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.

EDITOR

Romola Bucks

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PSIGE is the Faculty for Old Age Psychology
(British Psychological Society, Division of Clinical Psychology).
OVER THE LAST FEW YEARS, THE National Committee has been engaged in a process of reviewing its work in order to ensure that it is being effective in meeting the aims of PSIGE as outlined in the Constitution. In 2004/2005, the emphasis of this review was to look at the strategic function of the Committee, from which three main aims were produced. These were:

a. Representing and promoting the psychology of older people;
b. Disseminating psychological principles;
c. Providing for and nurturing the membership.

In order to meet these aims, six strategic objectives and two cross-cutting themes were identified for the committee for 2005/2006. The inter-relationship between the Committee’s aims and strategic objectives is shown below.

Furthermore, two cross-cutting themes were identified to support the delivery of these strategic objectives: (i) use of the media; and (ii) development and use of the PSIGE website (www.psige.org).

Given the use of this approach, the Committee decided to move away from the traditional officer reports for the 2006 AGM and, instead, to utilise the framework of the strategic objectives for reporting back to the membership.

Efficiency of Committee functioning and roles

In the last 12 months, the Committee has taken this work forward and used the strategic objectives to focus the work of the Committee. This has also allowed for the development of clearer job descriptions and role clarity, and administration of Committee meetings has been improved with the help of

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* This Strategic objective covers: (a) interpreting policy and practice guidance documents for the PSIGE membership; and (b) developing guidance on professional practice issues for the membership.
the DCP subsystems office. Future work will involve clarifying deliverable outputs of the Committee on an annual basis.

**Influencing policy and practice guidelines**

PSIGE is now standardly being invited to consult on guidance documents through the Society and through other routes. In 2005/2006, submissions were made on behalf of the Society by PSIGE to:

- NICE Anti-dementia Drugs review (two separate submissions).
- NICE Dementia Services review (plus attending meeting at NICE prior to submission).
- Inquiry into Mental Health and Well-being (plus attending launch meeting at the House of Commons and three subsequent meetings).
- Continuing Care review.
- NICE Dementia guidelines – feeding back on consultation currently.
- NICE Arthritis review.
- Everybody’s Business – psychological therapies section.
- All party parliamentary committee on Mental Health in Older people.
- Mental Capacity Act and subsequent guidelines.
- PSIGE members also fed back on a number of issues including the Assisted Dying Bill.

PSIGE will continue to seek to advise the DH and other bodies of psychological issues in relation to older people.

**Providing professional guidance to members**

The Newsletter continues to be produced quarterly, with back copies available on the website. An updated Briefing Paper 5 was released during the year, and PSIGE also had heavy involvement with the production of the Mental Capacity Act guidance document produced by the Society (both available on the PSIGE website).

An occasional paper on Young Onset Dementia is with the Society being prepared for print. The neuropsychological test compendium will be available on the PSIGE website, and there are plans to update the Memory Clinics document in 2006/2007.

**Training for members**

The Training Subcommittee continues to be very active. The remit of the Committee is to:

a. Maintain a watching/monitoring brief on training developments relevant to the older people’s specialty.

b. Monitor current practice on training courses regarding academic input and placement provision with older people.

c. Influence developments in training of relevance to working with older people both nationally and locally.

d. Support the provision of relevant training and CPD events for PSIGE members.

In terms of supporting people in the pre-qualification phase, the Training Subcommittee has submitted the *Capabilities for Working with Older People* document to the DCP, and this has been widely circulated to training programmes. The Committee intends to develop a KSF profile for trainee clinical psychologists (Band 6) for working with older people.

In terms of providing CPD for PSIGE members, a number of events took place in 2005/2006. Future events in 2006/2007 will include joint training events with the Division of Neuropsychology, Division of Health Psychology and the Division of Counselling Psychology. Training events are planned in relation to the Mental Capacity Act. Local training events are also taking place within geographical groups.

The National Committee is also actively exploring purchasing a distance learning e-resource from Edinburgh University, which would be free at the point of delivery to PSIGE members.
Strengthening links with other organisations

This year, the Committee concentrated on developing more of a strategic influence in promoting psychological issues in relation to older people. This has involved strengthening our links with both internal parties (e.g. other parts of the Society) as well as external bodies (e.g. DH, NIMHE).

In terms of our work with internal partners, the Chair of the DCP was invited to attend the National Conference and present to the AGM about the future of the DCP and its subsystems. PSIGE also now has representation on the newly-formed DCP Finance Subcommittee, and is liaising with the Division of Neuropsychology about training people to work with older people.

Externally, the Committee is working with CSIP/NIMHE on the Older People’s programme, the Committee contributed to the ‘Psychological Therapies’ section of Everybody’s Business, and the Committee is developing links with a number of other organisations (e.g. National Council on Ageing, British Geriatrics Society, Better Government for Older People, and the British Society on Ageing). PSIGE is also endorsing the Hawker Events/Journal of Dementia Care UK Dementia Congress (7–9 November, 2006, in Bournemouth).

Media communication

The PSIGE media profile has been variable and we are aiming to increase this.

- Conference – there was no media coverage of the 2005 conference. This year we sent out 12 press releases for the 2006 conference.
- The Media Officer attended a broadcast skills course run by the Society and subsequently undertook one radio interview. The Media Officer attended a Society media officers meeting.
- A media sub-group meets to identify press releases for conference and potential themed press releases throughout the year.

Use of website to publicise, communicate and disseminate information

Over the past year, the content on the site has grown and it has had a great deal of internet traffic. The site has the PSIGE membership as its main target user group but is also a useful way to communicate with other individuals and groups. Information on the site includes:

- Information about PSIGE and the Geographical Groups.
- Information about training events.
- Downloadable documents and other information.
- Communication between the membership.

A Bulletin Board was established on the site, but interest in this seems to have waned. Further consideration will take place as to how best to utilise the site for members.

Other reports

1. Bursary

Six assistant psychologists and eight trainee clinical psychologists were awarded bursaries to attend the 2006 annual conference.

2. Finance and Membership

PSIGE continues to stay in balance for the financial year, despite delays in payment of committee expenses from the DCP. Geographical Group subvention requests need to be made by 30 September each year.

The membership breakdown is as follows:

- Current membership: 494
  - Full DCP Members – 248
  - Subscriber Members 161
  - Trainee/Student/Assistant Members – 55
  - Overseas Members – 6
  - Institutional Members – 7
  - Retired Members – 17

Chair’s Report

The Chair made a presentation about the relationship between PSIGE and the DCP, highlighting areas of mutual benefit and areas of concern.
Presentation by DCP Chair
The Chair of the DCP presented a vision for the future of the DCP and its subsystems, which was followed by questions from the audience.

Election of Officers
PSIGE officers were elected.

Don Brechin
Before we move on to what is on offer in this issue, I want to extend my personal thanks to Sinclair Lough. Sinclair has been inspirational and dedicated. The five years during which he has edited this Newsletter have seen some of the finest issues; in terms of the range, quality and accessibility of the content. Sinclair’s last issue, No. 95, from the South West is, in my opinion, one of the best Newsletters I have read. Both Sinclair and the South West group are to be congratulated on a diverse and thought-provoking series of articles. If anything that you have read in this or any other Newsletter has stirred a response in you, please remember that we are always happy to receive letters.

In this issue, from the Annual Conference held at the University of Sussex in Brighton, we have papers on the theme of stroke and loneliness. Ian Kneebone’s paper describing the Stroke symposium and the paper from David Wallace and Vicki Carek focus on stroke care and assessment. Kerri Rees’ paper, along with those of Nicky Knights and colleagues, and Paul Terry, addresses issues of loneliness and support. We also have papers on care pathways, challenging behaviour units and fear of falling. Happily, I have been promised more articles based on conference presentations, so we can look forward to seeing those in future issues. Whether your work was presented at conference or not, keep the submissions coming please!

A condition of receiving a conference bursary is to write a brief report, a selection of which is published in this issue. Louise Barnard’s report was rather longer than required, but is published in full because it reflects all that is truly excellent about PSIGE in general, and was demonstrated so well by this year’s conference in particular.

I am also delighted to be able to offer the membership a selected bibliography about behavioural and cognitive therapies with older people. This reference list was originally developed for the Surrey DClinPsych programme and we are grateful to Ian Kneebone for sharing it with us.

Finally, looking forward, the PSIGE National Committee are truly happy to announce a Research Prize for 2007. Details can be found on page 67. We are hoping to make this an annual prize, funding permitting.

Happy reading!

Romola Bucks
Editor, PSIGE Newsletter.
Letter from the Chair

Steve Boddington

I AM SURE YOU WILL AGREE WITH ME that the Brighton conference was a tremendous success this year, and was a fantastic showcase for the ideas, creativity and energy of the PSIGE membership. Thank you to the conference organising committee for the inevitable hard work in putting on such an interesting programme, both academically and socially. Thank you to the Society’s Conference Office for supporting our Conference Organising Committee in making the event run efficiently.

Current issues that have been affecting the work of National PSIGE include the extension from the AGM discussion about our relationship with the DCP. I attended the inaugural meeting of the DCP Representative Assembly and was invited to present the information that we discussed at our AGM for wider consideration amongst DCP subsystems. You will be reassured to hear that many faculties and SIGs were in agreement with our concerns about the proposed changes. I have been invited to participate in a small DCP working group to resolve these proposals.

The National PSIGE Strategy meeting was held at the end of September in which we identified key objectives for the coming year. A key theme for our work will be to look at policy and implementation of depression pathways, and to ensure that we provide guidance and influence policy in this area. This theme will be evident through our training, information and communication structures.

The successful Brighton conference generated a surplus of £9000 which we are ploughing back into training and CPD. Given the current financial climate, we anticipate that many members will find it impossible to obtain funding to attend the conference in Nottingham. As such, we are committing an additional £5000 to the bursary fund specifically for qualified members. I would also draw your attention to the Research Prize announced in this edition. This is for recently qualified members who have undertaken a research thesis relevant to psychological needs of older people.

Finally, a huge thank you to Sinclair as he steps down as Newsletter editor after five years having been persuaded to take it on during an alcohol-induced momentary lapse of reason at the Oxford conference! You may be interested to track Sinclair’s influence on the Clinical Psychology Forum as he has joined their editorial collective. Welcome to Romola Bucks who has edited this edition of the Newsletter. I’m sure you will agree with me that she has stepped into this role with gusto!!

Steve Boddington
PSIGE Chair
Stroke: Experience and adjustment
Ian Kneebone

This paper provides a brief overview of a symposium on stroke presented at the 26th PSIGE Annual Conference held at the University of Sussex in July, 2006. The principal conclusion from the discussion, arising from the papers presented, was that psychologists should be taking a broader (more holistic, systemic) approach to post-stroke adjustment.

STROKE IS THE BIGGEST CAUSE OF severe disability in the UK. The National Service Framework for Older People (Department of Health, 2001), The British Psychological Society (2002), and The National Clinical Guidelines for Stroke (2004) have all highlighted the importance of considering psychological issues in rehabilitation after stroke. While the assessment and management of cognitive change is important, attending to the general psychosocial adjustment of patients and carers is one of the main areas in which psychology can contribute to improved outcomes. A symposium presented at the 2006 PSIGE annual conference at the University of Sussex, Brighton, focussed on this aspect of care.

Given over 90 per cent of the approximately 100,000 people who experience a stroke each year are older, it was considered particularly relevant for a symposium in this area to be presented at a conference of psychologists specialising in working with older people. It was also consistent with one of the conference principal themes, ‘developments in neuropsychology and rehabilitation’. Papers that were presented in the symposium focussing on user and carer views were also in tune with another theme; ‘enabling inclusion and user involvement’.

The symposium on stroke sought to offer insight into the view people who have had a stroke take of their adjustment and that they, and their carers, take of their health care experience. In addition, it hoped to understand what factors are pertinent to emotional reactions post-stroke and what were the new developments in screening for adjustment difficulties. Finally, it aimed to integrate the information presented to develop a view of how psychologists might best assist psychosocial adjustment after stroke.

Qualitative research identified two main themes when it questioned how people make sense of and manage the experience of a first-time stroke (Harris et al., 2006). Making sense of the stroke described how participants understood why the stroke had happened to them and its impact on their lives. This encompassed sub-themes such as a ‘seeking causal explanations’ and the viewing of post-stroke experience as ‘an uncertain journey’. Managing life after the stroke described coping with stroke-related experiences. This encompassed sub-themes such as the ‘use of social support’ and ‘strategies to manage emotions’. The importance of communication and activity level for a positive adjustment was highlighted particularly for people with aphasia (Bennet & Lincoln, 2006). In terms of screening to identify problems with adjustment, the BASDEC (Adshead et al., 1992) was found to be promising as a tool to identify depression in older people receiving in-patient rehabilitation after stroke (Healey et al., 2006). Finally, room for improving services was identified via research using semi-structured interviews to explore patient and carer experience of a stroke pathway (Morris, 2006). Specific issues included: availability of therapy; lack of information; lack of whole person care; and, inconsistency of care due to physical and professional demarcations.
The specialist nature of the stroke service was seen as a major strength by staff. Overall, the symposium discussion concluded that assisting adjustment of people who have had a stroke requires a holistic, systems approach. While psychologists currently have important roles in assessment and treatment, perhaps the time has come for them to comment on the broader service environment and its impact upon the adjustment of those who are recovering from stroke.

Acknowledgements
The author would like to thank his co-presenters Victoria Senior, Shirley Thomas, Rhona McGurk and Reg Morris. Samantha Hull considered a draft of this paper. The conference would not have been the success it was without the efforts of the 2006 Annual Conference Committee.

References


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Editor’s comment: The Department of Health is developing a National Stroke Strategy. Ian Kneebone is an invited member of the Steering Group as well as a member of the Post Hospital Care Group. Progress on the strategy can be found on the website, [www.dh.gov.uk/stroke](http://www.dh.gov.uk/stroke).


Background

THE MOOD SNAPSHOT GREW FROM a search for a useful measure of depression in stroke patients.

Gainotti and Marra (2002), in their review of literature on post-stroke depression, comment: ‘post-stroke depression has been considered as the most frequent and important neuropsychiatric consequence of stroke, since at least one-third of stroke survivors experience depression both early and late after stroke and since this condition can have an adverse impact on cognitive function, functional recovery, and survival.’

Previous work on mood and stroke had been carried out locally by Phillips (1995) and Hilton (1996). Phillips (1995) used a modified version of the General Well-being Schedule (Fazio, 1977) to estimate mood and establish a link with other parameters of stroke. Stroke patients were significantly distressed compared with non-clinical norms with ‘severe distress’ occurring four times more frequently. Distress was related to low mobility, but not to speech impairment in those sampled. However, patients with severe language impairment were excluded from the study, as the Distress measure was verbal. The view was commonly expressed by ward staff that patients with dysphasia were the most distressed. Hilton (1996) looked at the staff view in more detail and confirmed that this belief was widespread. This pointed to the limitation of available measures for stroke and mood.

A Stroke Rehabilitation Unit (SRU) was established in Calderdale in 2001 and this stimulated a search for a useful measure of depression. Also, the National Clinical Guidelines for Stroke (Royal College of Physicians, 2004) recommended routine mood assessment. The SRU, Acute Stroke Unit and three adjoining wards within Elderly Medicine came together as a Practice Development Unit and, as a result, the work on mood evaluation was extended to include all five wards. Two wards are for patients over the age of 75; the other three include some younger adults under 65 but predominantly older people.

Moving beyond the initial focus on depression in stroke, a group of staff looked at ways of assessing depression and other mood states in a mixed group of mainly elderly patients. Katona (1994) notes that ‘elderly patients with serious physical illness often have symptoms of depression … in many cases symptoms persist for an extended period and interfere with social functioning, or even basic self-care.’ Also, ‘If depression is not recognised and treated it may have an impact on recovery from the physical illness’ (p.63).

An observational tool was developed alongside the Six-Piece Jigsaw model (Wallace & White, 2006; Carek & Wallace, in preparation) as a way to facilitate multi-disciplinary discussion around mood, cognition, and behaviour and to inform the goal-planning process.

Development of the idea

What was needed to meet the requirements of the PDU was a manageable measure or evaluation of mood, which could be universally applied across all five wards to all patients, including those with communication problems. Verbally-based questionnaires presented most difficulties and were
not considered. Visual Analogue (VA) scales looked promising. Price et al. (1999) asked stroke patients to estimate pressure levels produced by a sphygmomanometer cuff using a variety of verbal rating and VA scales. They concluded: ‘Many patients after stroke are unable successfully to complete self-report measurement scales, including Visual Analogue scales.’

In view of this, observational scales looked like the way forward. The Signs of Depression Scale (SDS; Watkins et al., 2001) and the Stroke Aphasia Depression Questionnaire (SADQ; Sutcliffe & Lincoln, 1998) were piloted informally and the views of staff taken into account. It was felt that the SADQ was too long and, therefore, unlikely to be used regularly without a great deal of input from Psychology Services, which was not available. In any case, it was hoped that multi-disciplinary staff would gain ownership of the mood assessment and the search for individual solutions, which was the basic philosophical driver of the Six-Piece Jigsaw model.

The SDS appeared to have more potential and was accepted as the universal measure. Following discussion with the front-line staff, the SDS was expanded and reformatted to include space for comments, and also extra items covering sleep, appetite, and euphoria. It was used as a way to discuss mood and behaviour with little emphasis on the ‘score’. Also, discussion revealed that ‘high’ or euphoric mood could be as problematic as low mood.

A new approach was introduced in May 2005: the Mood Snapshot. This is intended as a way to facilitate clinical discussion around stroke and behaviour and not as a diagnostic tool. The Snapshot takes into account behaviour observed over a particular shift or in the recent past. There are eight bipolar items, seven of which are observational. The eighth (pessimism – optimism) requires some interpretation.

The ratings are colour-coded in an intuitively obvious way. Where no problem is noted the central column is ticked. Deviations to either side are considered to be clinically significant. The form also asks for the rater’s impressions and goal-planning points. Tick boxes cover: ‘discuss with psychologist’, ‘review medication’, and ‘psychiatric opinion’.

After one year of use the Snapshot was reviewed in our team ‘Well-being’ meeting. The response has in general been favourable (see Figure 1).

Figure 1: Some comments

- ‘This looks very good, I like how you have tied it to the goals.’
- ‘Looks great, especially including the appetite.’
- ‘I like the colour coding. Would be useful to use in MDT.’
- ‘It will be useful as a guide to how a patient is feeling without having to read all of their notes.’
- ‘Covers all moods and is very straightforward to use.’
- ‘A good tool for goal-planning.’

The process of ‘taking a mood snapshot’ helps staff to focus on behaviour closely associated with mood. The interpretation of what is observed is an essential part of the evaluation as some behaviours associated with low mood (lethargy, withdrawal, poor sleep, poor appetite) may be caused by pain or ill health. For this reason the Mood Snapshot is not regarded as a ‘mood measure’ but rather as a useful tool to facilitate discussion around mood and related behaviour.

The issue of producing a ‘score’ or quantification has been raised. The team feels strongly that this would be neither helpful nor appropriate, but there are pressures in the other direction. Our local PSIGE group was of the same opinion, that the strength of the Mood Snapshot is as a tool to focus discussion rather than as a rating scale.

This paper has outlined the philosophy and development of the Mood Snapshot. What is now required is a systematic evalua-
tion of its use in health care settings and its impact on goal-planning and actual patient care.

Acknowledgements
Thanks and appreciation to the ‘Well-being Working Group’ for Acute Stroke and Rehabilitation, Calderdale Royal Hospital, Halifax, and to the PSIGE Group for Yorkshire and Humberside for their help and encouragement.

References
Intermediate care services in Salford

THE CITY OF SALFORD IS A LARGE metropolitan borough in Greater Manchester, covering 37 square miles, with a population of 220,000, approximately 35,000 of whom are aged over 65 (Census, 2001). Intermediate care services in Salford developed in response to the National Service Frameworks for Older People (2001). A pilot project offering community-based physical rehabilitation for older people with complex needs has developed into three community and two residential rehabilitation teams, with further expansion promised. Intermediate care staff comprise physiotherapists, occupational therapists, social workers, nurses, rehabilitation technicians and assistant practitioners, psychology and counselling. Psychology/counselling input originally comprised 1.2 whole time equivalent (wte) clinical psychology, 0.8 wte counselling, and 1.0 wte assistant psychology staff. However, this level of input has changed little since the expansion of intermediate care (currently 1.4 wte clinical psychology, 0.5 wte counselling and 0.5 wte assistant psychology). Referrals to intermediate care number several hundred per month, and psychology services receive on average nine referrals for formal one-to-one input per month.

Fear of falling

Falls are a common reason for referral to intermediate care services, with national policy focusing on intermediate care to maintain independence and improve confidence and functioning (A New Ambition for Old Age, 2006). Research has highlighted the psychological consequences of falls, including depression and generalised anxiety (Downtown & Andrews, 1990; Cutson, 1994), as well as a specific fear of falling. Tinetti et al. (1990) describe fear of falling as ‘a patient’s ongoing concern about falling that ultimately limits the performance of daily activities, and loss of confidence in his/her abilities.’ Howland et al. (1993) found that older people report fear of falling more commonly than any other fear, including crime, and research indicates a 30 to 60 per cent prevalence rate for fear of falling amongst independently living older adults (Tinetti et al., 1994). Fear of falling can develop regardless of previous falls history or severity (Maki et al., 1991), can result in poorer quality of life and loss of independence (Lachman et al., 1998; Tinetti et al., 1990), and may increase risk of future falls.

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Promoting psychological approaches to fear of falling: Bibliotherapy and staff training in a physical health team

Vicki Parlane & Jessica Read

Recent Government policy highlights the importance of clinical psychologists training and supporting frontline health care staff in the identification, basic management, and appropriate referring on of mild mental health difficulties. In intermediate care services, fear of falling is a particularly common presenting issue and reason for referral to psychology. As fear of falling potentially has serious physical and psychological consequences, this issue was targeted for intervention. A self-help booklet was produced for older people with fear of falling, and staff in intermediate care and other health and social care providers were trained in identification and basic management of fear of falling. Evaluation showed a high level of staff and client satisfaction with the booklet, and an increase in staff knowledge of, and confidence in, managing fear of falling. Implications for further research and for service provision are discussed.

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(Childs & Kneebone, 2001). Therefore, reducing fear of falling and associated activity restriction in older persons may improve both health status and general well-being. However, physical therapy staff in our team had not received any specific training on identifying and managing fear of falling prior to the development of this package.

**Policy context and clinical rationale for development of package**

The pressure of high numbers of clients in intermediate care, combined with a very limited time-frame for effecting change (clients are expected to receive intermediate care services for no more than 12 weeks, and often there is an even smaller window of time available to maximise rehabilitation potential) mean that a traditional ‘out-patients’ referral model of psychology provision is not appropriate. Increasingly our service has aimed to use consultation models and sign-posting to other services, as well as ensuring that front-line therapy staff have the necessary skills to identify mental health needs in a timely way, and manage basic problems. This approach is in line with recent national policies, which highlight the need to maximise access to psychological therapies (Layard, 2004) and ensure that staff in mainstream services can identify and manage mild mental health problems (Securing Better Mental Health for Older Adults, 2005). Roth and Stirling (2005) suggest that clinical psychologists are well-equipped to take a key role in consultation, training, and supporting staff. Due to the high prevalence of fear of falling and the serious nature of its consequences, plus the limited amount of direct psychology input available to intermediate care, it was therefore decided to develop self-help material for older people, in conjunction with staff training on identification and basic management of fear of falling.

**Development of bibliotherapy and staff training**

Literature reviews and enquiries revealed a lack of suitable self-help material on fear of falling, despite the fact that written self-help material is recommended by NICE as a part of anxiety management. A booklet on fear of falling was developed by the assistant and clinical psychologists. This was based on Clark’s (1986) panic model, and Childs and Kneebone’s (2001) cognitive-behavioural model of fear of falling. The booklet was designed with older people in mind, using a large font, pictures, and straightforward language, and encompassing information about anxiety and vicious circles, and ‘step-by-step’ guides for coping with anxious thoughts, and feelings, and reducing avoidance of activity. The booklet was initially provided for intermediate care staff to give to their clients. In conjunction with this, a brief training session was developed for staff. This was aimed at both qualified and unqualified staff and, given the pressures on staff time, was intended to be a quick awareness-raising session that could be delivered in 30-60 minutes. The key components of this were the basic CBT model of fear of falling, skills in identifying fear of falling, some very basic strategies for managing anxious thoughts and feelings and tackling avoidance (Box 1), and when and how to refer to psychology.

**Box 1: Examples of interventions.**

- If the person is safe, encourage them gradually to walk more and further, rather than doing things for them.
- Check the person is ready to go when they start walking.
- Walk at the person’s pace, don’t rush them.
- Give lots of encouragement, positive feedback when someone is walking well.
- Remind them of all the times they haven’t fallen.
- If the person gets panicky, stop, wait, and encourage them to take a slow breath out, then a few slower, deep breaths. Try to reassure and calm them before carrying on.
Client and staff satisfaction evaluation
Following development of the booklet, both staff and client satisfaction were evaluated. The assistant psychologist was responsible for collating data from this initial evaluation. Intermediate care staff were asked to direct clients to a brief evaluation form attached to the booklet, and collect it on their next visit. An evaluation form was also devised and presented to staff in the supported discharge and community rehab teams in intermediate care. As the booklet was made freely available through a variety of sources in Salford, it was not possible to record exactly how many booklets had been given out, or obtain satisfaction data from professionals or older people more widely. However, both client (Table 1; Box 2) and staff (Table 2) evaluations revealed high levels of satisfaction with the booklet, and staff also reported increased confidence in identifying and managing fear of falling.

Broader impact
Fear of falling training has also been provided as part of a larger falls awareness training package, central to Salford’s overall falls strategy, and attended by 28 mobile and residential wardens, three Age Concern hospital support staff, and an intermediate home support team. Feedback for the overall package was very positive. Fear of falling training has also been provided to all three community teams in intermediate care, community matrons, and a new integrated care team.

Table 1: Client satisfaction (N=9).

<table>
<thead>
<tr>
<th>Did you read the booklet?</th>
<th>None of it</th>
<th>Some of it</th>
<th>All of it</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you try any of the ideas</th>
<th>None of it</th>
<th>Some of it</th>
<th>All of it</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was the booklet</th>
<th>Too Short</th>
<th>About Right</th>
<th>Too long</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>9</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How helpful did you find the booklet?</th>
<th>Not helpful at all</th>
<th>Not very helpful</th>
<th>Neither helpful or unhelpful</th>
<th>Quite helpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

Box 2: Client comments.

- The booklet is very, very, helpful. I lost my confidence by falling, reading this helped me to regain my confidence. It is easy to read, the pictures show what is going on. I understood it and it changed the way I think to make me feel better.
- Easy to read, not patronising or anxiety provoking, liked layout especially pictures. I couldn’t read it in the day centre as everybody else wanted to read it too!
- Helpful to know I’m not alone, and I am not silly for having this fear.
- Booklet is great. Helps you to see what you can do when you think differently. It has helped me a lot.
- The booklet has helped me understand about the things that have been worrying me. I think differently now; a lot more positive – I think the way I should be not thinking about things that make me depressed. Very easy reading with good diagrams. I looked at the symptoms of anxiety I thought that was just I but then I realised that you would have not made the booklet if there weren’t a lot of people who needed it. The relaxation section has helped me to sleep at night.
The supported discharge and community rehab teams use approximately 25 booklets per month, and the booklet has now been professionally designed and printed through Salford’s falls strategy budget, and is available at day centres, sheltered housing schemes, and at older people’s events in the city.

Interestingly, referral rates to intermediate care psychology for fear of falling have remained fairly constant, at an average of 1.5 per month, whilst formal and informal consultations to staff about clients with fear of falling have increased. We feel that the formal referrals that psychology do receive are more complex than those received prior to the booklet and training, perhaps suggesting that staff are more able to manage straightforward fear of falling issues themselves or with minimal advice and support. However, it is difficult formally to evaluate this retrospectively.

**Implications for current and future ways of working**

Our experiences have shown that a novel approach to sharing psychological skills and knowledge can be very positively received, and can allow for different levels of intervention to match different levels of need, making the most of thinly-spread psychology services. In developing and promoting this way of working, we have been fortunate to be part of a service that truly embraces partnership working – for example, Salford’s Falls Strategy Steering Group’s membership includes representation from the primary care, acute hospital and mental health trusts, as well as housing, warden services, and the voluntary sector.

Parry (1992) suggested that psychotherapy services should be evaluated according to six criteria: effectiveness, acceptability, accessibility, relevance, equity, and efficiency. The audit data and frequent use of the booklets, as well as ongoing requests for training, certainly show that this model of psychology input is relevant and acceptable to both older people and health and social care workers. The wider dissemination of psychological ideas that is possible through a mixture of self-help, training and consultation to other professionals, as well as direct working, increases accessibility and equity of access, as receipt of help and support is not reliant on getting past traditional gatekeepers for psychological therapy, such as the GP or attendance at an outpatient appointment. However, a key challenge facing our service is how best to provide firm evidence of the clinical and financial effectiveness and efficiency of this way of working. Further research is needed to establish clearly the effectiveness of the booklet, both with and without specialist psychology input, in increasing confidence and reducing avoidance of activity.

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![Table 2: Staff survey.](image)

<table>
<thead>
<tr>
<th>Reported confidence</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identifying</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-booklet</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Post-booklet</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td><strong>Managing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-booklet</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Post-booklet</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>
References


As is often the case, South Staffordshire Healthcare NHS Trust has been subject to its fair share of organisational change in recent years. The most significant of these changes was its creation five years ago from the amalgamation of two smaller trusts. At the time of the merger, the older adult dementia services in the two original trusts were quite disparate in terms of level of investment, commitment to multi-disciplinary working, desire for beds and so on. In order to modernise services and to achieve a greater level of service parity across the area served by the new trust, a number of pilot schemes has been implemented. This paper summarises the information we have gathered about local need and service delivery models and the research evidence that will help to guide further endeavours.

Service models
A number of different service models have been piloted over the past five years. In each case, the motivation for the creation of a new form of service was either to increase provision in that part of the trust which had been underdeveloped, or to address bed blocking in the inpatient wards (or sometimes, both).

Model 1
In 2000, the local trust, PCTs and social services conducted a joint ‘Services for the Millenium’ review. As a result of this review, a number of additional services aimed specifically at people with dementia with difficult to manage behaviours were created to complement the generic older adult mental health inpatient and CMHT services that already existed. These were: a five-bedded specialist challenging behaviour unit; three seven- to 10-bedded specialist dementia focus units; and, four specialist challenging behaviour beds commissioned within a privately run EMI nursing home.

The special needs unit
The special needs unit was a classically-designed challenging behaviour unit based within a hospital environment. It was small-scale (five beds), intensively staffed by specially trained personnel, and had strict admission criteria. It was very well regarded, both locally and by other trusts attracting visitors and media interest. However, it suffered at one time or another from both the pitfalls of this type of service. Although the unit itself could manage very challenging clients, this was due to the controlled environment and skilled staff. It was still very difficult to move some clients on so the impact on bed blocking was minimal. Also, because of the strict admission criteria, there were times when beds were empty and there was always a pressure to justify the high cost of running it at times when other wards were overflowing.

The focus units
The area covered by South Staffs Healthcare Foundation NHS Trust is split into six service delivery localities. Small-scale focus units were established in three of these. These were social services owned care homes that had a CMHN from the older adult mental health service permanently based there. This was a very different model from the special needs unit since the intention was to create a

This is a synopsis of a paper presented in Brighton at the 2006 PSIGE Conference.
permanent residential environment that the clients could stay in long-term without the disruption of admission and repeated moves. It was hoped that this would achieve several functions.

Firstly, having an experienced, qualified MHN continuously available would allow for individualised care plans that could be based on detailed observations, client-centred principles of dementia care nursing and an informed understanding of the person’s mental health needs. In the meta-analysis reported by Livingston et al. (2005), behavioural management techniques and psycho-education were found to be the direct interventions with the most reliable long-term benefit in challenging behaviour.

Secondly, giving care staff and managers a guarantee of direct and immediate access to mental health services would allow the placement of very challenging clients and pre-empt the need for admissions. Fossey et al. (2006) found that regular meetings between psychiatric staff and care home personnel significantly reduced neuroleptic use. They attribute this to the education provided by the psychiatric staff but it seems equally plausible to suppose that the knowledge that help was immediately available increased staff confidence in approaching demanding situations.

Thirdly, the provision of small localised units would help people to maintain their community and family ties and take advantage of the benefits of small scale facilities. McMinn and Hinton (2000) report a direct relationship between the degree of personal space and the number of other people in an environment and the incidence of aggressive behaviour in dementia facilities.

This model had a lot to recommend it in many ways and it is the case that the localities were these focus units were based managed with relatively few inpatient beds during this period without significant beds crisis or external placements. However, the system was pragmatically very difficult to maintain. Although the CMHNs placed in the focus units initially had personal ties with their other mental health colleagues, they quickly became very isolated and the posts became unpopular and, to some degree, impossible to fill.

**Specialist nursing home beds**

These beds were also intended to provide long-term placements for difficult to manage clients to reduce bed-blocking and admission. They were based within an EMI registered nursing home and were a little unit of four beds. In return for a large annual payment on top of the usual fee, the home was to provide a higher level of staffing including extra, qualified MHNs for these beds. This system never functioned satisfactorily. The difficulty was in establishing an agreement that allowed the trust to place people and allowed the home to retain some jurisdiction over its clientele. In practice, although the trust paid for the beds, it was still unable to place its most difficult clients in them.

**Model 2**

In 2004, the situation was reviewed again. The special needs unit was closed and the health service staff were withdrawn from the focus units. In place of the focus units, an intensive inreach team (IRIS) was developed in those localities they had served. The beds from the special needs unit were essentially lost but the reconfiguration of beds allowed two of the acute older adult inpatient wards to be separated into a functional ward and an organic one. At this time, the whole service was very committed to developing community services rather than admitting people and a new raft of innovations appeared: home care liaison, intermediate care, and reablement; although only home care liaison was specifically targeted at challenging behaviour in dementia.

**The IRIS team**

The IRIS team was designed to be a well-resourced inreach team which could go into nursing homes which were struggling with a client and provide up to six weeks of inten-
sive monitoring and intervention with that client to see if a successful management plan could be developed. It was funded initially for five CMHNs, four care assistants, one OT, 0.2 psychologist and a secretary, although it never achieved its full complement. The intention was that this team would primarily replace the presence of the health staff in the focus units and, perhaps, provide a resource to other homes so that homes were relieved of the stress of struggling to manage and would benefit from the modelling of successful care.

It suffered from its conceptualisation from the fact that it was largely staffed by the staff who had been withdrawn from the focus units so any attempt to help within this context was confounded by memories of the past relationship. In the end, the relationship with the focus units broke down. Although the IRIS team continues to provide some input to other care homes in the locality, it does so on a skeleton staff and is generally thought not to have lived up to expectation. At the most basic level, there has been no reduction in admission from care homes and, often, the team finds that by the time a home thinks to call them in, the home is in crisis and there is irreparable distance between the home and the client.

It is also questionable whether the model of taking over care from the home for a limited period and then trying to hand it back was a good one.

Care Home Liaison
This has been a low-cost success story within the trust. This is a consultancy and educational service provided by just two senior CMHNs. They keep in regular contact with the EMI residential and nursing homes in the area, disseminate information and respond to specific requests for either staff education or advice about a particular client. They have been very well received and have built up an increasing culture of shared training with the homes. The critical element seems to have been the establishment of a close relationship with the homes so that, when a difficulty arises, they are already known and readily approached.

What next?
Despite having piloted a number of different service models as detailed above, the management and placement of challenging clients has continued to present difficulties. During 2005 there was increasing concern about the level of injury that was being experienced on the older adult inpatient wards and an audit of these facilities was carried out recording the number of adverse incidents that were reported between September 2004 and September 2005 (see Table 1 overleaf).

This revealed high levels of challenging behaviour on the organic ward (Ward 1) and one of the mixed wards (Ward 4). Interestingly, although it is not generally considered best practice to have both functional and organic patients in the same ward, the mixed ward which is housed in a purpose-built environment with lots of air and light and space has a much lower incidence of challenging behaviour perhaps highlighting the impact of environment. There is clearly an ongoing need to be met in terms of finding better ways to manage challenging behaviour.

Interestingly, this audit also highlighted a couple of other factors. Firstly, it became apparent that whilst only 10 per cent of our clients were admitted from nursing care, 60 per cent were discharged to it. This suggested to us that very many of our admissions are triggered by a breakdown in care and that the admission would probably be unnecessary if there were not a time lag in finding an appropriate nursing home bed for the client. These clients, who are waiting for permanent placements, often present no significant level of management difficulty and are probably not well served by being in a hospital environment.

The other very significant finding was that 90 per cent of the challenging behaviour incidents were associated with clients who had dementia but that six clients alone accounted for 60 per cent of all inci-
dents (a further nine per cent was accounted for by two more clients). This clearly has implications for service planning since it suggests that it is a relatively small group of clients whose needs are not met by current service provision and that it would be possible to create a small targeted service if one chose to.

The argument for a small targeted service is the level of specialisation that could be offered to our most challenging clients. A small-scale new build could incorporate principles of the intimacy gradient, provide good quality lighting and environmental cues to reduce disorientation, and create curved pathways that lead through areas of interest rather than crossroads that demand decision-making (Stokes & Goudie, 2002). It would be possible to offer interventions that produce an immediate reduction in distress: daily massage, music therapy, cognitive stimulation therapy (Livingston et al., 2005), alternative bathing methods (Sloane et al., 2004) and, use of a garden (McMinn & Hinton, 2000). It would also be possible to ensure that the whole care culture was based on behavioural management techniques (Livingston et al., 2005), the improvement of well-being by withdrawing psychotropic medication (Fossey et al., 2006) and, person-centred care (Moniz-Cook et al., 2000).

However, the success of such units can still be disappointing. Livingston et al. (2005) reported that specialist dementia units are not consistently beneficial and Opie et al. (2002) found that the introduction of a specialist four-person team to create behavioural strategies for managing challenging behaviour did reduce the number of incidents but only by quite a small proportion.

<table>
<thead>
<tr>
<th></th>
<th>Ward 1</th>
<th>Ward 2</th>
<th>Ward 3</th>
<th>Ward 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14 beds</td>
<td>14 beds</td>
<td>9 beds</td>
<td>8 beds</td>
</tr>
<tr>
<td></td>
<td>Organic</td>
<td>Functional</td>
<td>Mixed client group</td>
<td>Mixed client group</td>
</tr>
<tr>
<td>Aggression to staff</td>
<td>82</td>
<td>10</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>Aggression to other patients</td>
<td>32</td>
<td>3</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Self-harm</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Damage to environment</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Other potentially damaging adversity, e.g. falls</td>
<td>48</td>
<td>19</td>
<td>53</td>
<td>76</td>
</tr>
<tr>
<td>Total per bed</td>
<td>9 incidents of challenging behaviour per bed per year. 3.5 other adverse incidents per bed per year.</td>
<td>1 incident of challenging behaviour per bed per year. 1.3 other adverse incidents per bed per year.</td>
<td>4.5 incidents of challenging behaviour per bed per year. 6 other adverse incidents per bed per year.</td>
<td>11.5 incidents of challenging behaviour per bed per year. 9.5 other adverse incidents per bed per year.</td>
</tr>
</tbody>
</table>
The other main alternative is to try to pursue the idea that hospital is rarely a good environment for people with dementia and to build on those models of community based services that have worked well. Two care models seem to offer the extension of home care liaison and the primary care model of expert patients. Our home care liaison has been successful and other services have achieved even more with more intensively staffed inreach teams (Ian James, PSIGE Conference, 2006) so this might well be a way to avoid the crises in care that can occur within care homes.

However, the body of evidence that we have not yet made use of is the impact that carer training can have upon the course of dementia. Of all the interventions one can offer, it would appear that carer education is often the most reliably effective (Livingston et al., 2005; Keady et al., 1995) and often found wanting (Scott et al., 2005). Carer education has been found both to reduce carer stress and burnout, to enable the implementation of behavioural strategies within the person’s own home, to delay admission to permanent care and to improve the well-being of the person with dementia. There is growing interest in the trust in the possibility of acting in a more preventative way as regards challenging behaviour. Both by increasing the availability of services such as intermediate care and reablement, which can provide intensive help in the home at times when care might otherwise be in crisis, but also by developing a long-term relationship with people with dementia and their carers and providing regular support and information, in much the same way that the diabetic nurse does in primary care, so that difficulties can be identified as they arise and help offered whenever needed.

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**References**


Developing consensus for a care pathway for psychological therapy for older adults with affective disorders

Naomi Boycott & Barry Greatorex

Care pathways have been increasingly more popular in the UK in recent years in order to improve the quality of patient care as well as reduce variation in clinical care (Currie & Harvey, 2000; Jones, 1999). This is despite the fact that there is no universal definition of what care pathways are, or what is being implemented when using them (Hale, 1997a; Luc, 2000).

Care pathways originated in the US in order to find a cost-effective way to reduce financial demands for health care being made on insurance companies and the Government (Currie & Harvey, 2000). The National Pathways Association gave the following definition: ‘An integrated care pathway determines locally agreed, multi-disciplinary practice based on guidelines and evidence where available, for a specific patient/client group’ (National Pathways Association, 1998).

There are several advantages to using care pathways in order to develop consensus for care. These include increased communication and collaboration between different disciplines (Layton et al., 1998; Zander, 2002; Luc, 2000; Currie & Harvey, 2000). They can also provide transparency in how care is developed and implemented. It is also seen as a way of standardising and improving care delivery, as found by Currie and Harvey (2000). Finally, it can empower patients to question their care (Currie & Harvey, 2000).

There are also some disadvantages. These include reducing professional integrity in making decisions on individual care (Jones, 1999; Jones & Kamath, 1998) and focussing on cost of care rather than quality (Layton et al., 1998; Norris, 1998; Currie & Harvey, 2000).

Within the Older People’s Services of Derbyshire Mental Health Trust, Clinical Psychology was commissioned to develop a care pathway for the assessment, treatment and care of patients with affective disorder. The chosen approach was to use the Delphi technique to establish consensus opinion on criteria for referral and subsequent psychological treatment.

The Delphi technique originated in the US to evaluate the outcomes of nuclear warfare (Misiner et al., 1994). It has been said to have multiple advantages, including allowing anonymous expert opinion on subjects with controlled feedback in order to achieve a consensual position (Helmer, 1967; Bowles, 1999). The process involves repeatedly questioning a group of experts on their opinions, whilst refining the questions at each stage to take into account ideas that were expressed in previous rounds. This eventually leads to consensual ideas shared by the majority of the group. This technique allows consultation to take place between multi-disciplinary professionals without any influence or group dynamics having an impact.

There have been some criticisms of the Delphi technique, for example, that the lack of group dynamics can also lead to a loss of information, as there may be a reduction in exploratory thinking (Bowles, 1999). There have also been questions about what constitutes an ‘expert’ and what is the definition of consensus. Finally, the Delphi technique has been criticised for vulnerability to sample bias, depending on who returns their questionnaires and researchers with strong viewpoints may influence the conclusions made by the process.
This project uses the Delphi technique as a manageable way to obtain the opinions of experienced clinicians in the area, who are represented by professionals who use some psychotherapy in their work with clients with affective disorders. This seems to be the easiest way of contacting a large number of people who work in the area, rather than conducting numerous one-to-one interviews or convening meetings. The process involves two rounds of consultation, the second of which is refined from the responses of the first. These opinions are then analysed and consensus will be defined as a level of two-thirds agreement or greater.

Method

Participants

Questionnaires were sent to 66 health care professionals in Derbyshire Mental Health Trust who had been identified as using Psychological Therapies on a regular basis by Best Practice Groups or Community Mental Health Teams in the area. A third of these participants were identified as working in an Older Adult speciality, with the remaining participants working in Adult specialities (predominantly with adults of working age). The questionnaires were recognised on the basis of speciality by printing them on two different coloured papers. These participants were invited to complete and return the questionnaire within two weeks of it being sent out.

As the questionnaires were anonymous, the second round of questionnaires were sent out to all 66 again, whether they had participated in the previous round or not.

Procedure

Initial ideas about positive and negative indicators for Psychological Therapies were generated during semi-structured interviews with professionals in the district: one Clinical Psychologist and two Psychotherapists. These views were combined with previous experience and guidance issued for therapy to produce statements about what would suggest that Psychological Therapy would not be helpful, and what information should be shared with other health care professionals on referral letters.

These questionnaires were then sent out to participants for them to agree/disagree/decline to comment on each statement (copies of the questionnaire are available from the second author on request). When returned, these data were analysed to produce percentage of agreement with each statement. At this stage any differences in consensus of those working predominantly with Older Adults/Adults was noted, but did not affect the next step of the process. Consensus was taken as over two-thirds agreement for all respondents.

New questionnaires were then produced, with each statement paired with a percentage of consensus from the first round (copies available from the second author). Any interesting new ideas generated by participants during the first round were also added to look for agreement from the other participants. The same set of participants was then asked to comment whether they agreed/disagreed with the consensus view for each statement.

Results

First round

Twenty-six questionnaires were returned from the first round, and data were analysed to find the percentage of agreement. This was calculated for the whole group, and then separately for Adult and Older Adult specialities to see if there were any interesting differences of opinion. Of the 22 questionnaires sent to people working predominantly with Older Adults 10 were returned (45 per cent). Of the 44 questionnaires sent to those working predominantly with Adults 16 were returned (36 per cent). This gave an overall return rate of 39 per cent.

As the first round questionnaire sought to identify the respondent’s profession, we were also able to compare the ideas of professions on the psychotherapeutic treatment of affective disorders. Table 1 (overleaf) gives percentage agreement for each
Table 1: Percentage agreement for criteria for referral or contra-indications for psychological therapy by profession and client population.

<table>
<thead>
<tr>
<th>Question</th>
<th>Clinical Psychologists</th>
<th>Non CPs</th>
<th>Older Adult Clients</th>
<th>Adult Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Items which may indicate that Psychological Therapy should be considered</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willing to talk</td>
<td>92%</td>
<td>86%</td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>Motivated</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Identify psychological issues</td>
<td>92%</td>
<td>86%</td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>Form an alliance</td>
<td>67%</td>
<td>100%</td>
<td>70%</td>
<td>100%</td>
</tr>
<tr>
<td>Willing to engage</td>
<td>92%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Tolerate distress</td>
<td>92%</td>
<td>93%</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>Take responsibility</td>
<td>67%</td>
<td>86%</td>
<td>60%</td>
<td>88%</td>
</tr>
<tr>
<td>Conflicts in relationships</td>
<td>100%</td>
<td>57%</td>
<td>100%</td>
<td>63%</td>
</tr>
<tr>
<td>Absence of relationship</td>
<td>67%</td>
<td>64%</td>
<td>60%</td>
<td>69%</td>
</tr>
<tr>
<td>Relationships are asymmetrical</td>
<td>83%</td>
<td>57%</td>
<td>90%</td>
<td>56%</td>
</tr>
<tr>
<td>Anxiety about health</td>
<td>67%</td>
<td>86%</td>
<td>70%</td>
<td>81%</td>
</tr>
<tr>
<td>After bereavement</td>
<td>58%</td>
<td>57%</td>
<td>60%</td>
<td>56%</td>
</tr>
<tr>
<td>Recent life changes</td>
<td>67%</td>
<td>76%</td>
<td>70%</td>
<td>75%</td>
</tr>
<tr>
<td>Physical illness</td>
<td>58%</td>
<td>57%</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>83%</td>
<td>93%</td>
<td>80%</td>
<td>94%</td>
</tr>
<tr>
<td>Personality difficulty</td>
<td>100%</td>
<td>64%</td>
<td>90%</td>
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<tr>
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<td>76%</td>
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<tr>
<td><strong>Items which represent contra-indications or adaptations required for therapy</strong></td>
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<tr>
<td>Contra-indications</td>
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<tr>
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<td>Adaptation needed</td>
<td></td>
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<tr>
<td>Mild/moderate</td>
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<td>71%</td>
<td>90%</td>
<td>63%</td>
</tr>
<tr>
<td>English not first language</td>
<td>67%</td>
<td>71%</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>Different culture</td>
<td>67%</td>
<td>71%</td>
<td>70%</td>
<td>69%</td>
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<tr>
<td><strong>Items for information which should be included in a referral</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social/family relationships</td>
<td>83%</td>
<td>76%</td>
<td>90%</td>
<td>75%</td>
</tr>
<tr>
<td>Life history</td>
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<td>86%</td>
<td>80%</td>
<td>81%</td>
</tr>
<tr>
<td>Cognitive function</td>
<td>92%</td>
<td>86%</td>
<td>100%</td>
<td>81%</td>
</tr>
<tr>
<td>Information on risk</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>Personality dynamics</td>
<td>67%</td>
<td>71%</td>
<td>70%</td>
<td>69%</td>
</tr>
</tbody>
</table>
item on the questionnaire divided into the different sections in the questionnaire; items which may indicate that Psychological Therapy should be considered; items which represent contraindications or adaptations required for therapy; and items for information which should be included in a referral. This table can be used to compare the percentage agreement between Clinical Psychologists and non-Clinical Psychologists, and between those staff who work predominantly with Older Adults and those who usually work with Adults.

These percentages of agreement were compared using a Pearson’s chi-square (SPSS Inc). There was a significant difference between Clinical Psychologists and other staff using psychotherapy in their views about difficulties with language being a contra-indication for therapy \((p = .034)\). More than 4 in 10 Clinical Psychologists thought a significant language problem from a stroke or other pathology would be a contra-indication for Psychological Therapy, whereas 7 in 10 of other Psychotherapists felt this way. There was also a difference in opinion about the contra-indications for a client with a significant suicide risk which approached statistical significance \((p = .08)\). In this case half of Clinical Psychologists and three-quarters of Psychotherapists felt that suicide risk was a contra-indicator for referring for Psychological Therapy.

When comparing the responses of people working with mainly Older Adults with those of people working with Adults there was again a difference in opinion about difficulties in language \((p = .017)\). Forty per cent of people working with Older Adults and seven of 10 of those working with Adults felt that significant problems with language would be a contra-indication to referring for Psychological Therapy. The risk of suicide approached significance \((p = .08)\) between the two groups (60 per cent of Older Adult group and 69 per cent of Adult group agreed). Also the issue of the client having poor physical health or using debilitating medication (meaning they find it difficult to attend therapy) being a contra-indication divided opinion and approached statistical significance \((p = .06)\). Here 4 in 10 of people working with Older Adults and over half of those working with Adults felt it would be a contra-indication.

**Second round**

Thirty-one questionnaires were returned in the second round of the process and percentage of agreement was calculated overall, for the Older Adult group and the Adult group. Again, 10 questionnaires were returned by staff working with Older Adults, but this time 21 questionnaires were returned by those working with Adults. This gave a return rate of 47 per cent. When the responses of staff working with Older Adults were compared to those of staff working with Adults, there were no statistically significant differences of opinion.

Table 2 (overleaf) gives the percentage agreement between Adult and Older Adult staff groups.

From the overall calculations of agreement there are 31 statements which achieve over a two-thirds consensus. These will now be used in producing the referral guidelines for Affective Disorder in Older Adults. The statements that failed to reach consensus were about whether language difficulties, high suicide risk or poor health/medications that make it difficult to attend therapy, were contra-indications to refer a person for Psychological Therapy.

**Discussion**

The aim of this project was to collect the ideas of staff in Derbyshire who use Psychotherapy on a regular basis in order to establish a consensus about referral guidelines for Older Adults with affective disorders. Interviews were conducted with three experienced clinicians who specialise in different areas of psychotherapy, and their views were combined with a review of published material to produce a number of statements concerning issues on referral for psychotherapy. These statements were trans-
Table 2: Percentage agreement in round two of Delphi consultation by client population.

<table>
<thead>
<tr>
<th>Question</th>
<th>Older Adult Clients</th>
<th>Adult Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Items which may indicate that Psychological Therapy should be considered</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willing to talk</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Motivated</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Identify psychological issues</td>
<td>70%</td>
<td>81%</td>
</tr>
<tr>
<td>Form an alliance</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Willing to engage</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Tolerate distress</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Take responsibility</td>
<td>70%</td>
<td>76%</td>
</tr>
<tr>
<td>Conflicts in relationships</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Relationships are asymmetrical</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Absence of relationship</td>
<td>90%</td>
<td>71%</td>
</tr>
<tr>
<td>Anxiety about health</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Understand mind-body link</strong></td>
<td>80%</td>
<td>86%</td>
</tr>
<tr>
<td>Recent life changes</td>
<td>100%</td>
<td>86%</td>
</tr>
<tr>
<td>After bereavement</td>
<td>90%</td>
<td>67%</td>
</tr>
<tr>
<td>Physical illness</td>
<td>90%</td>
<td>62%</td>
</tr>
<tr>
<td><strong>Lack of resolution</strong></td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>Personality difficulty</td>
<td>100%</td>
<td>71%</td>
</tr>
<tr>
<td>Increased risk/self-harm</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Items which represent contraindications or adaptations required for therapy</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Contra-indications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe cognitive impairment</td>
<td>80%</td>
<td>71%</td>
</tr>
<tr>
<td>Uncontrolled drug/alcohol abuse</td>
<td>60%</td>
<td>76%</td>
</tr>
<tr>
<td>Severe psychosis</td>
<td>80%</td>
<td>86%</td>
</tr>
<tr>
<td>Language difficulties</td>
<td>20%</td>
<td>29%</td>
</tr>
<tr>
<td>High suicide/ self-harm risk</td>
<td>60%</td>
<td>48%</td>
</tr>
<tr>
<td>Difficult to attend</td>
<td>30%</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Adaptation needed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild/moderate cognitive problems</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>English not first language</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Different culture</td>
<td>90%</td>
<td>90%</td>
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<tr>
<td><strong>Items for information which should be included in a referral</strong></td>
<td></td>
<td></td>
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<tr>
<td>Social/family relationships</td>
<td>80%</td>
<td>81%</td>
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<tr>
<td>Life history</td>
<td>70%</td>
<td>76%</td>
</tr>
<tr>
<td>Cognitive function</td>
<td>80%</td>
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<tr>
<td>Information on risk</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Personality dynamics</td>
<td>70%</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Need to know basis</strong></td>
<td>80%</td>
<td>95%</td>
</tr>
</tbody>
</table>

*Note:* Items in **bold** were generated from the first round of consultation and were added for comment in the second round. ‘Lack of resolution’ refers to someone’s difficulties remaining after a prolonged period of time (e.g. six months). ‘Need to know’ refers to information only being shared in a referral on a need-to-know basis.
lated into simple agree/disagree-style questionnaires, which were then posted to 66 clinicians working in the Derbyshire Mental Health Trust. Their responses were collated and analysed to produce a second round of questionnaires including figures showing the level of agreement from the previous round. Responses from this questionnaire were again collated and analysed, producing levels of consensus for each statement on the questionnaire.

Through this process, 31 statements achieved over a two-thirds consensus and will now go on to form the basis for the proposed referral guidance for Older Adults with affective disorders in Derbyshire Mental Health Trust. These statements are listed in an appendix available from the second author.

Further analysis has shown some discrepancies in the views of different professionals and those with client groups of different ages. The opinions of Clinical Psychologists and non-Clinical Psychologists were separated and compared, producing a statistically significant difference in opinion over one item. This was a question about whether significant language difficulties would be a contra-indication for using Psychological Therapy with them. This question also produced a significant result when comparing the responses of those who work predominantly with Older Adults as opposed to Adults. (This is not surprising as 9 out of the 10 Older Adult specialists were psychologists.) This discrepancy suggests that Clinical Psychologists who specialise with Older Adults would see it as less of a problem if a person were referred to them with significant language difficulties. This may be due to having more experience with language problems as strokes, which often affect language, are more common at a later age. It may also be that these Psychologists are more integrated into a multi-professional team, and so would find it easier to gain advice from/work alongside a Speech and Language Therapist or Interpreter.

Another item that approached statistical significance between the Clinical Psychologists and non-Clinical Psychologists, as well as between the Older Adult and Adult group, was the item about high suicide risk being a contra-indication for therapy. This again may be due to experience or because they may be surrounded by a multi-professional team who can provide extra packages of support if needed.

A third statement approached statistical significance between those specialising in Older Adults or Adults. This item was about physical health or medication being a contra-indication for Psychological Therapy. This discrepancy mirrors the others in that it could be due to experience with Older Adults, who often have other health complaints and medication, which may make it difficult for them to attend therapy. Those who work with Older Adults often offer home visits for people who are less mobile, so that this interferes with therapy to a lesser degree. This could be a reason why those working with Older Adults more often saw this item as less of a problem for therapy.

These differences in opinion between the specialities and professions are interesting, and could possibly be addressed by providing greater awareness about working with Older Adults and the issues/resources that are available. As the sample size in this project was quite small, there may have been more statements that would have reached a statistically significant difference in opinion if a larger sample of psychological therapists had been included. This may be an interesting area for future research.

The lack of difference in opinion between the specialities from the second round of consultation may reflect the methodology used in this project. In the second round of consultation using the Delphi technique percentages of consensus from the first round are given alongside each statement, and people are asked whether they agree or disagree with these. As people are often influenced by conformity to group norms, this may explain why there
were no differences of opinion found in the second round of this project. This is one of the criticisms levelled at the Delphi technique.

However, these findings suggest that the Delphi technique is effective in facilitating consensus for at least some clinical decisions in a relatively time-efficient way. Guidelines derived from this work are planned, and there are also plans to use this approach to achieve consensus on other parts of a care pathway for older people with affective disorder.

References


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Loneliness and befriending
Nicky Knights, Xanthippe Tzimoula, Hilary Clarke, Amy Bartlett & Georgina Charlesworth

Loneliness and befriending were the foci of a symposium presented by a team from the ‘Befriending and Costs of Caring’ (BECCA) trial. The aim of the symposium was to make the case for social support interventions for family carers of people with dementia. Loneliness and social isolation have previously received scant attention in comparison to the studies of carer burden and carer depression. However, loneliness in carers of people with dementia has been shown to be a significant predictor of depression (Beeson et al., 2000; Beeson, 2003), and in the general population loneliness has been associated with: poorer social interactions; low self-esteem; higher physical and psychological morbidity; and, higher mortality rates. Greater attention is needed to identify the predictors of loneliness in carers and possibilities for ‘social enhancement’ interventions.

The four presentations in the symposium included two literature reviews and two empirical papers. Nicky Knights reviewed the literature on the predictors and consequences of loneliness (Knights et al., 2006), providing context for Xanthippe Tzimoula’s analysis of predictors of loneliness for carers of people with dementia (Tzimoula et al., 2006). Amy Bartlett reviewed the evidence-base for social support interventions for isolated elders (Bartlett et al., 2006), and Hilary Clarke presented a provisional analysis of the characteristics of carers who chose to use the befriending service (Clarke et al., 2006). The work presented represented different psychosocial aspects of the BECCA project, which is an HTA-funded randomised controlled, cost-effectiveness trial of befriending of family carers of people with dementia by trained, lay volunteers. The economic aspects of the trial were not covered. In this paper, we aim to give a flavour of the symposium presentations.

Loneliness as a consequence of caring
Peplau and Perlman (1982) defined loneliness as ‘a discrepancy between desired and actual or perceived social network and/or intimate attachments.’ In an earlier work, Weiss (1973) had drawn a distinction between ‘social’ and ‘emotional’ loneliness where social loneliness was defined as a perceived deficit in social network/relationships and emotional loneliness defined as a lack of intimate attachment, or a dissatisfaction with the quality of intimate relationships. de Jong-Gierveld (1987) highlighted the possibility that cognitive processes and appraisals mediate between the social network and experience of loneliness. In other words, an individual’s appraisal style will influence whether or not a socially isolated carer feels emotionally lonely.

Carers may experience a reduction in their social network due to a lack of opportunities to socialise and/or the stigma associated with a dementing illness. Carers report less social interaction and fewer friendships (Lofgren et al., 1992; Croog et al., 2006). The emotional and physical burden of caring can result in family role conflicts that may reduce the amount of emotional support available, and a carer’s family and friends may ‘distance’ themselves physically and/or psychologically from the carer and care-recipient contributing to reduction in social support for the carer (Jones & Peters, 1992, Upton & Reed, 2006, Clyburn et al., 2000).
Predictive and protective factors
Loneliness in the general population has been associated with: personal inadequacy; unfulfilling intimate relationships; relocation and social marginality (Rokach & Neto, 2005); older age; lack of friends; lower socioeconomic status, living alone, widowhood and living in a rural environment (Dykstra et al., 2005; Savikko et al., 2005); higher stress appraisal, lower perceived ability to cope with stress and meet demands; use of passive coping and behavioural disengagement; and, a belief in uncontrollable outcomes and powerlessness (Cacioppo et al., 2000, Hawkley et al., 2003). Protective factors are thought to be: companionship (Rook, 1987); higher ‘social capital’; marriage; and, long standing friendships, especially for women and where the friendship is based on choice and not obligation (Hall-Elston & Mullins, 1999).

Using the BECCA baseline (pre-randomisation) data, Tzimoula et al. (2006) carried out an analysis of data on emotional loneliness for 149 spouse carers of people with dementia. Overall, levels of loneliness were low, with a mean score of 2.8 (range 0 to 8). Social isolation was not significantly related to emotional loneliness. Eighteen per cent of the variance in loneliness was explained by the variable ‘duration of caring’ and the life event ‘previous loss of a close relative’, and a further 13 per cent was explained by ‘perceived lack of social support’, and ‘loss of companionship with the person with dementia’. Gender and age were not significant predictors. The results indicated that improving the perception of social support could reduce a carer’s sense of emotional loneliness. In other words, carers may benefit from the provision of social support interventions.

Social support interventions
In terms of social support interventions, a range of models has been devised and evaluated, but reviews of the evidence base of social support interventions generally highlight the lack of methodological rigour in those evaluations (e.g. Andersson, 1998; Cattan et al., 2005; Hogan et al., 2002). A difficulty in such reviews has been the confounding of the loneliness and social support concepts (Cattan et al., 2005).

A commonly used model of social support is ‘befriending’, and there are many befriending schemes in the UK, most particularly in the voluntary and charitable sector. The aim of befriending varies between schemes (Bartlett et al., 2006), but the hope for the BECCA befriending scheme is that befrienders may reduce depression, or prevent its increase over time, through provision of companionship and emotional support. The mechanism for such an impact may be through increasing the size of the social network, improving the perception of social support or reducing loneliness. At the inception of the BECCA project in 2000, there were no high quality trials of befriending interventions for carers of people with dementia. Since then, a report has been published of peer support that found no significant impact (Pillemer & Suitor, 2002).

Intervention uptake
Of 109 carers in contact with the Befriender Facilitators (co-ordinators for the local befriending schemes), only 58 (53 per cent) requested to be matched with a volunteer befriender. In comparison with interventions offered in other trials with carers, the uptake is not unusually low, and indeed, compared to some it is very good. However, in an intention-to-treat analysis, low uptake interventions are at greater risk of showing no significant benefit over control. We were, therefore, interested to know which carers were most likely to take up the befriending intervention. A preliminary analysis of 94 carers randomised to intervention showed that spouses were most likely to take up the befriending intervention. The only other variable that approached significance was a measure of emotion-focused rumination. This was in keeping with previous research that demonstrated that people with...
a ruminative coping style seek more social support (Nolen-Hoeksema & Davis, 1999).

**Conclusions**

Loneliness is an important concept in understanding depression in carers of people with dementia. The provision of social support interventions may be valuable in improving carers’ perceived levels of social support, and thus reducing levels of loneliness and depression. To date, there are no published reports of large scale, high quality intervention trials for social support interventions for carers of people with dementia, and the BECCA trial was commissioned to fill this gap. Preliminary analyses of information on those carers randomised to intervention indicate that spouse carers are more likely to take up a befriending intervention based on companionship and conversation, and this is in keeping with the finding that lack of perceived social support and loss of companionship with the person with dementia are significant predictors of loneliness. Data collection for the BECCA project was completed in July, 2006, and the full report will be available via the HTA website once it is published, hopefully in early 2007. It is also planned that the results be disseminated through peer-reviewed journals.

**Acknowledgements**

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References


‘Gentlemen who lunch’: Developing self-help groups for people with early diagnosis of dementia

Kerri Lees

The following article outlines a group therapy intervention used with people who have dementia. It describes how a memory group for people with dementia developed into a long-term support group and explains the difficulties encountered in incorporating a self-help concept. A self-help group is defined by Self-Help Nottingham as ‘a group consisting of people who have personal experience of a similar issue or life situation, either directly or through their family and friends. Sharing experiences enables them to give each other a unique quality of mutual support and to pool practical information and ways of coping’ (www.selfhelp.org.uk/whatis.htm).

The following points will be discussed:

● the complications that arose in co-ordinating the group;
● the group dynamics and how leadership roles developed;
● the way in which the structure of the sessions evolved;
● the participants’ reluctance to say goodbye.

The author was struck by the complexity of emotions and discussions that took place during weekly sessions over a six-month period. Within this piece of work various responses and comments have been included that were made by the participants in order to demonstrate this. In accordance with the NHS code of conduct on confidentiality and the Data Protection Act (1998) all names used are pseudonyms. Consent to write this article has been gained from all clients.

Background

Support groups for people who have dementia aim to provide a therapeutic setting for clients to share their experiences, to problem solve and learn coping strategies from one another (Jones et al., 2002). Research has been conducted into the experiences of people who have dementia (i.e. Harris, 2002; Lingard & Milne, 2004; Clare, 2003; Sabat, 2002). Whiting (2001) studied services for young people with dementia and the ways in which these could be developed. Whiting explored the pathways into diagnosis and what help and support services were being received. The study concluded that most participants were happy with the services offered. Concerns were raised regarding the lack of information provided about the progress of dementia; counselling not being readily available; having to wait too long for a diagnosis and the general manner in which diagnosis was given (Whiting, 2001). Mental health services are increasingly shifting the profile of their services to supporting individuals in the early stages of dementia and it is evident that many mental health services for older people offer psychosocial interventions (such as memory clinics and memory support groups) for individuals with dementia. However, as the concept of developing self-help groups1 for individuals in the early stages of dementia is still relatively new, the principles and protocols for such groups remain unclear.

1 Evidence suggests that self-help groups do exist for people who are caring for family members or friends with dementia, for example, those organised through Alzheimer’s Disease International (as cited on www.alz.co.uk).
The Memory Group – how the group started
Initially, five clients (all male) were referred from a Memory Clinic to a Memory Group that would last six weeks. It was clear from the beginning that this particular group wanted to start preparing for the transitional stages of dementia, thus, the coping strategies commonly used in memory groups (i.e. the use of diaries, and calendars) were of little interest. They were very eager to use the group setting as a forum to discuss their emotions, feelings of loss, alienation, fear and distress. A real sense of friendship was observed within the first few weeks.

Developing the Support Group – how the group evolved
As the Memory Group ended, there was a strong reluctance to say goodbye and the participants expressed a strong wish to continue meeting. They needed more time to understand and come to terms with their diagnosis. A Support Group was set up to facilitate this need with a review after an eight-week period. The clinical objectives encompassed the following:
- To support each other in coming to terms with their diagnosis of having dementia.
- To provide an opportunity for people with dementia to express feelings of fear and distress regarding their future.
- To encourage and promote the experience of sharing such feelings with others.

Measures of anxiety and depression were taken independently of the clinical work at the start of the group to establish a baseline. The style of the group remained relatively informal with the subject matter or agenda of each meeting very much directed by the clients. It soon became clear that this weekly meeting was an important event for this group of men and a multi-disciplinary meeting was held to discuss the future of the group.

Developing the Self-Help Group
The idea of developing a Self-Help Group was proposed at a team meeting where it was suggested that the group continue to run independently of a facilitator. This proposal was discussed and agreed with the members of the group. Facilitator input was gradually reduced to spending the last 45 minutes of the session with the group to summarise the topics of discussion and answer any questions. A psycho-education element was also provided (i.e. theories on brain and behaviour, communication in dementia, medication awareness and the implications of anti-dementia drugs) in this part of the session, in addition to preparing some form of informal presentation to deliver, based on such issues. Thus, the primary aspect of the facilitator’s role for this group was now to act as a resource person for the participants.

Difficulties that were overcome
When the self-help concept was introduced, there was a consensus amongst participants that the group was ‘too fragile’ to run in the absence of a facilitator, however, the members wished to continue their weekly meetings and decided to give it a try. After a short period the group members were also concerned that their sessions were losing structure and they requested a group leader: ‘a little group like ours needs a guiding hand as it gives us a sense of direction, it’s difficult to organise ourselves’. It seemed that some members of the group were unintentionally dominating the sessions with others having less opportunity to speak. Once again this issue was discussed within a team environment where the need for a facilitator was recognised.

Due to a 12-month contract the facilitator was not in a position to continue facilitating the group and monitor the outcome of the group. This also evoked some emotion amongst the group members as they felt they were ‘losing another form of support’. However, as the necessity to continue the group became clearer a new facilitator was introduced. The sessions continued not only...
enabling a sense a security to the clients but also allowing service evaluation to continue and highlighting the NHS move towards service involvement.

Over time the group expanded. Whilst some members frequently requested that others join their sessions, some preferred to keep numbers relatively low and made comments such as ‘too many heads, too much confusion’. On reflection, it is thought that some people felt safe and secure within the confines of a small group and were perhaps threatened by the idea to expand the size.

What was talked about – the significance of the group

Diagnosis and causes

In the first few weeks of the group coming together discussion ensued regarding the diagnosis of Alzheimer’s disease and Vascular Dementia, possible causes (i.e. old age, family link) and risk factors associated with different dementia types, the progression of the disease, its unpredictable nature and the way in which dementia is a different experience for everyone – the frustration of not knowing what’s to come. The clients remained aware of their condition and had great insight into their early cognitive impairment. Reactions to the diagnosis ranged from relief at having it confirmed (finally an explanation for apparent confusion), to denial or indifference.

Ethical issues

1. Informing patients of diagnosis

Some members were keen to discuss ethical considerations in relation to sharing the diagnosis when people decide they would prefer not to know that they have dementia. Barry was quite passionate in his arguments stating, ‘everybody should be told their diagnosis’. This was attributed to Barry’s current situation. He appeared to be somewhat isolated and had little contact with his family. He, therefore, advocated the importance of knowing what the future holds for the independent person. On the other hand, John was opposed to Barry’s views on this matter and used the Human Rights Act (1998) to argue that people ‘have a right to make their own decisions’. John expressed empathy for those who may not want to know their diagnosis and want to continue living a ‘normal’ life.

2. Advance directives

The group spent considerable time talking about Advance Directives and the possibility of drawing up ‘living wills’ formally to make a person’s needs known about future care. This extremely sensitive issue produced high levels of expressed emotion and frustration leading to intense discussions on the ‘necessity’ of advance legal planning and the implications of this (i.e. confiding in family and friends in relation to future wishes). A protocol for Advance Directives is currently being formulated, as part of service provision for Mental Health Services for Older Adults.

Labelling

The group commonly discussed the use or misuse of the term ‘dementia’ and their grievances associated with the word. This was a topic that created heated debates on more than one occasion. John who argued, ‘because of the stigma attached to this word, people with dementia are often perceived as being six feet under’, expressed a clear example of this frustration. There was a strong desire to find a new word for dementia. Alternative terms included ‘cognitive disorder’ and ‘cognitive impairment’.

Research

The members of the group liked to remain aware of new developments/potential future research in this field and often arrived at the sessions with newspaper articles relating to this. They were keen to have guest speakers and requested presentations on a variety of different issues including medication, nutrition, speech and language therapy, and social services. Representatives from a range of organisations came and talked to them including: CROP (Citizen’s Rights for Older People); the local representative from The
Alzheimer’s Society; and, Kent County Council regarding assistive technology.

**Word-finding difficulties and memory loss**

Another common concern was word-finding difficulties and awkward silences in the company of friends as well the embarrassment associated with feelings of inadequacy. Mark talked about the way in which he substituted words (e.g. using apple instead of pear) when he had trouble remembering the correct word. When language problems were apparent in the sessions, supportive comments were made such as ‘that’s fine, all of us go through a period of drying up when talking and sometimes we stop for a moment until someone helps us out with a word’. A memory management aspect to the sessions enabled the clients to discuss the impact of memory loss and their feelings about it. Different coping strategies for remembering were explored and the group found it useful to share and exchange ideas on how to manage day-to-day problems.

**Loss of dependency**

There was often a regrettable sense of dependency amongst the group members – in particular, the possible changes that were taking place in established marital roles (i.e. wife newly managing all finances). This element of role reversal appeared to be more distressing for those who had successful academic and occupational backgrounds. There was a definite sense of at times ‘being a failure’. It was important for the facilitator to shift the emphasis towards what each individual was able to achieve and to encourage them to continue using those skills. Interestingly, the group adopted this approach with each other.

It was apparent that some members found it easier than others to talk openly about their feelings. However, as the group grew to trust one another they all opened up and agreed that talking through concerns helped to maintain self-esteem and prevent emotional build up/overload. Barry’s quote provides an example of this;

‘Some people are funny, some odd and some perfectly normal, but there are others like me, who cannot remember things, we are called as having dementia which includes those that have had a stroke or those that have Alzheimer’s disease. We are not a problem to the public at large but only to friends and ourselves because we are constantly forgetful. This is irritating to us but our new way of coping is to have a group of similar persons to meet weekly to discuss our problems in our own way and time. We learn from each other … with questions and answers it helps us to understand what is going on.’

**Physical and mental health**

Physical health and the complex interplay with mental health issues were also discussed. Older members of the group exhibited growing concerns about the ways in which physical illness (e.g. arthritis) and other types of chronic disease predominantly affect older people. There was a sense of ‘not being able to do as much as I used to’ as well as increased tiredness. It was also recognised by the group members how they attribute each ache and pain to dementia.

**Treatments**

Anti-dementia medication was a popular subject as was the psychological and physical symptoms of adverse drug effects. Joe experienced dizziness and occasionally an unusually slow heartbeat, which was disconcerting to both him and his family. He also experienced bouts of depression and anxiety and made comments such as ‘I don’t have a future anymore’. The group acknowledged and, to some extent related to, Joe’s feelings but nevertheless remained very positive and optimistic with responses such as ‘yes, you do, you have a wife and two daughters to live for’.

**Looking towards the future**

Finally, there was a focus on wellness and optimism. With acceptance of the unpredictability of the disease and the men’s reali-
sation that they may live for many years, the idea of not dwelling on the future and taking ‘one day at a time’ became more prevalent in later sessions.

**Gentlemen who lunch**

After a few months, the participants requested to meet outside their weekly meetings for social gatherings. For example, they arranged to attend the local fête of one group member. They also exchanged contact details and would occasionally telephone each other.

The group then started to meet every two weeks for lunch and with some assistance organised this between themselves. Joe’s wife was very supportive of the group and was not only a volunteer driver for the lunch dates but also contributed to and produced information and research evidence on matters such as alternative therapies and lifelines. Joining each other for lunch was particularly important to the group especially as they felt they ‘could be themselves’ and had little need to be embarrassed when they made mistakes such as forgetting what they had ordered or using the wrong cutlery.

**Conclusion**

To summarise, the self-help concept in relation to group therapy appears to be relatively uncommon. It was refreshing to meet a group of men who wanted to talk openly about their feelings, anxieties and concerns and to use a group forum to facilitate a process of emotional change. This group shows that early intervention can yield positive results not only in establishing support networks but also in reducing anxiety levels as indicated from anxiety scores following three months of intervention. This article has described how a memory group developed into a support group whilst incorporating a self-help concept. It has referred to some of the difficulties encountered in this process and described how they were overcome but, more importantly has highlighted the need for long-term support for people who are diagnosed with dementia as illustrated in the following statement made from Jim, ‘We feel that the operation of the group has been highly successful in terms of improving our situations. It has lifted the gloom and eliminated suicidal thoughts.’

On the other hand, the open-ended nature of this and similar groups also highlights concerns about how long they can last, when members become unable to benefit from such support as the cognitive disorder progresses.

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2 The content of the weekly meetings were analysed for the purposes of an in-service clinical audit to assess the effectiveness of early interventions with people who have dementia. For a full report of this audit please contact the West Kent NHS & Social Care Trust.
Kerri Lees

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Terrors of growing old: Dependency, loneliness and death

Paul Terry

Dependency

I was inspired to take up work with older people by seeing a videotape of Peter Hildebrand who pioneered work with older adults at the Tavistock Clinic (Hildebrand, 1995). Hildebrand recorded his work with an 89-year-old woman. He had agreed to see her for a few exploratory sessions. It was riveting to see this older client relishing the opportunity to be listened to and thought about. She grasped her therapist’s words with obvious delight. Hildebrand was also clearly enjoying this experience. He went on to work with this woman in weekly sessions until she died two years later.

I was particularly interested to learn that Hildebrand’s client was formidable until only a short while before she was referred. Prior to the referral, for the first time in her long life, she had contracted a severe physical illness. Although she soon recovered her physical health it was as though psychologically she collapsed: she was unable to resume her independent and active life. I was reminded of her when I started working with older people and met a client whom I called Mrs Taylor (Terry, 1997) who had also led an extraordinarily busy life into her 80s. She continued to help out in the family business often lifting heavy machinery, at the same time as housekeeping and gardening for her son and daughter-in-law. She suffered from an attack of shingles and though making a good recovery, she withdrew to her flat and spent most of the day lying on a sofa, weak and breathless, apparently unable to do anything for herself. She would usually begin her sessions addressing me with a pleading look to help her unbutton her coat as though she no longer had any capacities.

Although there was some physical basis for Mrs Taylor’s weakened state her doctors were puzzled by how helpless she had become. I felt impelled to help her with her coat and remained in some conflict about how to manage such demands from her, frightened that the demands would escalate and wary of being controlled by this apparently helpless old woman.

I worked with Mrs Taylor in once weekly sessions over a period of five months. The last two sessions were in hospital where she died. In the latter weeks I found myself worrying that Mrs Taylor was dying and I spoke to her about worries she might have about dying. Mrs Taylor said she wasn’t worried about dying and reiterated her belief that God would take her when He was ready. However, in a session just before she died she added that no-one had come back from the grave to say what it is like. I found when I interpreted some of Mrs Taylor’s anger with me, for example, about abandoning her during my holiday breaks, she was able to be more robust and lively. Although she rejected interpretations about a fear of death the interpretations seemed eventually to enable her to acknowledge a not-knowing about what death brings.

My subsequent experience of work with older people has confirmed a pattern in which people who have often led exceptional lives, in old age can suddenly become psychologically debilitated by the onset of a physical illness or other intimations of dependency. The psycho-analyst Brian Martindale has written a seminal work which sheds light on the underlying process (Martindale, 1989). He describes the experience of becoming ‘dependent again’ in old age as presenting particular problems when...
there have been failures in the dependency relationship early in life. The approach of dependency heralded by the decline in physical and mental capacities brings a revival of fears that once again dependent needs will not be met. As Martindale points out these fears can be powerfully communicated to therapists and others who consciously or unconsciously can dread clients becoming dependent on them (which may also resonate with fears the therapists may have about their own parents). Such worries can lead to difficulties in these older people receiving the help they need, for example by being referred from one professional to another.

Discoveries in psycho-analytic infant observation help us understand more about the catastrophic anxieties underlying a dread of dependency. Pioneering work by Esther Bick (Bick, 1968) reveals how important it is that the infant be sufficiently held by mother or primary caretaker, meaning physically as well as mentally held in mind. The infant at first has little sense of time or continuity in relation to his bodily or emotional experiences, and needs mother to hold the different aspects of him or herself together. Following repeated experiences of being held, the infant eventually internalises a sense of mother’s holding and containment.

If there is a prolonged experience of being unheld then the infant will experience **unintegration**, which Bick and others have articulated as a terror of ‘falling to pieces’ or ‘dissolving into space’. Thus in its earliest echoes a fear of dependency can reflect a dread of ‘unintegration’. Bick understood that when there has been insufficient holding the infant and child may develop ways of holding him or herself together in premature ways like using its own body or mind in the absence of an internal sense of containment. I think these often formidable older people who collapse into helplessness probably held themselves together and avoided depending on others until these defences were punctured by painful reminders of vulnerability and dependency which triggered terrors about falling to pieces.

I was asked to help staff in a nursing home about one of their residents, ‘Mrs Brown’, who had become rude and aggressive toward the staff, often shouting insults at them and other residents. She had started refusing to walk, and held onto the sides of her wheelchair as though she was frightened she would fall out of it. It seemed she was very knowledgeable, and was keenly aware of everything happening in the home. She had worked as a carer herself, and as the eldest of a large family looked after her younger siblings. Recently a nurse who had been very important to her had left. I talked to the staff about all the losses in this woman’s life, including the loss of her home and independence, and most recently the nurse on whom she had depended. I said I thought she had probably held herself together throughout her life, perhaps through her good grasp of general knowledge and through caring for others. The loss of her nurse may have been the last straw and revived an early infantile dread of falling to pieces. It seemed to help the staff bear Mrs Brown’s abusive behaviour when they could see that her harsh words and aggressive behaviour could be a way of stiffening herself and trying desperately to hold herself together again. It can also be useful in therapy when older clients may appear harsh in their criticisms or attacks, to consider whether in this way they are trying to manage a dread of unintegration and that these omnipotent defences may be a way of survival (Symington, 1985). The tension in using this understanding is undoubtedly to appreciate the revival of infantile terrors in an older person without infantilising them or overlooking their long life experience.

Mrs Brown made her carers feel contemptible and helpless. I think she projected these feelings into them with the unconscious hope that they might be able to bear such feelings, and perhaps understand how she felt. Projective identification was
first elaborated by Melanie Klein (Klein, 1946) who understood that in unconscious phantasy parts of the self are lodged in others who then become identified with those feelings. Klein's followers have developed an understanding of the communicative aspects of this projective process. Projective identification is often not just a phantasy but by various means in verbal and non-verbal behaviour – the tone of voice, a raised eyebrow and so on – feelings and states of mind can be evoked in the recipients of the projections who can mistakenly identify these feelings as their own, or as only their own, and not appreciate the feelings as a communication. This use of projective identification unconsciously to lodge parts of oneself in someone else effectively treats the other person as an extension of oneself, like gluing oneself to another and thereby denies separateness. Projective identification can also in unconscious phantasy be in a way of possessing and controlling another which can again can have an effect, as in the way Mrs Brown dominated her carers' thoughts and conversations.

A man in his 70s, ‘Mr Smith’ presented with a very disabling physical symptom for which no organic basis could be established. His life was severely diminished because his mobility was so restricted. It emerged that his son to whom he had been very close, had died after suffering a long and disabling physical illness. Mr Smith's symptoms were very similar to his son's. He had identified with his son in quite a concrete way, unconsciously he felt he was his son and had not lost him. To paraphrase Freud's memorable words (Freud, 1917), ‘the shadow of his object (his son) had fallen on his ego’. We can now understand the underlying process as a form of projective identification which obstructs mourning because it possesses and controls the lost loved one in the mind, not allowing them to die or to be separate.

Projective identification when used to deny separation and to possess and control, can have constraining and controlling effects externally on those who are important to us; and because such figures are incorporated into our unconscious internal world, it can stifle and constrict our our mind, our emotional resources and creativity. For example, Mrs Brown, the resident in the nursing home, was known to have some artistic talent but rejected any encouragement to continue such activities.

**Loneliness and Death**

Many older people will say they are more frightened of dying than death. Noel Hess who has written poignantly about the experience of loneliness for older people (Hess, 2004), has pointed to the terror of being left alone ‘without an organising and containing part of the self, which is felt to be lost in the catastrophes of old age: stroke, injury, illness and dementia’ (Hess, 1987). When an older person has suffered severe trauma and perhaps not had the opportunity or been able to speak of it, then there is also a terror of dying alone with all the trauma in one’s mind. When I saw ‘Mr Krol’ a man in his 70s who was a survivor of a concentration camp and who had not previously spoken of his experiences in the camp, he brought a terrible urgency to speak of his experiences and a dread that he would not be able to do so. These experiences were hard, if not impossible for him and me to digest, but the experience of us having a go at doing so eventually made a significant and beneficial difference to his life (Hildebrand, 1995).

Undoubtedly fears of dying are particularly intense especially in our society in which dying infrequently occurs in the security of one’s family and home and in which care of the dying is relegated to hospitals, nursing homes and hospices. However, I think that these conscious fears of dying may also contain anxieties about unconscious fears of death which galvanise around them. Elliot Jacques (Jacques, 1965) writes of the intimations of mortality which precipitate a mid-life crisis and he cites a dream which typifies an unconscious phantasy of death which is a persecuting phantasy of being fragmented, immobilised and mute but able...
to experience pain. Hanna Segal (Segal, 1986) has written of a two-year analysis with a man in his 70s which revealed this man’s unconscious fear of death. The analysis of his unconscious fears enabled him to establish easier relationships with his family and to incorporate these figures in a freer way in his internal world. At the conclusion of the analysis he went on to live a successful and vigorous life for a further 11 years.

In an important study about death, Franco De Masi (De Masi, 2004) points out that in views of death, whether conscious or unconscious the self is always present, even if only observing. What is unimaginable is nothingness, and as De Masi says the anticipation of death is, therefore, an excessive trauma for the mind and represents ‘an experience of separation unlike any other form of mourning’.

To conclude
Our poets remind us that the end is in the beginning and the beginning in the end. I think as infants we first catch a terrified glimpse of our mortality in the ordinary lapses of mothering on occasions when, even with good enough care, we were left for too long. Experiences of being unheld precipitate terrors of falling to pieces and dissolving into space. These terrors are revived in growing old, anticipating or experiencing dependency and loneliness, and are linked with an unconscious fear of death and the dread of nothingness. Projective identification which in unconscious phantasy aims to deny separateness and to possess and control can be used to try to overcome such terrors and may be associated with aggressive and tyrannical behaviour, and severe restrictions in the internal world and emotional resources. An understanding of these terrors and this projective defence may at least make some of the difficulties of older clients more bearable for carers, and in counselling and psychotherapy may contribute to hope and creativity in later life.


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References
The following case example provides an illustration of the ways in which context influences what it is possible to know and tell in relation to awareness of cognitive impairment.

The material on which this case example is based was collected in the course of a study exploring people’s experience of care planning meetings within an older adult inpatient ward (Dixon, 2002). Older adult service users, family carers and professionals who had each attended the same meeting were interviewed. This research was undertaken from a systemic perspective with a particular focus on the different perspectives of people in each of the three roles.

Semi-structured interviews were conducted separately with each participant both before and after the meeting. Interviews with service users took place in a side room on the ward. The researcher was not part of the clinical team in this setting. The initial interview aimed to establish the context of the meeting with respect to the background to the admission and expectations, hopes and concerns about the meeting.

The interview following the meeting explored participants’ experience of the meeting in depth. Participants described what occurred in the meeting and their appraisals of which aspects of the meeting were more or less helpful focusing on the experiences of the older adults and their carers. Participants were invited to comment on the behaviour, qualities and attitudes of others at the meeting, as well as their own experience.

The context within which the meeting took place was one of four themes that emerged from analysis of service user, carer and professionals’ transcripts.

The unit in which this study took place was a mixed mental health assessment unit catering for older men and women with a range of diagnoses including both functional illnesses and dementia. Those familiar with such settings will be aware that a significant proportion of patients, particularly those with cognitive impairment, are placed in residential settings at discharge.

Miss Christine Crisp

Miss Crisp was 75-years-old and had never married. She had been living alone in a bungalow with few social supports since retiring from her job as a senior administrator in a local college. She had no close relatives. At her request, Nora, a former colleague, who had gradually become involved in providing support to Christine, attended the CPA meeting.

Christine had been admitted to hospital under the Mental Health Act following an episode when she allegedly drank some bleach. Initially she was thought to be suffering from late onset paraphrenia because she expressed delusional beliefs. As the admission progressed it seemed more likely that these were secondary to memory impairment.

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1 Sinclair Lough would like to apologise to Marion for careless omission of this article from the PSIGE Newsletter 95, South West edition.
2 All names are pseudonyms.
Awareness of the context of the meeting

In the initial interview, the researcher tried to explore whether, based on her prior experience during her working life, formal meetings are a familiar context in which Miss Crisp had felt confident and competent in the past.

**Researcher:** ‘When you used to work ... did you used to organise meetings ...?’
**Miss Crisp:** ‘Yes I organised everything.’
**Researcher:** ‘Right, so back in those days were you quite sort of ...’
**Miss Crisp:** ‘Lucid.’

By this interruption and response, Miss Crisp indicated her understanding that the ward context was one in which her cognitive competence was under question.

Awareness of ability and disability

Miss Crisp was acutely aware that the purpose of visits home with the occupational therapist and physiotherapist had been to assess her ability to cope with tasks such as preparing food and drinks. She was aware that she had failed to demonstrate competence at these tasks.

**Miss Crisp:** ‘I fell down on marks when I went out to do that silly cooking test ... I mean, of course, I mean, you’re suddenly confronted with, with a cooker that you haven’t touched for six months and you’ve got to think about. Of course I fumbled with where the blasted things were ...’

However, she attributed her failure to the circumstance of being in hospital rather than her abilities and considers that the professionals making the assessment have themselves been unaware of all the relevant facts.

**Miss Crisp:** ‘... But I felt they were being too, too non-official when they answered my points and too ignorant of certain facts, and you know, and when they said about the cooker and I said ‘Well of course I was guilty of finding difficulty in using the cooker, I hadn’t used a b____ cooker for six months and I, and it was a new one when I had it not so long before, you see.’’

In the initial interview she attributed the previously untidy state of her bungalow to burglars.

**Miss Crisp:** ‘... they’d broken into it and the place was a mess and a lot of things were broken you see, I chucked most of it out anyway, I cleaned it up and made it look respectable again.

However, Nora was certain there had been no burglary.

**Nora:** ‘... The bungalow is a bit of a tip. What happened the last time she went home? Oh that’s right. She went home, she said she’d had burglars. Someone had been in there. She’s so muddled.’

**Researcher:** But had she had burglars or was that just her own (end of question left open).

**Nora:** ‘No, she hadn’t had burglars. No-one had been in the bungalow. No. It was the way it had been left.

The quotes below illustrate the tension between being able to acknowledge both her memory problems and her mortality whilst wishing to distinguish herself from other older people in similar circumstances

**Miss Crisp:** ‘Well I can get out and resume my life, in a normal manner instead of staying with all these poor people here who don’t really know what they are doing, I want to get on with me life, I haven’t got much of it left, let’s face it but I want to get on with it.

**Miss Crisp:** ‘They can’t say that there is something the matter with you just because you, you don’t retain your memory quite so well.

Influence of the context on knowing and telling about likes and dislikes

The ward occupational therapist and physiotherapist reports following the supervised visits home identified significant concerns about Miss Crisp’s ability to manage safely at home. Prior to the CPA meeting, Nora said that she felt Miss Crisp was no longer able to manage at home and had on occasion seemed open to the idea of residential placement. Nora hoped that Miss Crisp would agree to a residential placement in the meeting. However on the day, Miss Crisp had other ideas.
Nora: And she told me this before the meeting … (and) this is what she said in the meeting also, she wants to go to her bungalow, get it all sorted out, see how she is, because she feels that being in there she is getting worse. … Once she gets home, she will feel much better and then she will decide, once she’s got her bungalow straight and her bits and pieces straight and in order, she will then decide whether she wants to go into residential care.

Miss Crisp’s desire to go home then influences what she says in the meeting about her bungalow.

Nora: … she did say about loving her bungalow and this business. Well, she doesn’t. She hates her bungalow. And that’s what the social worker said to me ‘The last I heard’, he said, ‘she didn’t like her bungalow. It was in the wrong place.’ And yes, she has been moaning about that ever since she’s been there.

A context in which there is significant doubt about her ability to return home was not one in which it was possible for her to acknowledge, or perhaps even be aware of, her long standing dissatisfaction with her bungalow.

Outcome

At the meeting plans were made for Miss Crisp to return home for further supervised visits to establish whether she could continue to live at home with community support. This was not successful. Subsequently the consultant psychiatrist made an assessment that she lacked capacity to make decisions about her place of residence. A further CPA meeting was held seven weeks after the first one and shortly afterwards she was discharged into residential care.

Discussion

This case example illustrates the complexity of the phenomenon of awareness in dementia and the role of context in determining what can be known and told. The clinical team went to great lengths to involve Miss Crisp in her care planning meeting and to support her in her wish to return home. Eventually it became clear beyond any reasonable doubt that she lacked the capacity to make judgements about her safety and abilities of daily living that were relevant to decisions about where she should live.

However, the excerpts from the transcripts cited above illustrate that she was acutely aware that her memory was failing, her lucidity was under question and the context of both the ward environment and visits home was one of assessment which had profound implications for her future living arrangements. The tension between her desire to live independently and the threat to this, implied by the assessment of her abilities as a precursor to discharge from the inpatient setting, provided the context that shaped the views she expressed about her abilities and preferences.

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Reference

Behavioural and cognitive therapies with older people: A selected bibliography*

Ian Kneebone

Below is presented a list of references provided to University of Surrey, Doctorate of Psychology (Clinical) trainees in support of a 2006 lecture provided on cognitive and behaviour therapy (CBT) with older people. It is published here to provide access for clinicians who might wish to select from it to update their knowledge on the basis of considered review (over 10 years of teaching) rather than via traditional literature searches.

General Text

Special Journal Issue

Case Study Articles

Treatment Manuals/Guides

* It is acknowledged that many of the references listed use language no longer considered inherently respectful to older people. Unfortunately as published works it is not possible to alter them.


**Treatment Aids**


**General References**


**Acknowledgement**

The author would like to thank the information search systems made available by the NHS and the library of the Royal Surrey County Hospital, Guildford, UK.

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Achieving a Grand Old Age in Brighton?

It is perhaps appropriate that this year’s PSIGE conference took place on the south coast, a place that was saturated with images of retirement homes and ‘old folks’ crammed into a shelter on a windy pier, wearing ‘kiss me quick’ hats. The reality is somewhat different, of course, with tourist boards desperately trying to shun this image, embracing regeneration and exchanging tea rooms and fish and chip shops for boutique hotels, clubs and spas. This is perhaps a good metaphor for some of the themes picked up in this year’s conference. We heard from Steve Davies about the ageism that is prevalent in our society, our obsession with youth and the stigma attached to ‘getting older, or being old’! But his message was a challenge to all. Such ageism is also deeply embedded in our services, our policies and our day to day activities working in older adult mental health, even amongst many clinicians, working with older adults is seen as ‘unattractive’. As Hayley Griffiths discussed in her section of the talk, such negative attitudes and stereotypes do not go unnoticed by older adults, who feel increasingly isolated from our society. Professor Simon Biggs also picked up on these themes, in his thought-provoking session on ‘Policy, Personal Experience and the New Flexibility of Ageing’. Is it valid for us to talk about older adults as an entity, as if human diversity stops at the age of 65? On one hand policies are scooping up people in their 50s as being worthy of age-related discourse, on the other we have people heading off backpacking in their 70s (although Government policies will soon put a stop to such shenanigans and sternly point them back to the workplace!). Perhaps it is through promoting the diversity of individuals who are over that magic age of 65, that we find some way to generate more equality for our client group. So maybe those clubs and boutique hotels on Brighton’s seafront aren’t wasted on those in their ‘third age’ after all!

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St. Andrew’s Hospital

Personal misconceptions around cognitive behavioural therapy

‘Explorative’ – ‘Creative’. These are not words I had anticipated encountering in a cognitive behaviour therapy workshop. As a rather new and inexperienced psychology assistant I had begun to form some negative beliefs around CBT. In part, this had arisen from my slight suspicion of approaches which the Government advocate as cost effective, but also from mutterings at assistant networks or internet forums, suggesting that CBT is ‘too rigid’, ‘too structured’ or ‘too simple’ to really address clients’ individual needs. Indeed, I was beginning to wonder whether using CBT would be too prescriptive to address my own needs to be challenged in my creativity and thinking as a therapist.

How better to address these negative beliefs than by attending the ‘CBT with Older Adults’ workshop run by Ken Laidlaw at this year’s PSIGE conference? Ken Laidlaw has worked closely with all of the ‘big names’ in cognitive therapy (Beck, Gallagher-Thompson) and yet states that, ‘I genuinely find CBT challenging to apply with patients. It’s a real challenge to do it properly and well.’ From the outset, this workshop grabbed my attention. I had clearly been
missing something. The workshop was designed for a diverse audience enabling me to begin to develop my thoughts around this type of therapy. I am sure that by revisiting the information as I develop I will engage with it at a deeper level too.

Ken Laidlaw put across a clear message that although CBT is based on a simple theoretical idea, ‘the application of that idea so that it leads to a difference in the treatment outcome for your patient is not so simple.’ It seems that CBT is not so easy to do well and standard elements, such as measurement or agenda setting, may be poorly applied. This leads me to reflect on how well CBT is applied by staff with minimal training or even the new computer-based CBT packages! It inspires me to rise to the challenge of using CBT effectively.

In the older adult setting where I am based, I have learnt about Kitwood’s person-centred approach and have begun to think more broadly about an individual’s needs. The workshop has taught me that CBT can be modified for older adults by incorporating some comparable values. The Cognitive Model for Cognitive Therapy with Older People (Laidlaw et al., 2004) emphasises the importance of working with an individual’s cohort experiences, life stage, transitions, relationships, socio-cultural and health status. Ken Laidlaw describes CBT as ‘exploitatative’ in that ‘each person can be best understood in terms of their idiosyncratic model.’ This has challenged my misconception that CBT lacks the flexibility or sensitivity to meet the needs of older individuals.

My thoughts about CBT and its application have certainly been altered by this inspiring workshop and I am keen to grapple with the challenge of learning the techniques and structure of CBT well enough to apply them creatively and flexibly in the future. Thanks to PSIGE for a conference where so much enthusiasm for working with older adults has been generated.

Emma Sisley
Assistant Psychologist

**PSIGE Annual Conference report**

Being new to the whole older adults area, I was very interested to attend Ken Laidlaw’s full-day workshop on CBT for older people. I’ve been on placement in an older adults’ service in Croydon with Patrick McGuiness for the past six months and I have to admit, I have been finding CBT with older people tough going. Ken Laidlaw noted, early on in the workshop, that he also finds CBT with older people difficult and this was music to my ears. Maybe all my therapy-related negative automatic thoughts (‘I can’t do CBT’) and core beliefs (I am a failure as a therapist) are not entirely realistic after all. The workshop outlined how complex, multiple health issues, coupled with the chronicity of problems, in addition to cohort beliefs, can make treatment more tricky.

Here are three key points that stood out to me:

**Focus on maintenance factors**
The workshop described how it can be easy to focus on background, causal factors that have contributed to the problem, particularly when the problem is longstanding. While some benefit may be gained if the causal link is not well understood, it may not necessarily be an efficient use of time. Concentrating on maintenance factors directs attention to where change is most likely to occur.

**Don’t get tangled up in the client’s reality**
Often older people present with multiple, complex issues related to health, losses and life changes and it can be easy to think that there is nothing that can be done. However, often, underneath all the ‘realistic’ thoughts there is unrealistic, catastrophic thinking that can exacerbate the situation and this can be a fruitful area to explore.

**Keep up with the basic CBT stuff**
Set good homework assignments that are clearly linked to therapy goals in a way that makes sense to the client. Measure progress objectively (with the BDI for example). Set an agenda at the start of each session.
This was a very interesting and useful workshop and I am very grateful for the opportunity to have attended.

Joe Oliver

PSIGE Bursary
Thanks to a bursary from PSIGE, I was able to attend the final two days of the annual conference at the University of Sussex. Being relatively new to working with older people, I was hoping that the conference would provide me with an overview of the work that was going on throughout the rest of the country.

In the event, this was only one of many things that I got from the conference. The various symposiums and the freedom to move between the concurrent streams meant that I was able to attend seminars on a varied range of topics. Indeed some seminars which I attended, such as those exploring projective identification and early trauma from a cognitive-analytical perspective, gave me helpful frameworks from which to reflect upon the dynamics that I have encountered when working with older people. Furthermore another seminar encouraged me to think about how the principles of narrative therapy could be applied to working with older people. On a wider scale, the keynote speakers’ sociological perspectives and the seminar focusing on age discrimination and mental health increased my understanding of how social and demographic factors can influence wellbeing, and urgently need to be incorporated into services for older people. Similarly, attending the PSIGE AGM was a useful way of learning about the work that PSIGE has carried out over the last year and its future objectives.

Overall I found the PSIGE conference to be an enjoyable and inspiring experience that I would recommend to anyone with an interest in working with older people. It has certainly motivated me to consider working with this client group when I qualify. The presentations were lively and thought-provoking, whilst the friendly atmosphere in the seminars and the Thursday night disco and subsequent parties, meant that the conference also had a pleasant social aspect. Thanks again to PSIGE for enabling me to attend.

Julia Coleby
Psychologist in Clinical Training

Reflections on the PSIGE Conference
The 2006 PSIGE conference was hosted by South Thames PSIGE in Brighton. Thanks to a PSIGE bursary I was lucky enough to attend. As a third-year trainee approaching my first post-qualification job working with Older Adults, the conference was well timed for me. On one hand it helped me to focus my thoughts on working with this population. Having spent the last three years juggling the demands of a busy training course focusing on different client groups it was nice to have some dedicated time to do this. On the other hand it helped broaden my perspective of Older Adult working to consider issues that have not cropped up directly during my training: for example, palliative care issues, early onset dementia, strategic service planning and delivery, and critical analysis of challenging behaviour units.

This paper summarises some of my reflections and learning points from the PSIGE conference in the hope that they may be useful to other clinicians. These are divided into two areas. The first is reflections on current research. Not only did the volume of high calibre and innovative research presented at the conference impress me but it also provided several specific examples that I hope to incorporate into my clinical practice. The second part of this article focuses on valuable information derived from the presentations that considered models of service delivery for clients referred with behaviours that challenge services. The papers presented at the conference were divided into four streams with delegates...
attending one stream only, therefore, this paper is not representative of the conference in full, but is representative of the presentations I attended. Rather than merely summarise the presentations I attended I want to highlight areas of learning I have taken away from them in the hope that other clinicians will find at least some of them helpful.

**Research reflections**

A lively debate evolved in Amy Wood-Mitchel’s presentation on *Lying to people with dementia* with some people stating that this is unethical for any reason and others stating that lying is an integral part of human behaviour that helps us conform to social norms and, with guidance and reflection, is acceptable. From the conversations that ensued from this talk it is clear that people hold strong views, firstly about what is considered to be lying and secondly by the ethics of this. Lack of consistency about the practice of lying and the lies that are told is likely to increase confusion in people with dementia. Certainly, if a person with dementia is told by one person that their husband has gone to the shops whereas another person states that he has died this is likely to enhance confusion. Amy Wood-Mitchel has produced guidelines on this practice; given the strong opinions people hold about the practice of lying, it is clear that such guidelines will be very valuable to services.

Deborah Morris with Romola Bucks presented *A survey of practices in relation to obtaining informed consent for cognitive assessment*. This talk has certainly made me consider my own practices. Deborah presented research demonstrating wide variation in neuropsychological assessment consent-eliciting practices. She reminded us that the process of eliciting informed consent relies on providing full information about the proposed procedure to somebody who has the capacity to weigh up the pros and cons of undergoing or refusing the procedure and who is not coerced into their decision. I found it useful to be reminded of this and to reflect upon how often I am sure I truly gain informed consent for the neuropsychological assessments I perform. She advised that we should not only record the fact we have obtained informed consent in casenotes but that we should also have a written consent form, again to be kept in the casenotes, for anyone undergoing neuropsychological assessment.

By far the most well attended presentation I attended was Helen Guy’s paper on *Conversations people facing death have about dying*. Helen presented qualitative research she has conducted with people who are dying from cancer. The research focused on the communicative processes they have found useful and those they have found unhelpful. Although some of the processes may seem like common sense to psychologists, and when considering them we may recognise aspects of our own communicative style, it is very helpful to recognise that these are the strategies that the receivers of bad news recommend. An approach-avoidance pattern runs through all of the processes whereby people gather small amounts of information and then retreat from the topic until they have had time to process what they have learnt. A particularly useful strategy is *staging*, whereby the individual is warned that they are about to be given bad news and that the bad news emerges rather than being disclosed straight away. Another helpful process was *protecting*, whereby the individual facing death begins to face up to the prospect of death and wishes to protect those around them after they have died by organising their will, funeral and financial affairs. Although this presentation related to conversations about death and dying, I think some of the findings may generalise well to disclosing the diagnosis of dementia. Helen’s concluding advice was to check out your own communication style with clients by explicitly asking whether you are providing sufficient information and, if not, adjusting it accordingly. She also provided some useful questions to ask including:
‘What experiences have you had of talking about facing death’, ‘Is there a conversation you would like to have’ and ‘Do you think you would have a different type of conversation in the future?’.

**Models of service delivery for cases referred with behaviours that challenge services**

There was plenty of time outside of the presentations to chat with colleagues from around the country. Whilst doing this, I was struck by the number of non-psychologists attending the conference and heartened by the fact that other professions are sufficiently interested in the work we do to send representatives to our annual conference. Similarly, I also liked the fact that the two keynote speakers were not psychologists. I found the informal chats I had with people to be as useful as the presentations I attended. They provided a very useful opportunity to explore different ways of working and different models of service delivery and structure. It was helpful to hear about the difficulties other psychologists/services are experiencing (more often than not these concerned increasing financial constraints) and ways in which they were being dealt with. In addition to this informal networking, a number of the papers focused on models of service delivery.

Kate Ross presented an illuminating paper on South Staffordshire’s considerable efforts to design an appropriate challenging behaviour service. She provided a longitudinal perspective by outlining some of the difficulties her team has faced with regard to developing such a service within the changing needs and demands of local NHS structures. This paper highlighted that there is no ideal format for challenging behaviour services and that whatever type of service is developed may well have as many disadvantages as it has advantages. Even if a ‘perfect’ service is developed, the NHS structure in which it sits is likely to change and the service may no longer be ‘perfect’. I imagine for many people struggling with similar service-development issues there must be a certain degree of normalisation in hearing about the difficulties that other services have faced. On a more positive note, it drew my attention to the importance of being strategic and developing a tailor-made service for the community it serves. It also emphasised that there are many options for doing this and that creative thinking is the key.

Ian James, in his presentation *The ‘real’ emotional impact of challenging behaviour on staff*, stressed the importance of putting formulations back into challenging behaviour work. He commented that the use of formulation is one of the things that makes psychology unique, yet we rarely do it thoroughly when working with cases referred for challenging behaviour. He outlined his model of working. Crucially, the challenging behaviour team do not come up with interventions themselves. Instead, ideas for interventions come directly from care staff at a formulation sharing meeting between care staff and the challenging behaviour outreach team. By doing it this way, he explained that care staff have ownership of the interventions and, therefore, have an investment in their success.

Ian James also presented figures pertaining to the proportions of care staff who experience fear as a result of working with clients with dementia. A high proportion of staff reported being frightened of their clients. It is vital that psychologists take this fear seriously and consider ways of ameliorating it when designing new services or modifying existing services. For example, it is not uncommon to send staff home if they have been involved in a serious incident, but is this really the best practice or can it actually make the situation worse by encouraging rumination and discouraging debriefing? To be frightened of your clients, yet be expected to meet their basic needs is a difficult, and potentially dangerous dynamic. As psychologists, we need to consider what impact our interventions may have on this dynamic. Are we asking care staff to put themselves in situations they perceive will exacerbate danger? If care staff are having
difficulty implementing our interventions, we must ask ourselves whether we have unwittingly done this.

Summary
I hope this paper has given those people who were not lucky enough to attend the PSIGE conference this year a flavour of some of the things that were discussed there. Given that the research presented at the conference was necessarily a small subset of the research taking place within the Older Adult psychology community in general, it speaks volumes of the advances taking place within the profession. The overarching impression that I shall take away from the conference is that there are many older adult psychologists who are actively researching and reflecting on work in this area with an aim of providing effective and efficient services for this population and thereby striving to abolish some of the inequalities faced by this population.

Louise Barnard
Clinical Psychology Training Programme, University of Leeds.

Thank you, PSIGE
I am an Assistant Psychologist working for Bolton, Salford and Trafford Mental Health Trust. This was my first PSIGE conference but hopefully not my last; I say this with much enthusiasm, as the entire experience was wholly enjoyable as well as inspiring.

The keynote speakers and presenters raised my awareness of developments in neuropsychology and rehabilitation; innovative practice, professional and ethical issues, just to name a few themes covered. All areas of work were motivating, and at times quite moving, as well as highlighting the challenges research and service development can, occasionally encounter.

The seminars provided a variety of presenting styles and reassuringly for me, showed that presenting could be anxiety provoking regardless of a clinician’s status within a service. Additionally, it was very interesting to hear about diverse practices and research, both quantitative and qualitative. Helen Guy’s poignant account of her work regarding Conversations people facing death have about dying highlighted the experience of the person receiving such news, along with the helpful and not so helpful communication styles. This seminar also highlighted the importance of being a ‘flexible’ clinician.

The workshops I attended provided exciting concepts that could be incorporated into my clinical work. Steve Davies’s workshop offered the opportunity to consider the impact of regretful experiences in the lives of older people, and having clients that struggle with issues of shame and regret I found the model of therapy particularly useful. In their workshop, Working with Voices, Clari Harrington, Jo-Anna van den Bosch and Nik Maroney demonstrated a successful eclectic approach using motivating techniques to help reduce people’s distress. I was particularly interested in their use of creative ideas, especially using play dough, to facilitate engagement, and to help look at people’s feelings and challenge beliefs within a group setting. The poster presentations put forward an array of designs and encouraging research, in particular innovative non-drug based approaches to behaviour disturbances for clients with dementia.

The social programme gave me the opportunity to view clinicians before, during and after consuming a few alcoholic beverages – an interesting learning experience in itself. However, I do not think that I will be incorporating many of my colleagues’ dance moves into my own practice. It was impressive to observe the rapid return to professionalism the day after the evening of the gala dinner.

Attending the conference provided a fantastic opportunity for me not only to gather information but also to present with my clinical supervisor. Although our time slot was on Friday I was pleased to see that not everybody had absconded to Brighton Pier.
Overall, I learned that the conference is a complete must, not only for the dissemination of great work in support of older people but also for clinicians to network and unwind.
Thank you, PSIGE.

**Vicki Parlane**

**Annual conference – A review**

After the PSIGE annual conference had ended, I reflected on what this conference had meant to me as a trainee. Whilst I enjoyed many interesting and thought provoking lectures, it was the workshop by Elspeth Stirling on the *Positive psychology of ageing* that made the greatest impact on my own development.

The workshop raised some emotive discussion on why our society struggles to look positively at the lives of older people. Stirling took us through the dominant models of aging and just how these make us think about later life. The biological models, for example, that view older people as being close to death, were seen to provoke unconscious anxieties in society – a chilling *memento mori* that people do not want to face. Sadly, this attitude can result in the segregation of older people. Members of the workshop spoke strongly about the apartheid situation with older people, who increasingly spend their later life in special communities outside the main society which struggles to meet their needs.

Alternatively, there is the disease model of ageing that sees older people as broken machines – worn out and failing. And society’s response to this model? A multi-million pound industry designed to help people fight ageing for as long as possible, to stay looking younger because then they will be ‘worth it’. The paradox is that people want to live for longer, but not as old people. The only results of our quest for immortality have been increased longevity, with more people living for longer only to become ‘old’ and be burdened with this social stigma!

Because our society struggles to look positively at the lives of older people, they are often treated in ways that would be unacceptable for any other group within society. I was shocked to hear in our discussion of a policy that once existed in North America, which dictated what would happen should they suffer a nuclear holocaust. The policy stated that older people would be sent out to clear the rubble – what does this say about the role we give to older people within our societies?

PSIGE stands for equality and diversity for older people. This workshop reminded me that we have a lot of work to do, and not just in changing society’s attitude to older people but our very ideas about ageing. However, the positive, and person-centred work that I saw on display at the conference, as well as the emotive speakers for the rights of older people that I heard, tell me that we are certainly on right track.

**Emma-Louise Radbourne**
Geographical Group Convenors – Annual Reports

EAST ANGLIA

This year has seen changes to our Chair post, with Cath Burley replacing Vanessa Garfoot as Joint Chair with Kathryn Sams.

Our meetings are still being held bi-monthly at Fulbourn Hospital, Cambridge, and have been well attended over the past year. The branch has around 20 qualified members, as well as various assistants and trainees who attend.

In our meetings, presentations have been heard on topics such as, Progressive Supranuclear Palsy and assessing capacity, as well as our business meetings when we share what is happening locally within the trusts in our region. We have also tried to include a regular case presentation slot, to offer the chance for peer supervision, mainly for neuropsychology case material and this seems to be working well. We are planning a half-day strategy meeting in July for all of our qualified members, to enable us to share care pathways, referral criteria, etc.

A great deal of focus continues to be placed on liaising with the local clinical psychology training course at the University of East Anglia and ensuring students are able to have at least one older adult placement during their training. Links have been forged with the course to influence the teaching timetable and ensure there are relevant older adult modules. Next year our PSIGE group will host the joint teaching day for all year groups on the UEA clinical course, with a special focus on older people, in the hope that we can fill in any gaps in the current timetable for trainees. We are also working on ensuring the students ‘Blackboard’ topics contain information and references pertaining to older adults. Several people in our branch have been involved recently with the short listing and selection processes for the next intake of trainees. We are also ensuring that our presence is made at various course meetings, such as the supervision committee and the course training committee so we can ensure the voice of psychologists working with older people continues to be heard.

This year Cath has joined the national PSIGE committee so we now have a direct link into national PSIGE.

Kathryn Sams & Cath Burley
Joint Chairs of East Anglia

ESSEX AND HERTS.

The Essex and Herts. Branch of PSIGE was formed in 2004 and there are currently 22 members including qualified, trainee and assistant clinical/counselling psychologists working across the counties of Essex and Herts.

From August, 2006, Imogen Sturgeon-Clegg (Counselling Psychologist) and Sara Banks (Clinical Psychologist) took over from Steve Davies as Joint Convenors and Elizabeth Hughes (Clinical Psychologist) continues to act as Treasurer for this geographical group.

Meetings

There has been a recent re-organisation of meetings for the Essex and Herts. Branch of PSIGE, with the aim of encouraging more members to attend.

From October, 2006, meetings will take place on the first Thursday of every other month, between 1.00 p.m. and 4.00 p.m. It is intended that 1.00 p.m. to 2.00 p.m. will be used as an opportunity for local psychologists to meet and catch-up informally, and 2.00 p.m. to 4.00 p.m. used for: formal presentations, group discussions or for dealing with
other topics placed on the agenda. The location for meetings is now rotated across three sites in South Essex, West Essex and Herts.

Topics for meetings planned for the coming year include:
- The Mental Capacity Act and its implications for psychologists working with older people.
- Older Adult Placements: Opportunities and issues across Essex and Hertfordshire.
- Counselling psychology with older people.
- Discussion of complex clinical cases.
- Organisational context issues for older people’s psychology services in the modernised NHS.
- Group discussion of presentations from the National PSIGE Conference.
- Exploring boundaries in therapeutic work with older people.

**Training courses**
Trainee Clinical Psychologists attending placements within the geographical area covered by the Essex and Herts. Branch of PSIGE come from the University of Hertfordshire, University College London, Royal Holloway, University of East London and the recently set-up University of Essex-Tavistock course. Trainee Counselling Psychologists also have placements within the region covered by the Essex and Herts. Branch.

For further information on the Essex and Herts. PSIGE Branch, please contact: Sara Banks (Joint Convenor for Essex and Herts. PSIGE) by telephone on 01279 827276 or by e-mail on: Psychology.Secretary@haveringpct.nhs.uk.

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**NORTH EAST**
I was elected as Chair of the North East PSIGE group at our annual away-day in April, 2005, and am continuing in this position for the forthcoming year.

Since then, we have continued our two-monthly meetings alternating between different centres covered by our group. Recently, three trusts in the North East region have merged to form the Northumberland, Tyne-and-Wear NHS Trust. This has meant that the majority of the group’s members now belong to one trust. This is providing us with the opportunity to pull together information about our services to share with our mutual shareholders.

Our group continues to contribute to teaching on the Clinical Psychology doctorates of two local universities. We have a steady stream of second year and final year trainees through older people’s services. Although members of this branch of PSIGE have traditionally not taken first year trainees, we are now in a position of renegotiating that stance in the light of some curriculum changes at Teesside University.

Our meetings continue to be well attended by qualified and doctoral trainee psychologists with the host providing a discussion topic/presentation.

Other topics discussed/issues raised at our meetings have been:
- Two of our members are looking at developing a short course on neuropsychology and older people similar to others in the country which local members could access at less cost. This work is on-going, though they are finding it difficult to recruit speakers.
- Copying letters to patients – subsequent to a discussion spanning a number of our meetings, a second year trainee on placement in the North East is conducting a qualitative study on professional and client perceptions on trust policies regarding copying letters to patients.
- Interventions in nursing homes – several small-scale research projects and work by the Newcastle Challenging Behaviour Service continues to raise the profile of working with staff and residents in the care sector.
Agenda for change – over the past year there has been disparity in the bandings received by PSIGE members. Finally, with one or two exceptions people’s posts have been reviewed resulting in a similar structure to that recommended by the DCP and Amicus. We are hoping to have some input into devising the Knowledge and Skills Framework (KSF) gateways for psychologists in older adult posts.

Louisa Shirley
Chair

NORTHERN IRELAND/REPUBLIC OF IRELAND

A number of clinical psychologists who work with older people are meeting quarterly in Dublin. Our numbers have grown, from four initially, to 10 at a meeting this Spring. Just three of us were PSIGE members, although some others showed an interest in joining. All, however, were members of the Psychological Society of Ireland (PSI) and a Special Interest Group is going to be set up within that organisation which makes more sense given the balance of members.

It was agreed, however, that there would be a standing item on the agenda, where I could deal with any PSIGE business. We have found PSIGE guidelines useful in our discussions regarding input to training courses. Because there are a small number of us responding to the needs of five training courses we are looking at rationalising our efforts by offering a package centrally.

Brenda Carney-Gallagher
Consultant Clinical Psychologist, Down Lisburn Trust.

NORTH WEST

Membership
There are 47 permanent members in our group, made up of clinical psychologists, trainees and assistants. Psychiatrists and other specialisms are included in our membership and all communications. Trainees and assistant psychologists attend whilst on placement and when they are working with PSIGE members.

Meetings
We continue to meet every two months at a central venue, for about two-and-a-half hours. Meetings are very well attended. They alternate between a long business meeting and a presentation followed by a short business meeting.

In the last year presentations have included an introduction of the web-based
learning tools to support the national PSIGE curriculum delivery in Scotland, a presentation on the requirements of the entry qualification to the Society’s Division of Neuropsychology and a presentation on the research requirements of the three north west clinical psychology training courses by course staff.

Some business issues discussed in 2006

- Outcome measures. This has generated widespread interest and will be the subject (along with presentations on innovative practice in the North West) of a PSIGE away-day in November.
- Research interests. The North West PSIGE group keeps a register of members’ research interests and this is updated annually. This is partly to support trainee psychologists in choosing to do their major research with older people.

Posts and workforce planning
At each meeting representatives from the different NHS Trusts provide an update on workforce planning issues, including whether new posts have been established. Trainees regularly attend meetings when on placement, and this agenda item is usually the first place they get to hear about post developments. Across the region several posts have been established in the financial year 2005–2006, although posts have sometimes been frozen due to lack of funds. The implications of Agenda for Change on staff recruitment and retention have been considered.

Training issues
There are three training courses within our region – Lancaster, Manchester and Liverpool, and supervisors routinely take trainees from any of the three courses. This year has seen various positive exchanges between the course and the North West PSIGE attempting to clarify the similarities and differences of academic course demands across the three courses. Supervisors continue to offer one, two and in certain cases three placements per intake to place the average yearly demand of approximately 38 placements across the three courses. To be creative in meeting the expanding trainee numbers, a small number of trainees have been placed in allied specialisms for their six-month ‘older adult’ placements including neuropsychology and health. Numbers of training places across the North West have been cut for the 2006 intake of trainees. Each of the three courses will now offer 21 places. The North West has been hit disproportionately as 11 of the 30 training places lost nationally were from the North West region.

Special CPD events
North West PSIGE finances remain healthy and local CPD events have been held over the past year with support from national PSIGE and from earlier contributions from the North West CPD Scheme. For example, a fantastic day on ‘Consultancy models of older adult psychology services’ was offered by Anne Crawford-Docherty in May, 2006.
A mindfulness training course with a supervised practice component will begin in the Autumn for PSIGE members led by a local expert, Alistair Smith.

Thanks
Thanks are due to Amanda Thornton who co-convened the North West PSIGE group with myself until Christmas 2005.

Cathy Amor
Lancaster University.
OXFORD

The Oxford PSIGE group covers Oxfordshire, Buckinghamshire, Berkshire and Northants. The group have met on a regular basis across the year. Since July, 2005, the group have met on six occasions in Oxford. These meetings have generally been well attended by PSIGE members, trainees and assistant psychologists.

The meetings are organised into two parts. The first part is the business meeting. The second hour is a presentation from a PSIGE member representing one of the regions of the group. Topics this year have included:

- Women’s Self-esteem Group using the Wizard of Oz – Stephanie Oldroyd.
- Animal-assisted therapy – Jane Fossey and Sarah Barrett.
- Screening for depression and dementia in a general hospital – Chris Allen.
- A review of psychological therapy services in Berkshire – Ian Scott.

In the business section of the meeting we have standing agenda items. In the last year local course issues have been discussed and some planning for teaching has taken place. National PSIGE business has been fed back by Chris Allen, Media Officer for National PSIGE, and led to general discussions about professional issues such as CPD recording. Representatives from each geographical area have updated the group on local issues such as trust financial difficulties and implications for services. Agenda for Change outcomes has also been a regular agenda item.

In January, 2006, our long-standing PSIGE Chair and Geographical Convenor, Dr Chris Allen, resigned and Candy Stone agreed to take on this role. Ian Scott also stood down from the position of Secretary and Stephanie Oldroyd agreed to take on this role.

Dr Candy Stone
Consultant Clinical Psychologist.

SOUTH THAMES

The South Thames region includes South London, Surrey, Kent and Sussex. There are three training courses: Surrey, Salomons and the Institute of Psychiatry in our region. There are currently 73 PSIGE members in the South Thames region.

Sadly, Tina Lee and Padmaprabha Dalby have both stood down as South Thames Geographical Convenors, as they are both on maternity leave. Congratulations to both of them and thank you for all their extremely hard work for South Thames PSIGE over the last four years. Marina Palomo has taken over the Geographical Convenor role until the next AGM.

This year, South Thames PSIGE has been largely occupied with organising the National Conference, which took place in Brighton in July, 2006. There was a huge amount of work leading up to the conference, and its success was attributable to the commitment and dedication of the Conference Organising Committee (under the direction of Tina Lee and Carmel Lum). The South Thames PSIGE committee merged with the Conference Organising Committee last year – it is planned to regroup after the conference.

In addition to the National Conference, South Thames PSIGE has organised the following training events in the last year:
Research/Service Development and Training day at Salomons. This day was organised by Padmaprabha Dalby and provided local clinicians the opportunity to share their service and research developments and discuss training issues.

A training day on Psychology in Medical Settings was unfortunately cancelled due to poor uptake. This was a great shame as the day promised to be interesting and much hard work went into planning it by Adrienne Little, Tresa Andrews and Amy Copping.

CAT Therapy in Later Life by Dr Jason Hepple, organised in Brighton by Caroline Williams and partly funded by the DCP.

In the upcoming year, we hope to organise four training events including:

- Research and Training Event in September – this event has traditionally been held annually, and it is hoped that it will happen again this year, subject to the committee’s commitments to the conference allowing this.
- Clinical Neuropsychology with Older People Course at Salomons planned in Spring, 2007. This course has been run for a number of years now and is valued greatly by local clinicians.

Marina Palomo

SOUTH WALES

We have seen many changes in our South Wales PSIGE over the past two years. Our Committee has changed almost in its entirety so that we now have a new Chair, Clare Quinn, Vice-Chair, Rosslyn Offord, Secretary, Helen Barker, Secretary and Geographical Representative, Sarah Morgan, working alongside, our Welsh representative, Janice Rees, and Treasurer, Jimmy Jones. Thank you to all who have and continue to provide their support and commitment to South Wales PSIGE.

We continue to meet every quarter in different locations across South Wales to discuss business issues for half of our meeting and a presentation topic from one of our members during the other half. The meetings have been well attended with sometimes up to 30 people coming. We have tried to make the meetings as open as possible involving trainees and assistants when they are on placement, in order to encourage interest in Older Adult Psychology.

Over the past year, the business section of our meetings, has involved collating responses to the NICE Guidance on Anti-dementia drugs and Dementia, the Welsh National Service Framework and Capacity Act. The National Service Framework for Wales was published on 20 March, 2006. Interestingly, it has been nicknamed ‘No significant funding’ in some quarters of the NHS as it doesn’t seem to be coming with any funding to help us to implement the standards. Several of our PSIGE members were actively involved in developing the framework, so the coming years will be an interesting time.

In terms of our CPD, some of the topics presented and discussed at our meetings have included, Caseload and Workload Management, Working with People with Memory Problems in groups, Story Telling with different groups of older adults and Capacity. Additional CPD events have also been organised outside our meetings and we have been fortunate to have Andrew Balfour come to talk to us about psychodynamic issues in relation to older people, Claire Fisher on using CAT with older people, and Graham Stokes on managing challenging behaviour in dementia care. These events have been held in conjunction with the South Wales Clinical Psychology Training Course who kindly provided a venue for us and some of the events have been open to trainees thereby fostering our close links with the course.
The training course has also been going through a period of transition in terms of restructuring the way they organise placements for trainees. As a consequence to this we have had an increasing number of trainees on placement, and will ultimately have us providing a ‘rolling programme’ of placements, so that we will have a trainee on placement throughout the year. This has been challenging and refreshing in that it has provided us with a greater opportunity to supervise small pieces of research in our departments. Several of our members have also recently published papers, including Paul Elson, Julie Wilcox, Janice Rees and Rosslyn Offord. This influx of trainees will hopefully contribute to an expansion in Older Adult Psychologists if we can inspire them to specialise in our area and for us to find the funding for posts!

In terms of the number of posts in South Wales, members’ hard work in the development of services has paid off with a general increase in the number of posts, particularly in Pembrokeshire which has seen a three-fold increase in established posts. Gwent and Cardiff localities have also recently advertised five posts.

Our year has also been touched with a little sadness in terms of one of our most valued member’s retiring. Charles Twining OBE, retired in November, 2005. Charles had been a Clinical Psychologist for nearly 30 years and contributed massively to the development of the profession. To name but a few of his achievements, he was one of the founder members of PSIGE in 1980 and was the first Membership Secretary of PSIGE. Charles worked in Cardiff and developed work in the context of geriatric medicine in relation to Psychology and Health. He was also very active with Age Concern, Wales, and was the Society’s representative on the governing body of Age Concern. Charles also published two books – Helping Older People: A Psychological Approach (1988) and The Memory Handbook (Windsor Press, 1991). In latter years he was a pivotal figure in developing the National Service Frameworks for England and Wales. He will be sadly missed but we wish him all the best for his future and retirement.

On a lighter note three of our members have had children – potential future PSIGE members we would like to think! We would like to wish them many congratulations and best wishes.

Dr Sarah Morgan
Tonna Hospital.

SOUTH WEST

Over the past year, membership of South West PSIGE has grown to 36. Philippa Wilson and P.F. Joyce remain as Geographical Convenors and we continue to meet several times a year, usually for longer meetings due to the large geographical size of our region. These meetings continue to be well-attended and the professional links they provide have been particularly valued in recent months as members in some parts of the region are currently restricted from attending training events due to the financial difficulties of some local Trusts.

We have met on three occasions in the past year. In November, 2005, we met in Bristol. Paul Whitby gave an interesting talk at this meeting, entitled ‘The Myth of Sisyphus’, discussing some of the challenges facing dementia care services (and likening work in these services to the experiences of Sisyphus, sentenced continually to push a heavy rock up a hill). Kate Anderson also presented a summary of the recent Mental Capacity Act and we introduced a new case discussion slot.

We met again in Bristol in April, 2006. At this meeting, Reg Morris led a discussion about potential research into the issue of capacity, something which PSIGE members hope to pursue under Reg’s guidance. There
was also time at this meeting for discussion of local services and issues, with particular discussion of services which seek to use a ‘community psychology’ model.

In June, 2006, we organised a workshop entitled ‘Coping with Adversity’ in Cullompton. This workshop was facilitated by Stirling Moorey from the Institute of Psychiatry and was funded by a grant from the PSIGE Training Committee. The workshop focused on ways of working therapeutically with individuals in adverse life circumstances, drawing strongly on Stirling’s experience of using CBT techniques when working with cancer sufferers. The feedback for this event has been very positive. It provided both practical ideas and inspiration for us in our clinical work.

The South West PSIGE group was also busy with our edition of the Newsletter, which was published this summer. Several members contributed some thought-provoking articles, and we hope that you all enjoyed this publication when you received it.

Philippa Wilson & P.F. Joyce

WESSEX

Wessex PSIGE covers Hampshire, Dorset, Wiltshire and the Isle of Wight. Some parts of this area still do not have a clinical psychologist working with older people and we are a small group with a total membership of 17 paid-up members. Attendance at meetings is usually 10 to 12, including trainees from the course based at Southampton University. Some of our members also have trainees on placement with them from the Bristol course.

We meet quarterly in Salisbury. The first half of the meeting is for business matters and in the second part there is a presentation.

Issues discussed at the business meetings over the last year include the changes in clinical psychology training – core competencies, reorganisation of teaching and placements (older adult placements have been moved from the second year to the first year in Southampton) and the Quality Assurance review which took place in Autumn 2005, financial difficulties in the local trusts and their effect on services and links with South West PSIGE.

Presentations
December, 2005: Video diaries for people with dementia – Chris Allen.
June, 2006: Emotional Processing in Older People – Sam Dench.

Workshops
July, 2005: Psychosocial approaches to challenging behaviour – Mike Bird (held jointly with the University of Southampton Clinical Psychology Training Course).

Ann Marshall
WEST MIDLANDS

West Midlands PSIGE, continues to meet six times a year at the University of Birmingham. It is attended regularly by a small, core group of qualified psychologists (six to eight) and a larger number of trainees and assistants, with numbers fluctuating dependent on vacancies and times of year!

Clinical psychology, working with older people in the West Midlands, continues to grow as described in the West Midlands edition of the *PSIGE Newsletter*, January, 2006. Clinical Psychology Services across the region vary both in terms of size, therapeutic orientation and model of service development. We also have close links with the three local ClinPsyD courses of Birmingham University, Coventry and Warwick University and Staffordshire University.

The regular meetings of PSIGE West Midlands reflects this range, and very much focus on the purpose of the regular meetings to provide an opportunity to discuss professionals issues, developments within clinical work and matters relating to clinical psychology training.

The meetings follow the usual format of the first, providing an opportunity to discuss business matters relating to service developments and training issues, national PSIGE items, etc., and a clinical discussion. Topics here, particularly in the July and September meetings, focused on the production of the West Midlands edition of the *PSIGE Newsletter* which was published in January, 2006. This was naturally a time of increased activity for the Group but with the production of the final draft being available by the agreed deadline in October and containing many articles reflecting the range of work being currently undertaken within the region it was thought to be a very productive time for the Group.

In addition to the usual clinical discussions occurring at the PSIGE meeting two half-day study days were organised.

**21 March, 2006:** Workshop on Mental Capacity led by Mike Church and Sarah Watts with feedback from the Society’s Workshop on Mental Capacity by Nicola Belson.

This workshop made use of presentation and casework material to help develop our skills and confidence in looking at the role of clinical psychology in assessment of capacity, making use of a broad range of skills not purely neuropsychological assessment.

**16 May, 2006:** Workshop looking at the Development of Dementia Care Pathways, contributed to by all members of the PSIGE Group with particular reference to the publications by CSIP – *Everybody’s Business* and the draft PSIGE Guidelines on Memory Clinics.

West Midlands PSIGE has a new Secretary and Treasurer, whose details are shown below. Caroline Sincock remains as Chair until January, 2007.

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YORKSHIRE & HUMBERSIDE

Membership
Around 40 members at present mainly clinical but some academic.

Meetings
Our regular meetings occur quarterly and last three hours. They consist of a talk/workshop, usually led by someone from within the region (with an emphasis on clinical practice and lasting 90 minutes), a business section, and a short time for members from across the region to catch up with each other. Once a year we hold a day-long meeting with presentations by people from across the region focusing on their clinical practice.

Quarterly meetings
Reasonably well attended – around 15 people per meeting.
Talks on:
- Systemic thinking in clinical practice with older people – Florrie Gullion.
- Out of Focus? Exploring the issues of focality and verbosity in CBT with older people – Chris Clarke.

Extraordinary meetings
Four meetings held. Used to evaluate and plan the older people teaching on the Leeds DClin course and to allocate placements across the region for the Leeds course. There has been a focus this year on planning teaching around the competencies framework and using the PSIGE guidelines for course content. All placements offered by clinical psychologists working with older people were taken up by the course and there is a continuing policy of using all such placements before considering any other options for second-year trainees.

Annual one-day meeting
The topics at this year’s event were use of psychodynamic observation in work with older people, and assisting non-psychology staff to use CBT techniques.

Training events
This year we put on one major training event:
- Clinical Applications of Mindfulness Training – Alistair Smith.

Future plans
- We are working towards making something out of our web page – to include information about meetings, the departments and people in the region, and research activity and areas of interest.
- Working on planning the 2008 Conference.
- More invited speakers for local events.

Michael Jubb
Leeds Older People’s Psychology and Therapies Service.
NEW!
RESEARCH PRIZE

PSIGE is delighted to announce a new Research Prize. Trainees who completed a research thesis relevant to the psychological needs of older people and who graduated in 2004, 2005 or this year, in 2006, may apply.

The prize will be registration at the PSIGE Conference in Nottingham, 4–6 July, 2007, an opportunity to present your research at the conference, plus assistance with travel expenses (prize value £500).

Please submit a report (max. 3000 words), describing your research study. This report should be in the form of a research paper (introduction, methods, results and discussion).

Please give the following information:

● Name of applicant;
● Title;
● Supervisor(s);
● Training Programme;
● Year of Graduation.

Submit by e-mail to romola.bucks@soton.ac.uk by 6 January, 2007.

Entries will be shortlisted by Sarah Dexter-Smith, Sinclair Lough and Romola Bucks and a final entry chosen at the National Committee Meeting in February, 2007.

We are hoping to make this an annual prize, funding permitting.
Members' updates

Division of Neuropsychology Practitioner Full Membership – planned end to transitional arrangements

The transitional arrangements for reductions in the clinical portfolio requirements of the Division of Neuropsychology Practitioner Full Membership Qualification will end on 31 December, 2006. Details of the regulations are provided below. If you are aware of DoN members who may be affected by this but who may not have received this e-mail, please make them aware of the deadline.

Further details:

Transitional Reduction in Clinical Portfolio of Practitioner Full Membership Qualification

Many candidates for the PFMQ are already aware that the Board of Examiners has the discretion to grant a reduction in the required Clinical Portfolio component (Part 3). Such reduction is only considered in circumstances where the candidate could not have achieved grandparenting to PFMQ (because they did not have the required two years’ experience when grandparenting closed in December, 2003), but had already started some clinical neuropsychology practice before the new qualification opened in January, 2004. These circumstances usually apply where:

1. The candidate gained qualification as a Clinical Psychologist (or Educational Psychologist for Paediatric PFMQ) in 2001, 2002 or 2003.
2. The candidate was already gaining clinical neuropsychology experience prior to January, 2004.
3. The candidate was receiving supervision from an appropriately qualified person (usually a PFM of DoN) before January, 2004.

The Board will consider granting a reduction in the required clinical portfolio, with a maximum reduction of 12 months, such that Regulation 7.4.1 (page 11 of Regs & Syllabus) is reduced from a Case Log covering ‘a minimum of two years’ to a lesser period with the greatest reduction taking this to ‘a minimum of 12 months’. Normally the Board will only grant a reduction equivalent to the period for which the candidate was already practising before January, 2004. (So, for example, a candidate who qualified as a Clinical Psychologist in September, 2003, and was then in a full-time neuropsychology post from October, 2003, would be likely to receive a three-month reduction in required clinical portfolio).

The Board will grant a reduction in the required accrued clinical supervision (Reg. 7.5.1, page 11) pro-rata with the reduction in length of practice, with the greatest allowable reduction being down to 40 hours, for those candidates only required to complete 12 months supervised practice.

The minimum period of registration before PFMQ can be granted will also be reduced for candidates granted a reduction in required clinical portfolio.

Reg. 3.13 (page 7) states a minimum period of registration of two years, but this can be reduced by up to 12 months, in line with the reduction in supervised clinical practice.

These transitional arrangements will end on 31 December, 2006.

Candidates for whom an agreement has been reached with the Board of Examiners may still be completing their agreed supervision plan beyond that date, but the granting of any transitional arrangements must have been completed by 31 December, 2006. Candidates (or potential candidates) who wish to be considered for transitional reduction in clinical portfolio who have not yet requested this should do so by writing a letter explaining their circumstances, to myself, via the Society’s address.

Dr June Robson
Registrar to the Board of Examiners for PFMQ of DoN.

Visit our website: http://www.slam.nhs.uk/
Local Implementation of the Mental Capacity Act: Development of Regional Networks for Practitioners

A joint event between the British Psychological Society and the Royal College of Psychiatrists has been planned for Tuesday 5 December, 2006, 10.00 a.m. to 4.00 p.m. at the Society’s London office (30 Tabernacle Street, London EC2 4UE).

It is for senior psychologists and psychiatrists, across all specialty areas, who are interested and able to assist at a local level in establishing core groups of practitioners. These core groups will then provide support and advice to practitioners in their regions. The plan is to help disseminate knowledge and expertise in the implementation of the MCA, especially in cases with additional complexity or ethical/professional dilemmas.

The day will include presentations on the work of the Care Services Improvement Partnership (CSIP), small interdisciplinary group work on case examples; it will also involve lawyers/solicitors and clinical ethicists to help in discussions. The day will close with a session for local groups to plan the way forward.

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Mental Capacity Training Day – Early Notification – February, 2007

This training day for any psychologist will focus on case vignettes, tying them into theoretical aspects. There will be presentations on psychological models which inform assessment of capacity, i.e. Social Psychology, Decision Making and Theory of Mind. Cost £20. Location: the Society’s London office (30 Tabernacle Street, London EC2 4UE).

Details will be circulated via your Geographical Groups before the end of the year. Other Capacity training sessions are in planning for the New Year for PSIGE members only.

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Dementia Services Guidelines

PSIGE’s response to the NICE/SCIE Dementia Services Guidelines will be placed on the website (www.psige.org.uk). Please read this alongside the NICE/SCIE Guidelines which are on their website (at www.nice.org.uk/page.aspx?o=315284). This is because our response had to be made in relation to each particular section. To make sense of our comments you will need to read the relevant section of the guidelines, followed by our comments. I would like to thank the PSIGE membership who helped produce our response within a tight deadline.

Chris Allen

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Mental Capacity Act Consultations – Involvement of PSIGE Members

A number of PSIGE members have contributed to consultations about the Mental Capacity Act.

Catherine Dooley contributed to the general consultation on the Draft Code of Practice. Romola Bucks contributed to the consultation on the Lasting Powers of Attorney and more recently to the consultation on Research Capacity. South Wales PSIGE Geographical Group made a detailed response to the Draft code of Practice which formed the basis of the final Society response.

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UK Inquiry into Mental Health and Well-Being in Later Life: A first report. Mental Health Foundation, June, 2006

The UK Inquiry into Mental Health and Well-Being in Later Life was launched in 2003. It aims to:

● Raise awareness of mental health and well-being in later life;
● Involve and empower older people;
● Create better understanding;
● Influence policy and planning; and
● Improve services.

The inquiry is working in two stages. The first stage focussed on what helps to promote good mental health and well-being in later life. The findings and recommendations are presented in a report which is available for download from www.mhilli.org.

Chris Allen was an Advisory Group member and Bob Woods was on the Board.

The second stage will look into the prevention of mental illness in later life and the provision of support and services to older people with mental health problems and their carers. Findings and recommendations from this stage will be presented in the Inquiry’s final report in 2007.

* * * * *
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www.researchdigest.org.uk
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Notes for Contributors

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

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

Submission Procedure
Please submit articles as a Word file via e-mail to romola.bucks@soton.ac.uk. 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: romola.bucks@soton.ac.uk
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