and age-inclusion. ‘Everybody’s Business’, ‘Next Steps’, ‘Your Care. Your Say’ are all part of this. Within all this there is, however, a covert age discrimination which favours those of working age and ability. In order to understand that we need a much broader understanding of what we mean by ‘old age’ and what it means to maintain and progress a well-informed and evidence-based specialism of later life in a modernised mental health service. This conference brings together some of our leading researchers and clinical practitioners in gerontology and psychogerontology to help us with this. Ms Lindsay Royan, Consultant Clinical Psychologist, North East London Mental Health Trust, is our Chair for the day.

PROGRAMME

Dr Ken Laidlaw is Consultant Clinical Psychologist (Professional Lead), NHS Lothian and Senior Lecturer in Clinical Psychology, University of Edinburgh. Dr Laidlaw will explore the conceptual basis for our specialism, through the lens of the UK/European sociopolitical perspective that fuels national and international despair in later life.

Dr Hepple, Medical Director, Somerset Partnership Trust and Cognitive Analytic Psychotherapist, will explore ageist and reverse ageist reciprocal-roles, through which he effectively re-formulates ageism within an interpersonal understanding.

Prof. Alan Walker is the Professor of Social Policy and Social Gerontology at the University of Sheffield, and Director of the New Dynamics of Ageing Programme and European Research Agenda in Ageing. We will hear about the quality of later life as it is being lived currently from the perspective of older people.

Prof. Peter G. Coleman is Professor of Psychogerontology, University of Southampton. Prof. Coleman will be talking about the nature of growth and development, and its associated domains of research, in later life and extreme old age, as a counter-point to the current over-emphasis on decline and loss.

Dr Laura Sutton is Consultant Clinical Psychologist, Suffolk Mental Health Partnership NHS Trust. Dr Sutton will consider the recovery of mental health through some of the hardest challenges of mature adulthood in an ageist context.

For further information or application form please contact Sara Hyde, Business Manager, Education & Workforce Development, 1st Floor, St. Clements Hospital, Foxhall Road, Ipswich, IP3 8LS, or telephone 01473 329286. The conference costs £80, and is hosted by Suffolk Mental Health Partnership NHS Trust, with sponsorship from PSIGE.
The Wadebridge Memory Bank Group and beyond

Mike Bender

This article is to celebrate the first two years of the Wadebridge Memory Bank Group, a support and self-help for people in North Cornwall diagnosed as suffering from dementia. I will then outline possible developments in that area.

When I retired from working full-time, after a little while, I was grateful not to have to do much of the routine work I had had to undertake. However, there were one or two bits of ‘unfinished business’. One of these was a support group for people with cognitive losses. Yale (1995) had written about setting such groups up, but they were time-limited and she seemed to spend much of the book worrying about careful selection. What I wanted was one that had simple admission criteria; that met frequently; in which the member was the only person who could make the decision to leave; and most crucially, that was ongoing. (The cruelty and lack of ethics in setting up a support group for the purposes of a research grant and then stopping it as soon as enough data has been gathered, leaving the members unsupported and grieving, has long appalled me. There is no reason why ongoing groups cannot be used for research purposes, so there is no excuse for such wanton cruelty.)

There are two major reasons for expecting such a group could and would be a major source of support and encouragement to its members. Firstly, Snowdon (2001) in the Nun Study, shows that the plaques and fibrules, characteristic of Alzheimer’s, are not cognitively damaging per se. They require activation by a cerebral vascular event. This means: (a) we can be more optimistic, since we have at least a partial technology and knowledge base to decrease the frequency of CUEs; and that (b) there is not a primary condition of Alzheimer’s disease, which thus suggests the whole field of cognitive loss requires rethinking (Bender, 2003). Secondly, assuming there are organic processes causing cognitive deterioration, surely their effects can be lessened if we minimise the secondary effects of that condition – depression, loss of self-esteem, anxiety, etc.; and also (try to) prevent it reinforcing the sense of worthlessness of being an older person in our society?

With helpful advice and encouragement from Tony Wainwright, Director of Psychology, and Lesley Beresford, Team Leader, North and East Cornwall, I ended up at an exploratory meeting in a GP practice, with Joy Williams, the CPN, who worked in the surgery. I had thought of talking in terms of running a therapy group. But I was mindful of a maxim given to me by my long-time colleague and fellow group worker, Ron Wood, that the hardest thing in group work is to get enough people to the starting line together. I thought that would-be members might be reluctant to agree to attend something described as a therapy group. It therefore seemed sensible to say we were seeking to run a 12-session psycho-education group, with each session led by a speaker, which would then transmute into a support group. This was agreed by the practice, so we had access to an ideal location – a newly-built, non-psychiatric building used by lots of people with all sorts of needs, in a magnificent setting – a room that looks out on the River Camel as it flows down to Padstow and the sea, with swans, oyster catchers and other wildfowl feeding on the low-tide mudflats. The meeting room can be divided into half for subgroup working.
I was especially lucky with my colleagues. Many locality teams engage in little long-term work, saying that they are working within a problem-solving approach, despite such an approach’s manifest unsuitability to chronic illness and pain – I use ‘pain’ here in the emotional, as well as the physical, sense. People with such conditions need a named worker, who is readily available, but the intensity of whose input varies depending on the state of the condition, and the occurrence of other life events that are causing distress. So, such a case may require routine monitoring, the occasional phone call, for months and then a period of intensive input, then a decrease, etc. What is necessary is the availability of a named and known worker. I was very lucky that in North Cornwall, the EMHT worked in this way, and this allowed an ongoing group to be an attractive way of monitoring and supporting clients.

We started with seven members, six of them men, using the criteria that they had been diagnosed by a psychiatrist as having dementia, and were on the caseload of one of the EMHT; and two professional staff – one OT experienced in groupwork, Gilly Constance, a CPN, Brenda Harris and a HCA (health care assistant), Marilyn Goddard, who had the ability to make members feel incredibly welcome with a cup of tea/coffee and biscuits as they came in. We know this from the end of term Evaluation. (Regarding biscuits, Garibaldis – squashed fly biscuits – provide that touch of class that makes one feel valued!) The group convenes around 10.15 with coffee, and is not called to order till around 10.30; and then runs without a break till 12.00.

We aided attendance in the first group by a reminder phone call on the morning of the group. The group has always met on a Friday morning since its start. The members are always sent the minutes of the last session before the next one, which reminds them of the next one and keeps relatives, if they are shown them, abreast with what is going on. Relatives have an interest in their family member attending, since this gives them a morning to themselves. Along with the longevity of the group, all these factors have now lessened the need for the reminding phone call. Indeed, phone calls tend to be made to stop members leaving too early for the group.

A psycho-education group, given the speakers can deliver their points in a suitable manner and come across as involved and concerned, really should not fail. As Table 1 shows, the attendances were very good and have stayed that way across seven terms. (We like the word ‘term’ as it means that newcomers, perhaps uncertain of the benefit, are only making a time-limited commitment; and its echoes of school suggest the positive implications of learning.)

Table 1: Attendance of members and staff for each term.

<table>
<thead>
<tr>
<th>Term</th>
<th>Number of sessions</th>
<th>Numbers of members</th>
<th>Percentage attendance by members</th>
<th>Percentage attendance by group facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring, 2004</td>
<td>10</td>
<td>7</td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>Summer, 2004</td>
<td>11</td>
<td>8</td>
<td>81%</td>
<td>94%</td>
</tr>
<tr>
<td>Autumn, 2004</td>
<td>11</td>
<td>7</td>
<td>86%</td>
<td>91%</td>
</tr>
<tr>
<td>Spring, 2005</td>
<td>10</td>
<td>8</td>
<td>79%</td>
<td>87%</td>
</tr>
<tr>
<td>Summer, 2005</td>
<td>9</td>
<td>8</td>
<td>78%</td>
<td>93%</td>
</tr>
<tr>
<td>Autumn, 2005</td>
<td>10</td>
<td>8</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Spring, 2006</td>
<td>12</td>
<td>9</td>
<td>80%</td>
<td>89%</td>
</tr>
</tbody>
</table>

PSIGE Newsletter, No. 95, July 2006 29
Each term, of about 12 to 14 weeks, starts with the group re-forming and deciding on the content of the sessions of the term; each term ends with an Evaluation session led by myself. (This allows a little more distance than if the facilitators led this session; and allows me to hear the feedback.) The group is reminded of the content of the previous sessions; then split into two groups, each led by a facilitator, to consider and report back on three questions: What was good about these sessions? What was not so good? What changes would they like to see? The reason for framing criticism into a positive form ‘not so good’ is that we have learnt from experience that older people will not readily risk loss of service by criticising it. As we have discussed and shown in our articles for the Journal of Dementia Care (Bender & Constance, 2005, 2005a), the feedback has invariably been sharp and incisive. The following week, the session time is used for an ‘end of term’ lunch at a local restaurant to which members can bring their relatives.

The problem at the end of the first term was how to move from education group to support group. The members liked the structure of a topic, and when the topic concerned medical or cognitive aspects of ‘dementia’, this gave them hope, which Yalom (1995) defines as one of the key ingredients of successful group therapy. For three ‘terms’, we did go along with the members’ wish for a structured topic each week, although by the end of this period, many of the sessions were being taught by the group facilitators.

However, the structured, topic-based format had the effect of members having less opportunity to explore their situation and realise that they had the ability to help each other. Given the members’ liking for structure and they have the final say in the initial topic-setting meeting of each term, change had to be gradual. For the next two terms (the fourth and fifth), we, therefore, suggested that there be a topic every second session, the following session being used to recapitulate the main points the speaker had made, and look at how these affected the members’ lives and well-being. This seemed logical, as people with problems with memory and retention would benefit from greater time to discuss a topic. This was well-received and encouraged us to a further initiative. In the sixth term, we moved into a three-week cycle, one with a topic, the second to discuss it, as before, and the third initially called ‘problem solving’. The idea here is for the members to review their lives over the last three weeks and communally discuss problems. However, this title was uncomfortable as it implied that our members must have problems. We have, therefore, re-named this session ‘Reflection’, while keeping the same goal.

This move seemed more risky in terms of member reception, but here we had a piece of serendipity working in our favour. As indicated earlier, members could only resign from the group (or die); they could not be excluded from the group. Of course, between ‘terms’, their key worker could discuss with them whether they were enjoying the group. In this way, one woman was able to resign, saying that her dysphasia was getting so bad that she was finding the group frustrating. Two male members died while still members of the group – demonstrating to group members (and to ourselves) that the group can support people almost to the end, as opposed to the common belief that the ‘inevitable progress’ of dementia would make participating in a group an impossibility long before death. A fourth went in a residential home and lost touch with the group. Three of their replacements were women, so that as we moved into the three-week cycle, for the first time, we had a small group of women members. They undoubtedly helped make the Reflection sessions a success, because they were more prepared to self-disclose problematic or sad-making issues. (This stronger voice shows the correctness of Yalom’s (1995) dictum that one should always have two or more of a minority group, if possible, in a group. We were mindful of this, but it took time.)
There were various reasons for this success. By the fifth term, the facilitator group had stabilised, being Gilly Constance, the OT there from the beginning, and Joy Williams, the senior CPN, who provided active support from the start and co-led the second term, and then was a permanent presence from the fifth term onward. I usually take the first and last (Evaluation) session and one of the teaching sessions. I have taken the Reflection sessions in the last term, since the facilitators tend, on occasion, to come in with solutions, rather than let the members explore the issues. However, I am working to hand over this role in the next term. Visitors can only attend if agreed by the group in advance, and, if they are students, we like them to attend for a few weeks, not just as a one-off. Facilitator stability and cohesion provide a familiarity which I think members value. Also, I had provided two supervision sessions during each term from the start, but these had taken place immediately after the session, which was not really satisfactory, as people were mindful of their next appointment. We have now moved supervision to a different day and this has proved much more satisfactory.

The push towards Reflection sessions was partly fuelled by the belief that at least some of the difficulties that people with the diagnosis of dementia have is because they are ashamed by their diagnosis. Of course, ‘dementia’ is not the only shaming diagnosis in our society. Various forms of cancer, for example, bowel cancer, are similar. The release of energy of gay men coming out, and their political and legal achievements since then, is indicative of what can happen if people release themselves from shame. Breast cancer is another example. Much of the power of Christine Bryden’s Dancing with Dementia is her forceful ‘coming out’ as a person diagnosed with dementia, along with her colleagues in the Dementia Support and Advocacy Network International. Yet, if you read almost any article on dementia, the authors rush to assure you that the names they are using are pseudonyms. I am sure that, while the aim is to protect, this is short-sighted, because it prevents the people diagnosed with dementia from seeing their achievements and successes being attributed to themselves, so that they can show them to relatives and friends and say (if only to themselves) ‘That’s me. I did that.’ Imagine writing an article, and an editor soothingly suggesting that it is published under a pseudonym! It was for this reason that I got agreement to use real names in our Journal of Dementia Care (JDC) articles; and in the one we’re writing on the second anniversary, all but one member has agreed to be in a group picture with real names.

Once you start to think about honesty and openness, you notice a strange thing about therapy articles. They never give the age of the therapists. But it doesn’t need Einstein to work out the dynamics of a group led by two 20-year-olds (daughters? granddaughters? to the members) will be different from one led by two 50-year-olds (authority figures? parents? sibs?); or even more interesting, one led by a 50-year-old and a 20-something trainee (dirty old man? toy boy?) etc. We, therefore, decided to put the age of the facilitators in one of our JDC articles. You can hardly ask the members to be open, if the therapists aren’t. All the members were given copies of the JDC articles, so this was a small gesture of openness by the facilitators, witnessed by the members. In the same way, we start each group with ‘a positive event that you at least partially brought about’ (trying to activate Agency – that people diagnosed as demented can have some control over their lives). The facilitators, as part of the group, are part of this round, telling of rooms painted, children’s birthdays, etc.

We are continually taken aback by two features of the group. Firstly, how much members remember of previous sessions – including details that we had not paid attention to or forgotten. It is clear that, when material matters to the person with cognitive losses, retention is significantly improved.
A second important and positive feature of the group, is the high degree of participation and decision-making. One obvious example is that we had initially called the group by the deliberately bland title of ‘The Wadebridge Group.’ Members objected to this blandness, so we asked them to go away and come back with suitable names, a task they took on enthusiastically. A vote was held between five alternatives that they had come up with and ‘The Memory Bank’ was the clear winner. This is far from being the only example of the members improving their own group.

Members have volunteered/been asked to lead sessions. Mary has done a ‘What’s on in Wadebridge’ session, which fitted in with our drive for members to maintain an active social life. Trevor did a detailed account of how to get from one side of the county to the other by public transport – by no means, an easy or simple process! Gilly had given a talk on Life Story books, and some time later, Pat gave a talk on how he had created his; and this inspired other members to work on theirs – the group facilitators will help if asked. (Pat and his wife have also addressed the Diversity Steering Group on his experiences as a service user in the NHS.) On another occasion, Roy talked about his experience of short stays in a residential unit. This was groundbreaking, as the group had previously shied away from considering the time when they may need to go into care; and probably could only look at the issue because it was being presented by a member.

The discussion of topics at the beginning of each term is a lively business. Obviously, the group facilitators have ideas about where they want the group to go. It is their clarity of purpose that makes the group a predictable and safe environment. Of course, some of our suggestions are vetoed. Taking part in research – qualitative or quantitative – is anathema to some of the members. Palliative care is another area which they prefer to avoid. This is their right; and it does not mean that the topic will never be discussed. Membership changes – I have already commented on the positive effect of having a stronger female voice – and the group grows in confidence. For example, when difficult matters have been discussed at meetings, members have felt stronger. A final example of member participation was when we had a full house for an Evaluation session, but the meeting room had, for the first time ever, been double-booked. Half the group quickly agreed to do their evaluation in a nearby café. Such positive changes motivate the group leaders.

The model has attracted national interest after the publication of two articles in the JDC in the Spring of 2005. In Cornwall, memory clinic staff in a number of localities have run groups for clients who have been assessed; but these are time-limited, education groups.

I am sure that we have demonstrated the utility of an open-ended group – at a minimum, it is an efficient way of monitoring changes in eight clients – and that there is the unmet demand for more long-term groups.

Some of our members live near Bodmin. Even if they preferred to stay with the Wadebridge group, I am convinced that if we started a second group in Bodmin, there would, within a short time, be sufficient demand. For areas where there is no such group, groups could be started with little difficulty, as long the issue of transport is competently tackled.

The problem, of course, is staffing. Each group requires two facilitators and a HCA. The HCA deps up when one of the facilitators is on leave; and also helps with coffee, and transport. I am confident that the HCAs could play a larger role, if Gilly and I were allowed to run a training course on group-work with follow-up supervision.

One reason for wanting to set up a new group was that it would allow us to negotiate a contract with members of the new group whereby there was a research input. The present members are given the Mini-Mental every six months, as part of their clinical monitoring; but it would be good to chart
level of self-esteem, quality of life, and network strength and harmony; and also to plot changes in these variables with events and processes going on in the group (We give other researchable variables in our 2005a article.) We deliberately did not seek such a contract when setting up the first group, as we wanted to get the therapeutic side of things sorted out first, and feared that wearing two hats – facilitators and researchers – might lessen the chances of the group succeeding; but now we know that we can offer a nourishing and valued group, we have the confidence to ask for agreement on a research input from the members of a new group, were the opportunity ever to arise.

The variables I have specified above are relatively easy to measure and to monitor over time. I think there is a more basic reason for running an ongoing group which is harder to operationalise. This is that the group offers a weekly, unconditional, statement of your worth, independent of your cognitive losses, which allows you to utilise your resources. Without such a group, as in perhaps Alcoholics Anonymous, there are no handholds to stop you slipping into an abyss of terrifying low self-esteem and helplessness.

Ideally, it would be good if more staff wished to run groups, so that there could be a slow turnover (and over time, return) of facilitators and of supervisor.

There is no reason why this group cannot continue for many years. Replenishment of members will come through GPs and the local consultant. The two main risks are: (a) an insistence that members make their own way to the group, which would be practically impossible for a number, given the lack of bus services; and (b) the over-reliance on the two key facilitators, Gilly and Joy. If one called it a day, that might make life difficult. If both were moved, or had to give up for some reason, they might prove impossible to replace. The low status and value given to groupwork, despite the fact that research has consistently shown that it is at least as effective as individual work (Yalom, 1995; Bender, 2004), remains, and remains a threat.

Some years ago, I was driving back from a visit in Cornwall with a trainee. As we proceeded slowly towards the Tamar Bridge, he commented ‘You’d only work here if you were semi-retired or had a damaged personality.’ I let it pass, though I’ve often wondered since if I was included in this summary, and if so, which count I came under. But there is a third reason, which is the willingness to try new ideas.

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References
The dominant approach to understanding dementia has for many years been the organic, or medical model. More recently, however, clinicians and researchers have recognised that this model ignores both the experiences of the person with dementia and their place within a social world (e.g. Harding & Palfrey, 1997; Cheston & Bender, 2003). Along with the recognition of personhood and subjectivity has come acknowledgement of the need to find ways of empowering people with dementia to find voices to express their thoughts, feelings and needs, reflecting the emphasis in community care legislation (DoH, 1990). Furthering the understanding of the experience of living with dementia provides a foundation on which to provide adequate and appropriate care based on a person’s actual, rather than perceived, needs (Wilkinson, 2002).

Several authors have suggested the use of a longitudinal approach in dementia research, which aims specifically to capture the process of change over time (e.g. Clare, 2003). Longitudinal studies exploring the experience of dementia are scarce, and the current study has as its aims to elicit people’s understanding of the development of their emerging memory difficulties.

Three participants, all of whom were on the waiting list for a memory assessment at a memory clinic were recruited. None of them, therefore, had a diagnosis of dementia at the beginning of the study. It was hoped that their understanding of their memory difficulties could be explored prior to the assessment, as well as identifying any new meanings that might emerge following a diagnosis. Qualitative data were obtained by means of separate interviews with participants and their partners. The interviews focused on participants’ understanding of their memory difficulties, the impact that their memory difficulties had on their lives, and their hopes for their forthcoming memory assessment. Participants were re-interviewed a number of weeks later after they had had their memory assessment and this interview had as its focus whether participants’ understanding of their difficulties had changed as a result of the memory assessment. Although the partners’ interviews were not analysed for the purpose of this study, they did provide an interpretative context for the analysis of the participants’ transcripts, and allowed for the triangulation of the interviews.

The interviews were transcribed and analysed using Interpretative Phenomenological Analysis (Smith, 1996; Smith et al., 1997; Smith et al., 1999), an approach that aims to explore the participant’s view of the topic being investigated and remain close to that perspective. The interpretative element acknowledges that the researcher plays an active role in the research, with the participant’s perceptions being elicited through a dynamic, interactive process.

Results
Throughout the results, the notion of uncertainty emerged as a meta-theme. Although most frequently mentioned in light of not understanding what is happening in terms of their memory difficulties, it also has an impact on people’s identity. This meta-theme contained within it three sub-themes (See Table 1 below):
In analysing the interviews that were conducted following their assessment at the memory clinic, it became apparent that there was a divergence of experience that was, in part, dependent on the outcome of the memory assessment.

**Discussion and future directions**
The aims of the current study were to elicit people’s understanding of the development of their emerging memory difficulties, and how this understanding develops over time. In analysing the results of the current study, a meta theme of uncertainty emerged, which appears to mediate people’s understanding of their difficulties, as well as their sense of self. Although there is little research exploring the nature of uncertainty in the context of memory difficulties, the concept of uncertainty has been explored in the context of illness (Mishel, 1981). The theory of uncertainty in illness describes uncertainty as a cognitive stressor, and emphasises the importance of structured information, assistance and support from the health care environment. Research within the field of chronic illness is consistent with the idea that uncertainty has a considerable impact on people’s ability to come to terms with their situation, and to incorporate the ‘illness’ into their identity.

**Table 1**

<table>
<thead>
<tr>
<th>Themes prior to memory assessment</th>
<th>Themes post-memory assessment</th>
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<tbody>
<tr>
<td>Meta theme of UNCERTAINTY</td>
<td></td>
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<tr>
<td>Trying to make sense of the memory difficulties</td>
<td>Continued search for meaning</td>
</tr>
<tr>
<td>Impact of the memory difficulties on identity</td>
<td>Change in identity</td>
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<tr>
<td>Impact of the memory difficulties on relationships</td>
<td>Experience of assessment</td>
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**Table 2: Summary of themes.**

First interview (before the memory assessment)
Three super-ordinate themes emerged from the interviews prior to the assessment:
1. *Trying to make sense of the memory difficulties* illustrates participants’ struggle to understand what is happening to their memory, and outlines a number of explanations that they have arrived at themselves.
2. *Impact of the memory difficulties on identity* captures participants’ identity in light of their memory difficulties, and reflections on their sense of self before the onset of memory loss.
3. *Impact of the memory difficulties on relationships* describes how the onset of the memory difficulties has affected the relationships with those around the participants.

Second interview (after the memory assessment)
The analysis of the interviews after participants attended for their memory assessment produced three super-ordinate themes:
1. *Experience of the memory clinic*
2. *Continued search for meaning*
3. *Changing identity*
Social constructionist ideas are useful in considering the climate in which people create meanings, as they explore the dominant discourses of societies, as well as of individuals. In Western culture, medical knowledge is held in high estimation, and accurate diagnosis of medical conditions is the gold standard. However, in the field of memory difficulties, diagnostic accuracy is less assured, indeed a diagnosis of Alzheimer’s disease can only be given at post-mortem (Curran & Wattis, 1989).

This raises important questions about what people are told about the outcome of their memory assessment. Mild cognitive impairment is, in most cases, a pre-cursor to a diagnosis of dementia (Rasquin et al., 2005). Research has found that those who have been told their diagnosis have found it helpful (e.g. Husband, 1999) and that a diagnosis can provide an end to the struggle with uncertainty (e.g. Gubrium, 1986). For individuals who show ability and a desire to know their diagnosis, withholding their diagnosis may contribute directly to their feelings of distress (Pratt & Wilkinson, 2003). However, it is evident that in this study that the diagnosis of mild cognitive impairment was not always meaningful to participants, particularly those who were keen to have an explanation of their memory difficulties.

A number of conclusions can be drawn from the current study that may be useful for clinicians working in this field to bear in mind, both in memory clinic settings and for assessments carried out in the community. People living with memory difficulties face a high degree of uncertainty, which does not always appear to be alleviated with a diagnosis of mild cognitive impairment. Information, given in writing, about what this diagnosis means for the individual may be helpful. This is in line with research found by Moniz-Cook et al. (1998) that found that increased information about diagnosis and prognosis was associated with increased partner well-being and improvement in the cognitive well-being of the individuals with memory difficulties, compared to those in the control group. Equally important would be the inclusion of practical memory management techniques, both for the individual and for his/her partner or carer to provide strategies for how the current symptoms may be managed.

Given that this study has demonstrated the diverse and individual nature of the development of memory difficulties, care should be tailor-made to reflect people’s differing needs, specifically about people’s expectations of their memory assessment and potential diagnosis. One way that this could be achieved is to offer pre- and post-assessment counselling by someone who is not biased towards individuals attending for the assessment. This may eliminate the uncertainty that health professionals feel as to what to tell individuals about their diagnosis (Keightley & Mitchell, 2004) as well as the uncertainty demonstrated in this study.

Finally, health professionals giving voice to the uncertain nature of memory difficulties may validate clients’ concerns, and connect with clients’ own feelings of uncertainty and anxiety. For some this could reduce the desperate search for a meaning that was evident in the current study. Acknowledging the uncertain and often fluctuating course in disease progression is a model employed by giving a diagnosis of HIV/AIDS (e.g. Remien & Rabkin, 2002).

In summary, for individuals experiencing the development of memory difficulties, uncertainty leads them to search for an explanation of their difficulties. The impact of a memory assessment is useful for people who feel that they have the explanation that they were looking for, but for others it does not end the quest for a meaning. By validating this sense of the unknown future, whilst giving concrete memory management strategies, health professionals may assist individuals to come to terms with an identity that incorporates their memory difficulties. Such a small study cannot attempt to produce generalisations in the sense that larger quantitative studies can. However, arguably the value of qualitative research is...
to connect with clinicians’ experiences and to foster connections and insights into areas of clients’ experiences. What is evident, from this study and from other studies that are emerging, is that in-depth, qualitative research provides the opportunity for the voices of this marginalised group to be heard.

References

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In October 2005, the wards and day hospital for older people at Barrow Hospital had to close at very short notice. The hospital was built in the 1930s several miles south-west of Bristol. It was used as a military hospital during the Second World War before being opened in 1947 as a self-sufficient mental health hospital serving the Bristol area. In recent years, use of the hospital has declined, with several boarded-up buildings falling victim to vandals, and staff struggling to provide modern mental health care in buildings designed in a previous era. Despite these difficulties and the reputation associated with the hospital’s name amongst inhabitants of south Bristol, it was appreciated by many for its peaceful countryside location. Barrow Hospital was built amidst ancient woodland, with bluebells, squirrels and occasionally deer observed amongst areas of beech and ash trees. For this reason, the decision to close the hospital and relocate mental health services to a new purpose-built unit in a more accessible and urban area of south Bristol was met with mixed feelings by both service users and staff.

The hospital was scheduled for closure in June, 2006. However, a series of events precipitated the closure of services for older people nine months early. Firstly, levels of legionella bacteria, which can lead to the development of Legionnaires Disease, were found within the hospital water system. This led to concern for older patients who might be at higher risk of contracting the disease, particularly those with other health conditions, such as chronic lung disease and conditions leading to a compromised immune system. Secondly, on a Friday lunchtime in October, 2005, a section of ceiling collapsed in the dining room of one of the two wards for older people. This event, described in the local press as ‘the day the sky fell in’, resulted in a number of minor injuries as well as a great deal of distress for those sitting beneath the unstable ceiling, shocked by this unexpected interruption to their lunch. A further consequence of this event was the decision to immediately close the ward, followed by the closure of the second ward and day hospital for older people within a fortnight. Services were relocated to Southmead Hospital in north Bristol. Temporary wards were swiftly created in corridors previously used for offices, and the day hospital combined with an existing one on the Southmead site. Other staff, including psychologists, moved to a community team base. In June, 2006, all of these services relocated to Callington Road Hospital, newly built in south Bristol. This unexpected and quick relocation of services has led us to consider the possible psychological implications of such a move on staff. Local psychologists have been involved in facilitating support groups for staff involved in the hospital closure. Our reflections have drawn to some extent on these groups as well as our own experiences of a sudden change in working environment.

Much has been written about the closure of old psychiatric hospitals and the move towards community services. However, the literature has tended to focus on the experience of closures carefully planned over a long period of time, as opposed to a sudden, unexpected closure such as that which occurred at Barrow Hospital. Research has found that staff may feel unsupported and anxious about possible redundancy or a change in role (Massey, 1993), and experi-
ence feelings such as ‘alarm, anxiety, anger and guilt’ following news of a hospital closure (Massey, 1994). Stress levels may be particularly high when relocation involves a sense of lack of control or choice (Dimmick & Hirons, 1994), as was the case at Barrow Hospital. Massey (1994) identified this process as particularly difficult for nurses who had devoted much of their working lives to a hospital, perhaps with family members who had also made a similar commitment. This position described the experiences of many nurses at Barrow Hospital.

Any process of change or transition is likely to involve a period of loss and mourning as an individual lets go of the old before embracing the new (Dunne & Davis, 1994) and models of loss and bereavement have been drawn upon in understanding staff members’ responses to the closure of a hospital. For example, Massey (1992) likened the reactions of nurses to the closure of a large mental health hospital to the grief experienced following the death of a loved one, and proposed the term ‘institutional loss’ to describe this phenomenon. He found this reaction did not seem to occur within staff who had worked at the hospital for five years or less, who instead responded to the closure by looking forward to future challenges. However, length of service may not be the only factor which influences this reaction. The impact upon an individual of the closure of a hospital may also relate to the degree of daily involvement in the existing service and the emotional investment they have made in the hospital (Bailey & Berkley, 1991). This is often the case for staff working in a hospital such as Barrow, which is situated in a location away from a centre of population and has become a focus for a range of social activities as well as staff members’ working lives. There is also evidence that an untimely loss or bereavement is more difficult to deal with than one which has been expected (Worden, 1991). To some extent, this is the case for the staff of Barrow Hospital, leaving their wards and day hospital nine months sooner than anyone had anticipated.

There are many well-described models of loss and bereavement which attempt to identify different stages of grief and associated emotions – for example, Kübler-Ross (1969) proposes that loss may result in feelings of disbelief, anger, bargaining, depression and finally acceptance. Other models propose a number of ‘grief tasks’ such as accepting a loss, experiencing the pain of grief, adjusting to an environment without what has been lost and investing in new relationships (Worden, 1991). Whilst these models do not always acknowledge individual differences in terms of beliefs about a loss and our capacity to cope with it, they do highlight a number of emotions and experiences which can occur in ‘institutional loss’.

Massey (1992) observed feelings of disbelief, emptiness, resentment, anxiety and anger amongst staff leaving a closing hospital. We have seen similar feelings amongst staff leaving Barrow Hospital. Certainly there has been anger at the perceived lack of management presence and support, as well as anxiety about the future – particularly that the planned move to the new unit might not take place and that the temporary wards might become permanent. Massey also observed poor physical health amongst staff within a hospital facing closure and we have similarly noticed high sickness rates. One member of staff reported taking up smoking after several years of abstinence as a direct response to the stress of the hospital closure. Massey (1992) observed the tendency for bereaved individuals to idealise what they have lost. In line with this, we have heard staff and service users talking fondly of the peaceful environment of Barrow Hospital and the benefits of its proximity to nature.

There have been many practical difficulties in the move from Barrow Hospital to the temporary wards in a different hospital. The short-term nature of this move, plus difficulties associated with working alongside existing staff teams, have sometimes made it hard to resolve these difficulties. However, not all of the responses to the move have
been negative. Staff have valued the support they have gained from each other and the sense of being a cohesive team, many of whom have worked together for a long time, united in their ability to face new challenges and support patients through these changes. They have also been able to use humour and to look for benefits in their new location. Finally, they have been able to look positively towards the future and plan for their move to a new purpose-built unit.

Recommendations about how to cope with the loss of a hospital include an emphasis on staff training and support as well as good communication and planning for future career changes. There has been recognition of the need for staff to be kept up-to-date with plans and changes by management teams, as well as the importance of providing opportunities for staff to express their feelings about change (Bailey & Berkley, 1991). There is a need for staff to feel ‘empowered and involved’ (Cole et al., 1994) and to feel they can have some influence over changes that have been made. However, this approach also needs to acknowledge that the feelings of loss and uncertainty are stressful also for managers, who may also be leaving behind something in which they have invested emotionally. It seems that there are at least three potential roles for clinical psychologists in such a situation: providing a conceptualisation of the experiences of staff leaving a hospital; normalising the grief reactions they may be feeling; and offering a safe, supportive environment in which they can express and explore their feelings.

Our experiences of a sudden hospital closure have identified a number of similarities with the observations of Massey (1992) in terms of the responses of staff to the closure and, at times, our own feelings of anxiety and sadness. However, we have also observed some more positive responses – most significantly the importance of staff supporting each other and drawing on existing relationships within teams as we face a new challenge together.

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References
'STORIES LOST & FOUND'
A study day of diverse & stimulating presentations on Psychodynamic Arts Therapies and Psychotherapy approaches with Older Adults
Wednesday 13 September 2006
10.00 am – 5.00 pm

Arts Therapists presenting a variety of case studies & new developments in Research and Mental Health including:
Professor Diane Waller (Art Psychotherapist), Sophia Condaris (Drama Therapist), Aimee Yates (Music Therapist), Silvana Reynolds (Dance Movement Therapist), John Tyler (Art Psychotherapist and Transpersonal Psychotherapist).

And exciting psychodynamic theoretical developments in the field from:
Dr. S. Evans, Consultant Psychiatrist in Old Age Psychiatry, Senior Lecturer and Group Analyst.
Paul Terry, Lecturer, Course Director and Consultant Clinical Psychologist and Speciality Lead for Older People.

Fee: ATOLL members = £10 Students = £20 Registered BAAT members = £40 Other professionals = £45. For all enquiries contact Kimberley Lyemere on 01223 218858, e-mail Kimberleyanne52@hotmail.com.
See www.baat.org also for further information.
Organised by ATOLL, Art Therapy Outlooks on Later Life, in association with the new Diploma in Therapeutic Care with Older Adults in the Faculty of Continuing Education at Birkbeck College, London.

CPD certificates will be provided for the day.
What keeps us going?
South West PSIGE members

In preparation for this edition of the Newsletter, we asked South West PSIGE members to tell us what they enjoy about working with older people. We wanted to know what inspires, motivates and excites them, and what keeps them going when things get tough. We received responses from people at many different points in their careers – assistants, trainees, newly-qualified psychologists and some who have been around a very long time. Here is what they said (in no particular order):

❋     ❋     ❋     ❋     ❋
I like the variety. I like the complexity. I like sometimes having to go back to basic psychology to solve a problem. But most of all, I like hearing people’s stories. Who needs Eastenders, Coronation Street or The Archers when you can go to work every day and hear ordinary people’s extraordinary life stories? And best of all, sometimes you can make a difference to how the next episode turns out!

❋     ❋     ❋     ❋     ❋
What motivated me was broadly the same as in other specialties – common humanity. What was perhaps more specific to older adults was the way I got glimpses of possible futures. Sometimes this motivated me to try to make things better, sometimes it was inspiring just to see what people had done in their lives and how growth and change had sometimes continued throughout the lifespan in a positive way, rather than the stereotyped change as decline stuff. Also, for me working in Older Adult Services raised ideas about society and how we choose to treat the most vulnerable. I also had similar thoughts in LD, but there is something about a vulnerability that we are all potentially on our way towards. I wondered about how the difficulty of facing our own mortality impacts our work with older adults. For me personally I thought about how I would like to be treated if I become frail and in need of care. I thought about how motivated I would be to maintain my independence. I thought about what it would feel like to have to ask for help. I thought about what it means to have dementia and wished I’d had time to read the living in the labyrinth book.

❋     ❋     ❋     ❋     ❋
I love the variety of working with older people – neuro assessments/therapy/work with family or carers/home visits/out-patients/in-patients/consultation/facilitation/groupwork, etc., as well as the fact that every older person has a long history that is often interesting and sometimes fascinating.

❋     ❋     ❋     ❋     ❋
Everything you get in Adult Mental Health and then some. Clients always think you are young, have wonderful stories and still use words like Whizzo and What ho! which are always useful in user-friendly reports.

❋     ❋     ❋     ❋     ❋
What has surprised me about working with older people is … how it’s impacted positively on my own family relationships. I’ve also been struck/saddened/inspired by the diversity in the ‘quality’ of peoples’ marriages. Some of them are absolutely inspiring, and others are far more complex and hurtful. (Am not sure why that is surprising – lots of possible reasons and reflections!)
Working with older people has offered me the opportunity to learn how to be human. I am occasionally inspired, sometimes awed and commonly reassured by what people have coped with and how they have survived, more than survived. I am amazed by the magnitude of some people’s past trauma; astonished by how others have been sustained for so long by so little. I have learned to live with loss.

❋     ❋     ❋     ❋     ❋

I guess my word would be variety. Our work connects with issues and draws on approaches that are otherwise mostly found in the property of one other area (psychosis/adult mental health, capacity/learning difficulties, tests for brain damage/neuropsychology), which means lots to learn, lots to get involved in, and lots of scope to shape your interest

❋     ❋     ❋     ❋     ❋

What I enjoy most is the fact that older people have such a wealth of experience. I enjoy hearing the stories about their lives, how they have survived difficult circumstances with a sense of humour. I like to be able to add something for them, and advocate for them, if I can because they are a disadvantaged and marginalised group, who are often not respected despite their contributions to society over the years.

❋     ❋     ❋     ❋     ❋

I enjoy working with older adults because … the population is so varied (e.g. from a younger than his years 80-year-old to someone of ‘retirement age’ with dementia, from someone with complex longstanding difficulties to those who are ‘new’ to services, but more fundamentally in relation to how clients may differ in terms of their values and expectations as a result of previous life experiences, and how this relates to the different ways in which clients can be helped to adapt or overcome challenges associated with older age) … and also because of this diversity in what constitutes ‘old age’ you get to do a bit of everything, e.g. neuropsychological assessment, therapy, carer support, cognitive remediation, behavioural management, team-work and so on

❋     ❋     ❋     ❋     ❋

Before I started working with older adults, I took the time to consider what expectations I might have about this client group and what working with them might entail. Looking back over the last few months, I can now see that some of the older adults I have worked with have actually surprised me with the regard to the things they have said and the way they have behaved. On reflection, it seems that even though I didn’t think I had any fixed beliefs about older adults, looking back on my experiences with them has caused me to realise that I had formed certain opinions (possibly a long time ago), but I just wasn’t consciously aware of them. In fact, I can remember one particular gentleman, who although physically very frail, had a very fiery personality and was a very strong and determined individual. Although I didn’t realise it at the time, I had made the assumption that his personality would reflect his situation and had assumed that he would be meek and subdued - I was certainly wrong about that! Similarly I have met another gentleman in his 80s who is very independent and has a very active social life (more so than myself, I believe!). At the time, I didn’t think that adults at his stage of life had such very active lives.

I think the reason that many young people today hold negative or stereotypical beliefs about older adults is because in our society, young and older people often do not interact to a degree that would allow these myths to be dispelled. By working closely with older adults, I have been able to deconstruct commonly held stereotypes about them, and thereon see each person for who they really are – unique individuals. At the same time, I hope that I have been able to...
give the older adults I have worked with some insight into what younger people are really like and perhaps dispelled any misconceptions that they might have had before they met me. Young people are often perceived by older adults as being unwilling or too busy to listen to their points of view. I hope that the clients I have worked with have seen that younger adults are interested in what older people have to say and that contrary to the beliefs they may have held, we actually enjoy taking the time to do this!

Ultimately, the reason I enjoy working with older adults so much and continue to do so, is because I feel that there is so much I can learn from each older person I meet. As a result of this, not only can I disseminate knowledge about my experience of older adults to other people, young and old, (therefore helping to reduce prejudice and ageism), but I feel that the things I learn about myself will make me a better psychologist and in the long-run, a better person.

* * * * *

My career has taken me to interesting places, and over the past five years I have been working and living in the Channel Islands. The depth of history, the impact of the Occupation of the Channel Islands by the Germans during World War II, and the differing experiences of the individuals who lived through that time, has clearly been far reaching at so many levels – and has clearly helped to make them the characters and personalities that they are today. Depending on whether people were evacuated, deported or remained in the islands, during the German Occupation, has left its psychological mark in many ways on the individuals who lived through those times. Undertaking psychological work with people who have undergone such experiences has been both rich and humbling, and I feel privileged to have been able to work with this generation of people who have lived through such different times, whereby they experienced significant challenges to their liberty and independence.

Thinking more broadly about what I find particularly interesting about working psychologically with older people, is the fact that a true developmental perspective can be taken, whereby their childhood, early adult life, middle age, and then later life can all be addressed to some level during work with one individual – thereby utilising the full range of skills we acquire during our generic training as clinical psychologists within the UK system. Working with carers of older people who are unable to function independently also means that systemically we are often working with people of a range of ages, including adult children and grandchildren, and professional carers.

The challenges of working with older people are numerous, and include such things as the greater likelihood of various physical problems related to later life; potential neglect of older people due to prejudice related to later life; and difficulties in engaging with an older person, who may not be used to the concept of discussing their difficulties within a psychological arena. Clearly many of you will be able to list far more reaching challenges – and that is what makes work with older people so interesting in my opinion, and it is an area which I personally find the most rewarding of all the specialisms within clinical psychology.

I find I learn so much from each individual whom I work with – and believe wholeheartedly that wisdom does grow with age and experience, but that it can be accelerated by interacting with older people, who have their own pearls of wisdom to impart. I wish more community projects could help younger people to interact more with older people, so that they could each learn from one another, and support and help one another.

* * * * *

Doris had painted her newly-deceased husband with whitewash she had found in the cellar, laid him on the sofa and proceeded with life as usual ...
On this Gothic tale I became hooked on work with older people – it is the stories, the back beat, that thrill and interest me now as they have done over the last 30 years. I have been witness to stories that would be unbelievable or surreal in fiction – the romantic couple that met aged 10 on adjacent desks in their primary school and were still obviously devoted and as ‘in love’ with each other as ever. I was moved and envious. Stories of tragedy and loss, of corners turned the wrong way and decisions which appear muddleheaded and illogical even with hindsight. There have been tales, sometimes sagas, of regret and envy when older women tell me about stale empty marriages, or worse, from which there was no escape. It has formed my view of what it is to be a woman in my own life stages and ageing. I have come away from a visit and cried all the way back to the office and on one occasion wept alongside the client when a particularly cruel blow had been struck. I have listened with, I hope sisterly understanding to women who have had no children ‘because they never happened’ and memorably to a lady who after eight miscarriages lost her beloved daughter tragically early and in late life showed no bitterness and was facing a solo old age with positive vibrancy and stoicism. She remains one of my secret ‘icon women’.

Through working in this specialty I know what I know about being a Spitfire pilot and what it is like on a submarine, in Burma or being a Japanese POW or working in covert operations and much much more. I have heard about working patterns which seem impossible to me and the high regard for being a ‘good provider’. I wonder about the indulgences of my two boys and wonder how they would survive and manage conscription and privation.

In fact I spend a great deal of time thinking – would I, could I, what if? The people that I meet are usually those for whom this is first contact with mental health services and this feels strangely privileged and a marker of the difference of the specialty. These are people who have succeeded or managed and survived the rigours of this living business and for whom things are going awry when they are least able to cope or when their emotional or physical resources are depleted. They are ‘me to be’ in a way that other specialties are not and it is this that keeps this really old hand going.

I enjoy working with older people for many reasons – but mainly it’s about the chance to hear about people’s fascinating lives. I never stop being surprised and impressed and shocked by the things that people have achieved and the resources they find in the face of tragedy, loss and disability. Truth is, indeed, stranger than fiction. Perhaps there are fewer happy endings, but there are more heroes and some phenomenal plotlines!

The other thing I love about this work is the other people I work with. It is inspiring to find so many people dedicated to an area which isn’t seen as ‘sexy’ but which seems to inspire a huge sense of loyalty and commitment amongst those who perhaps stumble across it, but often seem to stay.

I often feel honoured and humbled that older clients choose to share with me (a young whippersnapper) their thoughts, feelings and experiences about their lives. I was brought up to respect my elders and I hope I show this to my clients so in a way it feels a special privilege to be able to contribute to an aspect of their life that may be difficult for them.

In terms of working with older people I would say that as a trainee I had the good luck to spend five months with a supervisor in Devon. That placement started the illustrious career that you have all grown to admire and love. My supervisor’s enthusiasm
sort of grew on me and I never looked back. I think also working with older people is like dipping into a history book – you meet incredible people. A tax inspector who still had shrapnel in his head from the Normandy landings. A New Zealander who drove the landing craft that dropped men onto the beaches. A German lady who was in Berlin when it fell to the Russians and who as a child saw Hitler. Recently a woman who, against all the odds, went on to get her degree ...

* * * * *

I enjoy working with older people for numerous reasons, such as: Being there for people at a time when loneliness is overwhelming, the variety of work and hearing people’s stories.

* * * * *

I like the fact that you are constantly challenged when you work with older people: challenged by having to employ all of your clinical and personal skills on a weekly, if not daily, basis; challenged by having to constantly revise your stereotypes and expectations; challenged by having to face the reality of ageing, illness and mortality; challenged by wondering whether you should accept that cup of tea! I also like the fact that I am regularly amazed and uplifted by the strength, hope and resilience of older people who have experienced difficulties in their lives.
THE ESTABLISHMENT OF THE Division of Neuropsychology (DoN) formalised Clinical Neuropsychology as a distinct specialist entity in clinical psychology practice and there is now a clear training route towards becoming a full member of the DoN as a practising qualified clinical neuropsychologist.

Clinical practitioners who work in specialist patient populations (e.g. older people, children) and who do not seek to become clinical neuropsychologists also require support for specialist training in clinical neuropsychology. The caseloads of practitioners employed in the older people sector can be expected to show an increase in clinical neuropsychology practice – one which will parallel the demographic growth of the aged population. Currently, the Division of Neuropsychology and PSIGE support a proposal for a short post-qualifying course for practitioners working with older people.

It is envisaged that a specialist course in the neuropsychology of older people will provide an academic standard to benchmark a basic level of knowledge and practise of clinical neuropsychology pertaining to the conditions prevalent among older people, e.g. dementia, stroke, neuro-psychiatric conditions, pharmacological iatrogenic conditions, etc.

There are current discussions underway with Soloman’s Training Centre (Canterbury Christ Church) for a Graduate Certificate Course in Older People Neuropsychology. This qualification can be expected to require the equivalent of six weeks of academic study, divided between distance and on-campus learning. The options for a non-certification route and single module study as well as possible course credits for those wishing to pursue a post-qualifying course in clinical neuropsychology at a later date are under discussion. This course, if it proceeds, will replace the existing six-day (non-accredited non-qualifying) CPD course.

In addition, to help inform the development of this course and derive an understanding of the needs to clinical psychologists, a survey of current neuropsychology services and practise in the Older People Services is proposed. So watch this space! If anyone wishes to contribute ideas or comment on this initiative, please send me an e-mail (Carmel.Lum@sussexpartnership.nhs.uk)

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Current initiatives regarding a post-qualification training programme in the Clinical Neuropsychology of older people

Carmel Lum
PSIGE Committee Member takes centre stage at Awards ceremony

THE PENNINE CARE NHS TRUST is delighted to announce that at the prestigious Greater Manchester Awards ceremony sponsored by the Manchester Evening News, Oldham’s Life Story Project not only won its category of ‘Getting the Message Across’, but was also presented with the Strategic Health Authority Chair’s Special Award at the end of the evening.

The Life Story Project works on a person-centred model of patient care, which positively involves older people themselves, and enables their carers and staff to better understand the person behind the diagnosis. Patients are offered more dignity, they feel listened to, respected and valued. The Life Story work enables the patient to celebrate their life and promote the growth of their identity, helping staff to build up a therapeutic rapport with them.

Warmest congratulations to all concerned!

From left to right: Terry McCabe; Marjorie Forster; Julie McBride; Polly Kaiser; Simon Pierce; Chris Newton; Mick McNamee and Linda Green.
The Tavistock Clinic Training Programmes

Commencing October 2006

Tavistock Certificate/Diploma in Psychodynamic Approaches to Old Age (Ref. D2)

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A copy of the academic prospectus 2006–2007 is available on request or visit www.tavi-port.org
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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).

**Research Updates**
The *Newsletter* is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, e.g. ideas for discussion or early stage results, which are not ready for formal publication. Try to keep them below 500 words. The Editorial Board reserves the right to make minor changes to any submissions. Where major editing is necessary, the authors will be informed. All contributions must be typed.

**Submission Procedure**
Where possible, please submit articles as a Word file via e-mail to romola.bucks@soton.ac.uk. If this is not possible please send an electronic version on disc to the postal address below. Language should be inherently respectful to older people and consistent with the British Psychological Society’s guidelines.

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

*All contributions should be sent to:*
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Contents

1 Editorial
P.F. Joyce & Philippa Wilson

2 Letter from the Chair
Steve Boddington

3 Supporting residential care homes for older adults and improving the quality of life for people with dementia
Elizabeth Drew

7 Evaluation of a support group for spouse carers of older people with dementia
Falguni Nathwani

14 Eking it out
Kate Anderson

17 Contexts of knowing and telling: Reflections on dementia and the concepts of ‘insight’, ‘awareness’ and ‘denial’ from a social constructionist perspective
Marion Dixon & Liz Curtis

23 To Have and Have Not
Mike Bender

28 The Wadebridge Memory Bank Group and beyond
Mike Bender

34 The development of memory difficulties: A journey into the unknown
Oonagh Koppel

38 The day the sky fell in: Reflections on hospital closure
Philippa Wilson & Dickon Millett

42 What keeps us going?
South West PSIGE members

47 Current initiatives regarding a post-qualification training programme in the Clinical Neuropsychology of older people
Carmel Lum

48 PSIGE Committee Member takes centre stage at Awards ceremony

50 PSIGE Committee 2005/2006

52 Geographical Group Convenors as at September 2005