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

For information or to contact the editor please use the following address:
E-mail: romola.bucks@soton.ac.uk
WE WERE PLEASANTLY SURPRISED at the number of people in the North Eastern region who offered to write papers for our edition of the PSIGE newsletter. Even more surprised to find that almost everyone that offered has managed to produce a paper! Owing to the high response rate to our clarion call, the NE contribution is spread across this issue (97) and the Spring issue (98) of the newsletter. This editorial will mention the articles appearing in this journal and then briefly outline the papers appearing in Issue 98.

Preparing the newsletter has actually been a timely exercise for our group, coming at a point when most of us between North Yorkshire and Scotland are being swept into three Trusts (Northumberland, Tyne & Wear and Tees, Esk & Wear Valleys, North Tyneside PCT). Our PSIGE meetings are increasingly becoming places where we discuss service trends and developments, and begin to form cohesive groups. Becoming larger groups within Trusts also provides opportunities to share some of the work we have been doing individually over the last few years.

A further consequence of the integration is that managers are beginning to look at issues of equity for older people across localities. For example, now that Northumberland and Sunderland are in the same trust, discrepancies in service provision are more apparent, and there is a greater drive for them to be addressed. To date, our discussions with managers in the northern trust (Northumberland, Tyne & Wear Mental Health Trust) have been positive, with managers clearly valuing the consultancy and supervision roles that psychologists can offer. Examples of psychologists working in this manner are provided in the current edition by Sarah Dexter-Smith (Teesside). Her paper provides an example of how to change ward-practices through the promotion of formulations in these settings.

A further two articles in this edition examine service and organisational issues. Both are somewhat provocative, questioning things that may be regarded as fundamentals to our practices. Firstly, Louisa Shirley (Northumberland) questions whether we should be promoting independence in our clients. From an attachment perspective, she suggests that it may be more appropriate to foster healthy dependence. Secondly, Tim Prescott (Teesside) suggests that we need to radically rethink our perspectives on ‘end-of-life’ issues.

In our collection of papers, a number of colleagues have discussed important clinical issues. Gillian Bowey (South Tyneside) presents her survey of generalised anxiety disorder in older people, and Catherine Andrews and colleagues (Gateshead) present a thought-provoking qualitative study looking at people’s experiences of hallucinations and treatment. Malcolm Stephenson and colleagues (Newcastle) discuss the misuse of alcohol in older people in the community, and examine how well current services cater for such problems. In addition, Lynne Patience (Northumberland) examines the problem of assessing driving in dementia. She poses a number of important questions that a special interest group has been set-up with the NE are wrestling with.

Two psychology-led challenging behaviour services for older people have been formed in the North of the region, and PSIGE members from these groups have produced papers that contribute to our understanding of care staff processes. Ian James and colleagues (Newcastle) show the effectiveness of asking staff about their own
toileting habits, and how this may help to bring about change in attitudes toward toilet regimes in care homes. Also, Sylvia Rutledge (Newcastle) investigates the potential impact of staff’s emotional responses to challenging behaviour. This qualitative study examines the nature of fear experienced by staff engaged in caring for people with dementia.

At a time when we are being asked increasingly to quantify the service we provide, in this series of articles we have been able to demonstrate the breadth and complexity of the role of a typical clinical psychologist. This opportunity to consolidate and reflect has been useful for many of us involved in the publication. Indeed, as noted by Neil Sabin (Newcastle) in his personal account of mindfulness, at times of uncertainty it is very easy to become distracted and lose one’s focus.

The articles appearing in the Spring edition reflect many of the themes outlined above. From a clinical perspective, Maire Sharkey (South Tyneside) describes her work on examining post-traumatic stress disorder in people who have experienced a stroke. While from their research portfolio, Louisa Shirley and colleagues (Northumberland/Newcastle) demonstrate the importance of taking process factors into account during neuropsychological examination. In contrast, Amy Wood-Mitchell and colleagues (Newcastle) present data from qualitative projects undertaken with medical colleagues, looking at recent guidelines related to prescribing practices. This paper call on us to take more interest in the vitally important topic within our conceptualisations and interventions. In the final paper in the series, Ian James (Newcastle) suggests that person-centred care has come to the end of its shelf-life, and controversially proposes that we should adopt a ‘fast-food’ model of service.

In summary, we feel that this collection is a good reflection of the work going on in the Northern region, and we have enjoyed the opportunity it has given us to pull together some shared ideas. We would be pleased to hear from others interested in these areas to continue the dialogue some of these papers start.

Louise J. Shirley & Ian A. James
Letter from the Editor

I T DOES NOT SEEM POSSIBLE THAT IT is already time for the next issue. This one is a bumper offering from the Northern Geographical Group. Indeed, there were so many articles from the group that some have been held over until April’s newsletter. Thank you, to the Northern Group, with able editing from Louisa J. Shirley and Ian A. James, for starting 2007 so well.

I have really enjoyed reading all the articles submitted, not least because much of it is so directly relevant to issues with which I am currently grappling in my own post. One particular issue, for me, has been how to develop a psychology service on a ward which has never before had psychology input. Two articles which deal directly with the process of sharing psychological knowledge/formulations with staff are Sarah Dexter-Smith’s paper on a formulation-based approach and Victoria Carek and David Wallace’s article on a ‘Jigsaw’ approach to sharing psychology with stroke rehabilitation staff (my apologies are due to Victoria and David whose article I omitted from Issue 96 in error). I am sure that, like me, you will find much that is interesting and thought-provoking here and in all the other articles.

I am also delighted to be able to publish a letter from Una Cosgrove. Una has been a longstanding and much valued contributor to PSIGE and to the newsletter and her thoughts are always illuminating and welcome.

Last, but not least, the deadline for submission for the Trainee Research Prize has been extended to 9 February, so there is still time to send us your paper.

Happy New Year.

Romola Bucks
Editor, PSIGE Newsletter.
Letter from the Chair

Steve Boddington

If, like me, the arrival of your copy of the PSIGE newsletter is a welcome break from the daily grind of working as a psychologist in an overstretched clinical service, then I’m sure that you will be looking forward to the inspiration that is found within these pages. Enjoy!

Four PSIGE members were able to attend the stakeholders meeting for the NICE scoping exercise for guidelines on public health interventions for mental health and older people. Please let us know if you would like to join a small group who will read and respond to the draft consultation documents from this initiative over the coming months.

Thank you to Chris Allen for collating the PSIGE feedback on the NICE guidelines on dementia services, and to Bob Woods for all his input as a member of the guideline development group. This was published towards the end of last year and it is great to see that psychological interventions in their widest forms are given due attention.

If any newsletter readers can think of ‘good practice’ examples that can be fed into the New Ways of Working for Psychologists process, please forward them to Tina Ball (Chair of Managers faculty) as it would be great to have older people’s services properly represented in the documentation that will eventually be published.

Please note that a call for submissions for the PSIGE conference in Nottingham has been circulated (check our website). Hopefully, the online submissions process will run more smoothly this year so please put forward your proposals. The conference is such a great opportunity to share and learn from the tremendous work that so many of you are doing!

Finally, congratulations to Polly Kaiser who contributed to a multi-agency project on ‘life story’ work that received a highly commended Positive Practice award from CSIP. Do let me know of any other members who are receiving recognition for their work and keep flying the flag!

Steve Boddington
Chair, PSIGE.
LISTEN WITH A STRANGE MIX OF emotions when Patricia Hewitt speaks. She appears keen to deny that the NHS is to be privatised, but determined to point out that there is no limit to the contribution that private organisations may make to many areas of health care treatment. I am one of many thousands of NHS professionals who wonder quite what to make of her carefully chosen words. I am tempted to say that I have some sympathy with the political agenda she has to face, but frankly I have no sympathy at all for Pat.

I do, however, recognise that the cost of providing health care treatment exceeds what politicians believe the taxpayer is willing to provide. That is bad news for politicians. It is probably bad news for patients, and not exactly music to the ears for well-paid health care professionals.

For a few years now, DoH Secretaries of State have tried to shift the focus of blame for inadequate health care to local decision makers through a process of organisational re-structuring, i.e. the creation of small and local PCTs and provider Trusts. It was never a hugely successful strategy and the recent initiative to save £250 million on management costs has brought a series of organisational reconfigurations that is stretching the locality logic beyond plausibility. Trusts are merging into much larger organisations and looking forward to achieving Foundation status. Local decision making to meet the needs of local populations is ‘so last year’.

I now work on the University of Teesside training course but in my last NHS post I was a member of a Liaison Psychiatry Service (or Hospital Mental Health Team) for older adults in a general hospital. From time to time I was asked to see patients to help medical staff think about capacity and consent issues. On occasions I was surprised that the medics were not fully cognizant of the fact that their patient was dying. Instead, their attention was focussed on further intervention. NHS expenditure on acute medical care during the last few days and weeks in the lives of older adult patients accounts for an enormous proportion of the NHS budget. I do not want doctors to give up on their older patients when they can intervene to good effect, but I think we live in a culture that has terrible difficulty in recognising and accepting the inevitability of death.

The £250 million that we hope to save on management costs is chicken feed in the bigger financial picture and the heavy costs in terms of staff morale of yet another non-evidence-based restructure is difficult, even for Clinical Psychologists, to make sense of.

Newly-qualified Clinical Psychologists are no longer greeted by a long list of vacancies from which to select. Some are going back to Assistant Psychologist posts. The NHS managers who still have jobs seem to think we are rather expensive.

A new environment is emerging and, as psychologists, we need to think about how we adapt to the political and financial agendas. The days of jobs for life and ‘big boy’ final salary pensions are gone. If we are going to survive and thrive in the new NHS, we might need to work differently, to demonstrate more clearly what value for money we give.

Older people are very expensive to care for, they live for far too long and they suffer from far too many health problems. It seems to me that the financial impossibility of these inconsiderate tendencies in the elderly population will inevitably prompt some new thinking on the ethics of euthanasia in the years ahead.

Interesting times that we live in; I wonder where these trends will lead Clinical Psycho-
logists working with Older Adults. Our cultural struggle with death and dying is a complex and frightening territory. But someone needs to be brave enough; and I’ll tell you what, there’s money in it. The discussions about when to intervene and when to stop intervening are too often avoided, and desperate and undignified deaths occur as a result.

Renal medicine has developed the concept and practice of Conservative Management; paying respectful attention to dignified alternatives to medical treatment. The no treatment option that will end in death is often chosen.

We are better able than other NHS professionals to help doctors, patients and their families think and talk about treatment decisions. We can live with others while they experience the emotional impact of illness and the prospect of dying. In 2004, I attended a liaison Psychiatry conference. There were over 200 delegates present, but I was the only Clinical Psychologist. There are good clinical and financial drivers that should create much more work for Clinical Psychologists to help staff and patients in acute medical services find the right decisions at the right time. Ready when you are Pat.

Correspondence
Tim Prescott
Consultant Clinical Psychologist,
Doctorate in Clinical Psychology,
University of Teesside.
E-mail: T.Prescott@tees.ac.uk

Media Training Courses 2007

Working with the media? Want to gain some valuable tips and experience?

Whether you are a complete beginner or looking to update your skills, you will find our training sessions stimulating and enjoyable.

An Introduction to Working with the Media
A one-day immersion in the media – newspapers, magazines, radio and television – with lots of hands-on experience. This course is designed to give a general introduction to how the media operates, as well as introducing some of the skills necessary in media liaison, e.g. press release writing and interview techniques.

Members’ Cost: £126 (inc. VAT) Dates available: 19 February 07; 14 May 07; 17 September 07; 3 December 07.

Broadcast Interview Skills
A one-day course that covers everything required for speakers to feel confident about taking on broadcast interviews. It will focus on radio interviews, but will also cover TV interview techniques.

Delegates will be provided with plenty of practical opportunity to get in front of the microphone and to gain experience of actually being interviewed.

Members’ Cost: £179 (inc. VAT) Dates available: 5 March 07; 24 September 07; 10 December 07.

All courses take place in London and include lunch and course materials.

Registration form and further details from:
Dawn Schubert
Administrator, Publications & Communications Directorate
Tel: 0116 252 9581; E-mail: mediatraining@bps.org.uk
Meditation is everywhere

Neil Sabin

Not known because not looked for,
But heard, half heard in the stillness
Between two waves of the sea.
Quick now, here, now always,
A condition of complete simplicity
(Costing not less than everything).

From The Four Quartets by T.S.Elliot

Stumbling and searching

MOST OF US SPEND MOST OF
our personal and professional lives
on automatic pilot, passively carried
along by forces and habits, which we fail to
explore. Sometimes we have the fortune to
wake up from this suffering. I thought I had
when I first read Mindfulness meditation in
sums up the content of this wonderful book
and I, mistakenly, thought I understood.
But, I hadn’t, because I carried on in doing
mode – I read more and thought about
things. It wasn’t until a few years later when
I came across Segal, Williams and Teasdale
(2002) that I began actually practising medi-
tation in my everyday life.

Segal and colleagues had gathered as a
group to create a maintenance form of
cognitive therapy (CT). While there was
some evidence that CT reliably reduced
relapse rates in depression, they were trying
to improve this further. The data implied
that CT had taught ex-clients something that
once learnt protected them from depres-
sion. The researchers thought that they
might devise a way of teaching this something
to people who had recovered. After much
work they identified that CT, which osten-
sibly focused on changing the content of
people’s thinking, had actually changed
people’s relationship with their thoughts. The
recovered clients were now standing back, de-
centring from their cognitions. Therefore,
the researchers sought to find more targeted
ways to enable this de-centring style. Their
journey took them to meet Jon Kabat-Zinn
who had been working since 1979 at the
stress reduction clinic at UMASS. He taught
mindfulness meditation to clients with a
range of physical and mental health
problems. Segal and colleagues learned
about the methods and synthesised these
into attentional control training. However, the
results of this particular intervention were
poor and they returned to Kabat-Zinn to
discuss this and he asked, Do you have your
own practice?

They didn’t.

This time they went away and began both
practising and writing the book which
summarises their story and details the eight
week course: Mindfulness-based cognitive
therapy for depression.

For me – well, I spoke to a colleague, he
talked to an old friend and meditation
teacher and we began our journey together.
But more of that later.

A bit of science

A model of mindfulness recently proposed
by Shapiro et al. (2006) incorporates three
axioms: Intention, Attention and Attitude.
All of which are contained in meditation
practice and everyday mindfulness and all of
which are also open to scientific scrutiny.

Intention refers to why one is practising.
Shapiro (1992) identifies a path from self-
regulation to self-exploration to self-liberation,
which emphasises their dynamic and
evolving nature, and allows them to change and
develop with deepening practice awareness and
insight.

Attention is a cognitive skill, which involves
focusing on one’s moment to moment

PSIGE Newsletter, No. 97, January 2007
© The British Psychological Society
internal and external experience. It can refer to our ability to sustain attention to a single object (in Mindfulness meditation this is the breath), an ability to switch attention from object to object at will (in a body scan from the various parts), and an ability not to get lost in secondary elaborative processing of our thoughts, feelings and sensations. So that when our minds wander from the breath, as they surely will, we gently bring it back without evaluation or interpretation.

**Attitude** is the approach we bring to the process. It involves practising patience, trust, acceptance and openness, even when what is occurring is contrary to our wishes or expectations.

This process of mindfulness can lead to increased emotional, cognitive and behavioural flexibility. It additionally enables us reflectively to choose our values rather than those that are reflexively adopted or conditioned.

**A bit more**
Baer (2003) summarised the results of Mindfulness based stress reduction (MBSR) courses across a broad range of presentations:
- Chronic pain – significantly less pain, medical and psychological symptoms;
- Generalised anxiety disorder – improvements in anxiety and depression symptoms;
- Binge eating – improvements in eating and mood;
- Fibromyalgia and psoriasis – clinically significant improvements.

The same kinds of effects are seen with mixed clinical and non-clinical populations. She acknowledged that the results were tentative because they were based upon a few studies. Nevertheless, on average, participants with mild to moderate psychological distress would be brought into, or close to, the normal range. She noted that most people completed the courses and three-quarters continued to practice meditation up to four years post-study. There were methodological issues in that there were no control groups, no comparisons with other approaches, small sample sizes and therapist competence was variable. Germer et al. (2005) explored the integration and application of Mindfulness in a variety of therapeutic frameworks and because of its fundamental nature posited that a mindful way of being could be potentially beneficial to any therapist.

**Surely it can’t be that simple!**
It is that simple! – But it is also difficult.

Ruminative thinking, for example, underpins depressive relapse and reflects a more general goal-based mode of processing in which judgements and evaluations and discrepancies between actual and desired states are central. Mindfulness allows individuals to switch out of this. It is, therefore, important that meditation practice is not conducted in a goal-oriented manner.

Teasdale (2003) indicated that Mindfulness could be unhelpful in certain situations. Indeed, clients with two (or fewer) previous episodes of depression did not seem to benefit. However, those with three or more episodes improved with a 50 per cent reduction in relapse. He also emphasised the importance of Mindfulness being linked to an alternative and coherent view of the client’s problems, shared with them through formulation and reinforced through practice. The work of Hayes et al. (1999) is an exemplar.

**Following a well-trodden path**
Here in Newcastle, over the last four years, our core group members have delivered introductory workshops to over 150 staff members. Additionally, we have run four, eight-week MBSR courses for 60 people; the content of which was provided to us by Alistair Smith, a Clinical Psychologist from Preston, who has been organising courses for older people recovering from depression for the last few years. We formally evaluated the most recent MBSR course (Mitchell,
2006) and found that the attendees reported increased levels of mindfulness and reduced levels of work strain to a level comparable with other MBSR programmes (e.g. Shapiro et al., 2005). There are monthly, hour-long opportunities to practice meditation on three different Trust sites. A Clinical Implications group had its inaugural meeting in the summer. In September we held our first, facilitated practice day for those who had attended the eight-week courses. Due to a huge Mental Health Trust merger across the Tyne & Wear there is now scope for the network to widen. There are two more introductory workshops being run this Autumn and two eight-week courses in the Spring, depending upon interest.

To paraphrase Lao Tzu, if we practice not doing, everything will fall into place!

Correspondence
Neil Sabin
Consultant Clinical Psychologist,
Newcastle Older People’s Service,
Northumberland, Tyne & Wear
Mental Health NHS Trust.

References

Organisations
http://www.bangor.ac.uk/mindfulness

The British Psychological Society and Blackwell Publishing’s unique partnership – BPS Blackwell – delivers an essential range of books for those seeking information on the latest psychology practices, research and methodology.

Recent titles include:

**Continuing Professional Development for Clinical Psychologists**
A Practical Handbook
LAURA GOLDING & IAN GRAY

**Health Psychology**
AD KAPTEIN & JOHN WEINMAN
The book provides students with a critical, thought-provoking introduction to this rapidly expanding discipline, covering health, illness and healthcare.
2004 - 440 PAGES

**Educational Testing**
A Competence-Based Approach
JAMES BOYLE & STEPHEN FISHER
Educational Testing acts as a ‘course text’ for those undertaking training in, and provides support for training providers of, the Certificate of Competence in Educational Testing (CCET) (Level A).

As a BPS member, you are entitled to a 20% discount on any BPS Blackwell title.
[As a BPS student member, you are entitled to a 30% discount on any BPSBlackwell title.]

Visit the website for further information
www.bpsblackwell.co.uk
Promoting attitude change: Staff training programme on continence care

Ian A. James, Petra Carlsson-Mitchell, Jenny Ellingford & Lorna Mackenzie

This paper presents findings of a survey (N=92) conducted during a continence training programme for staff working in care homes. The survey was conducted as part of an experiential exercise within a workshop designed to promote attitude change. It required staff to indicate whether or not they employed any ritualistic habits when using public toilets (e.g. hovering over the toilet seat without making contact). It was envisaged that asking staff to reflect on their own toileting habits would make them more empathic about residents’ potential anxieties concerning the use of toilets in care settings. Feedback from the training suggested that the survey was an effective vehicle for initiating attitude change. The paper also presents data on the perceived value of the training programme from a sub-set of the participants (N=41).

Incontinence affects 30 to 50 per cent of individuals with dementia, for which not all cases can be attributed solely to bladder or bowel dysfunction (Burns et al., 1990). It has been emphasised that a multitude of factors such as disease, disability, emotional disorder, and environmental features should be taken into account when assessing and treating toileting difficulties (Stokes, 1996). Toileting difficulties develop as a result of an interaction of a variety of internal and external factors with respect to the individual (e.g. Flint & Skelly, 1994; Stokes & Goudie, 2002).

Psychological approaches found to be successful in the treatment of continence problems have resulted in the development of person-centred models that address the subjective experience of dementia and the wider context of the individual (Stokes, 1996). These person-centred approaches are advocated in the National Service Framework for Older People (2001), alongside emphasis on the importance of teaching, training and evaluation.

It is important not only that staff have sufficient knowledge and skills when working with individuals with continence problems, but also that staff work with an appropriate attitude. This is particularly poignant given that rates of caregivers’ helping behaviour are at their lowest when the perceived cause of the behaviour is seen as internal and controllable by the person (Weiner, 1980). Ajzen and Fishbeins’ (1973), model of reasoned action suggests a bi-directional relationship between attitudes and behaviour.

This study aimed to promote attitude change through the process of staff personalisation of toileting-related behaviours. That is, encouraging staff to empathise more with the residents’ toileting dilemmas by asking them to reflect on their own toileting preferences.

Method

Participants

Ninety-two staff were recruited from care homes and inpatient wards (66.3 per cent female, 14.1 per cent male, 19.6 per cent failed to report gender). Sixty-one (66 per cent) participants were care workers and 31 (34 per cent) were qualified nurses (RMNs, RGNs). Other details relating to staff were not recorded to ensure anonymity. Participants were recruited during workshops on promoting continence. There were seven workshops in total; four were two hours in duration, involving a didactic presentation, an experiential exercise (long workshop); three were one hour, involving a didactic presentation (short workshop).
Forty-one (44.6 per cent) staff members participated in the ‘long’ workshops and 51 (55.4 per cent) staff members attended the shorter versions. The training events were held in various nursing homes and geriatric wards in Newcastle. Training sessions were devised and run by members of the Newcastle Challenging Behaviour Service (RMNs and Psychologists).

Design
All participants were required to complete a questionnaire entitled Survey of Toileting Habits and Routines Questionnaire (STHRQ). Those undertaking the ‘long’ workshops were required to complete a pre/post-workshop repeated measures questionnaire entitled the Long Workshop Toileting Questionnaire (LWTQ – see below).

Materials
The two questionnaires employed were:

The Survey of Toileting Habits and Routines Questionnaire (STHRQ)
The STHRQ required staff to reflect on their own toileting habits, with the aim of encouraging them to empathise with the residents’ experiences of coping with the toileting regimes in their care setting (see Table 1). The STHRQ asked the staff six questions, which related to their toileting habits. For example, Question 3 required staff to select the frequency with which they engaged in any of the following activities: avoided contact with the seat, placed tissue on the seat prior to sitting, wiped the seat, avoided touching the taps, etc. Questions were based on pilot work from previous training events on continence.

Pre- and Post-Long Workshop Toileting Questionnaire (LWTQ)
The pre- and post-teaching LWTQ questionnaires were designed to measure change in staffs’ perceived confidence, knowledge and understanding with regards to working with people with toileting difficulties. The pre-LWTQ questionnaire contained a case vignette of someone with continence difficulties and five questions. Three questions elicited staffs’ perception of their ‘confidence in helping’ and ‘knowledge and understanding of strategies to help’ and ‘knowledge and understanding of factors that contribute to toileting difficulties’. The two remaining questions asked staff to give examples of how to help the person in the case vignette, and possible causes for the person’s difficulties.

The seven-item post-LWTQ asked two additional questions, for auditing purposes, regarding the impact of the workshop. The first question asked how helpful the STHRQ had been in increasing awareness of how a person with dementia might feel about using toilets in a residential home. The second question required staff to document whether the workshop would change their current working practices (Yes/No), and then detail the nature of such changes.

Procedure
Staff participated in either a long or short workshop; the content followed a similar format in both cases. There was an initial section on information giving (prevalence of incontinence, continence issues in care settings, mobility problems), and then a period of reflection and discussion. Those in the longer workshop spent more time reflecting and discussing issues. Staff participating in the ‘long’ workshop completed the pre-teaching LWTQ on arrival and the post-teaching LWTQ when the workshop had finished. All staff completed the STHRQ during the reflection period.

Results
a. Survey of toileting habits and routines questionnaire (STHRQ, N=92)
Ninety-two members of staff completed the STHRQ. Table 1 (alongside) shows the quantitative results.

Descriptive findings for STHRQ
Forty-five (48.9 per cent) participants answered the open-ended question (Q.4)
Table 1: Summary of responses to Questions 2, 3 and 5.

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Sometimes</th>
<th>Very occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>2  Do you avoid going into public toilets?</td>
<td>7.1%</td>
<td>28.2%</td>
<td>54.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>3  Do you engage in any of the following activities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Do you squat to avoid making contact with the toilet seat?</td>
<td>32.6%</td>
<td>38.0%</td>
<td>13.0%</td>
<td>16.3%</td>
</tr>
<tr>
<td>ii Would you place toilet paper on the seat if you have to sit on it?</td>
<td>38.0%</td>
<td>22.8%</td>
<td>12.0%</td>
<td>27.2%</td>
</tr>
<tr>
<td>iii Would you wipe round the toilet seat prior to using it?</td>
<td>46.2%</td>
<td>37.4%</td>
<td>8.8%</td>
<td>7.7%</td>
</tr>
<tr>
<td>iv Would you avoid touching the flush handle by using, e.g. paper or another part of your anatomy?</td>
<td>25.3%</td>
<td>30.8%</td>
<td>17.6%</td>
<td>26.4%</td>
</tr>
<tr>
<td>v  When washing your hands, do you avoid touching the taps by using your wrists to turn taps on and off?</td>
<td>16.5%</td>
<td>27.5%</td>
<td>17.6%</td>
<td>38.5%</td>
</tr>
<tr>
<td>vi On leaving the toilet do you avoid touching the door handle?</td>
<td>20.9%</td>
<td>26.4%</td>
<td>15.4%</td>
<td>37.4%</td>
</tr>
<tr>
<td>5  Would it put you off using a public toilet if ...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i  The toilet cubicle was open at the top or bottom?</td>
<td>47.8%</td>
<td>52.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii There was 'something' already down the toilet?</td>
<td>88.9%</td>
<td>11.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii There was no toilet paper?</td>
<td>90.1%</td>
<td>9.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv It was smelly?</td>
<td>89.1%</td>
<td>10.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>v  It was cold?</td>
<td>33.0%</td>
<td>67.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vi The floor was wet?</td>
<td>82.4%</td>
<td>17.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vii The floor was littered with toilet paper, etc.?</td>
<td>78.0%</td>
<td>22.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Q.1 – requested demographic information; Q.4, Q.6 – requested qualitative information.
‘Is there anything else that would put you off using a public toilet’. Responses included: ‘a broken lock, gap at bottom or top’, ‘damp seats’, ‘dirty stained toilets’, ‘un-maintained and dirty decor’. The participants’ responses to Q.6, which enquired about any ‘unusual’ toileting habits for ‘self’ or ‘others’, included: 
Self – ‘don’t go if other family members can hear me’, ‘use the same number of pieces of toilet paper each time’ and ‘put loads of paper on the seat like a nest before using a public toilet’,
Others – ‘dad reads the paper’, ‘aunt keeps loo roll on her just in case she needs a public toilet’.

b. Pre- and post-Long Workshop Toileting Questionnaire (LWTQ, N=41)
Scores for pre- and post-LWTQ in terms of ‘confidence’ and the two ‘knowledge’ scores are reported in Table 2 (below). The significant difference between the pre- and post-training with respect to the three features demonstrates that the training improved staffs’ confidence in helping people with toileting difficulties, knowledge of ways of helping people with toileting difficulties, and knowledge of factors contributing to continence problems.

In the post-LWTQ, participants were asked to rate how helpful the STHRQ had been in increasing their awareness of ‘how someone with dementia might feel about using toilets in a residential home’. Thirty-four (82.5 per cent) of the participants stated that the STHRQ had been either ‘helpful’ or ‘very helpful’, suggesting that the STHRQ was an effective vehicle in terms of attitude change.

The final questions in the post-LWTQ asked whether the teaching would result in a change in practice. The majority of staff answered affirmatively (85 per cent) while a small percentage (15 per cent) of staff did not think it would result in a change. The subsequent question asked staff to state what they would do differently. The responses fell into three broad categories, which are presented in Table 3 (alongside).

Discussion
Post-training, staff reported an increase in confidence, knowledge and understanding regarding practical and emotional issues concerning those residents experiencing toileting difficulties. In addition, the majority of staff reported that the training in the long workshops was likely to change their working practices in the future when dealing with a resident with continence problems. This is an encouraging finding in terms of the relevance of the necessary step of creating behavioural intentions to promote behavioural changes (Ajzen & Fishbein, 1973).

Furthermore, there was an increase in staffs’ empathy towards residents’ difficulties. It is proposed in this paper that the STHRQ was the main tool in increasing staffs’ empathy. This is supported by reports that the majority of the participants felt the survey was helpful in increasing their awareness of residents’ feelings. In addition, comments made ‘post training’ indicated an awareness of relating to the resident as ‘a person with wants and needs’ and suggested recognition of the person behind the illness. For example, staff felt in the future they would ‘find out residents preferences/'
The findings are also important for the reconceptualisation of residents’ ‘out-of-the blue’ aggression associated with being taken to the toilet. Indeed, we can now see that the person’s behaviour is actually normal, as we too would object to being taken to a smelly, dirty toilet under-escort. Hence, the findings help explain residents’ behaviours that might otherwise have been labelled as challenging. In a similar vein, it may allow those residents hitherto perceived to be disinhibited to be re-categorised as understandably avoidant. Indeed, a number of our residents may not be disinhibited; rather they may simply prefer to use a plant pot than an horrid WC.

The findings of this study are now being used in training sessions to facilitate staff reflection. With such sessions, the STHRQ is used as an experiential exercise. Typically, staff are asked to think about toilet facilities in the home in which they work, and any potential improvements that could be made to their facilities. A question frequently posed is: ‘What things would you do to the toilet for you to feel happy about using it?’ Participants are asked to reflect on cleanliness, temperature, lighting, escorting policies and privacy issues, smells, etc. In line with this argument, sessions discourage the use of separate facilities for staff and residents, as this clearly perpetuates the de-personalisation processes.

This real world study has several limitations. Importantly, the study was unable to measure the degree of attitude change, and measures were not in place to assess changes in overt behaviour. In addition, attempts were not made to match the training to the participants’ level of experience such as level of training, experience and years in the job. The research can also be criticised on a number of methodological grounds. Nevertheless, we have tried to incorporate a ‘driver for change’, and thus in a rather innovative manner tried to initiate changes in care practices.

---

Table 3: Variation of themes extracted from staffs’ comments about changes of future work.

| Theme: Adapting toileting facilities to meet the resident’s needs (N=5) |
| Comments: |
| ‘Make sure that signs are around properly and make the resident as comfortable as possible in toilets.’ |
| ‘Ensure toilets are clean whenever possible, keeping floor and toilet seats clean.’ |
| ‘Look at physical surroundings in more detail.’ |
| ‘Ensure toilet clean, comfortable and private.’ |

| Theme: Better understanding (N=5) |
| Comments: |
| ‘More understanding, different way of approaching.’ |
| ‘Read notes, listen and put into practice what I have learnt.’ |
| ‘Be more aware of what I have been taught.’ |
| ‘I learnt to understand why they might be the way they are.’ |
| ‘You become more personalised with the resident by saying their sayings.’ |

| Theme: Person-centred care (N=13) |
| Comments: |
| ‘Spend more time per resident, find out residents preferences/habits.’ |
| ‘More open to the perceptual/feelings/thoughts about toileting. Explore alternative ways of looking at this behaviour.’ |
| ‘Think of how the patient was before and how they are now. Try to meet their needs.’ |
| ‘Try to understand why they are having problems, also don’t judge them.’ |
In terms of future research, greater rigour is clearly needed. In particular we would like to test some of the views expressed above. Indeed, one would predict that in those homes, which had improved their toileting facilities, higher levels of continence would be observed.

**Conclusion**

The study provides initial findings of the effectiveness of training on toileting difficulties. It also describes a potentially useful mechanism for change, namely the *STHRQ*. The measure is thought to be successful due to underlying repersonalisation processes for staff working in residential care setting. The study has implications for raising care standards and delivering high quality care.

**Correspondence**

**Ian A. James**

Consultant Clinical Psychologist,
Newcastle Challenging Behaviour Service,
Northumberland, Tyne and Wear Mental Health NHS Trust,
Centre for the Health of the Elderly,
Newcastle General Hospital,
Westgate Road,
Newcastle-upon-Tyne NE4 6BE.
E-mail: ianjamesncht@yahoo.com
Tel: 08448115522 22551
Fax: 0191 219 5040
Doctorate in Clinical Psychology,
Newcastle University.

**Petra Carlsson-Mitchell**

Trainee Clinical Psychologist,
Doctorate in Clinical Psychology,
Newcastle University.

**Jenny Ellingford**

Assistant Clinical Psychologist,
Newcastle General Hospital.

**Lorna Mackenzie**

Challenging Behaviour Nurse,
Newcastle General Hospital.

**References**


Alcohol misuse within the older population has received increasing attention in recent years. Due to population increases within this cohort, together with recent Government guidelines, this issue has become an important area within the arena of health care provision for older people. This study explores health care professionals’ knowledge and practices with respect to alcohol use and misuse in older people. Three specific areas are addressed: (i) the extent to which staff perceive alcohol misuse to be an issue; (ii) specialist knowledge and training; and (iii) clinical practice. A survey of all health care professionals working in an integrated older people service was undertaken. The results showed that the issue was not routinely addressed as part of the assessment process, and thus its incidence was probably being under reported. Staff also reported limited specialist knowledge and training experience, and the majority felt that the profile of alcohol misuse should be raised within the service. These results have implications for service development at both a service and clinical level.

Consequences of alcohol misuse in older people
Older people have a lower alcohol tolerance than those below the age of 65 due to a decrease in their fluid to fat ratio; therefore, the same amount of alcohol may produce a higher blood alcohol concentration (Institute of Alcohol Studies, 1999). High alcohol consumption interacts with medication. Alcohol can increase depression when used alongside antidepressants, may reduce the effectiveness of antibiotics and, if taken with anticoagulants, haemorrhaging may occur. Alcohol can affect balance in older people, increasing the risk of fractures. As alcohol has a diuretic effect, incontinence is more likely to occur. Other increased risks in the older drinker include anxiety and depression, insomnia, anorexia, vomiting, abdominal pain (stomach ulcers), cirrhosis of the liver, Type 2 diabetes, vitamin deficiency and poor personal hygiene. Alcohol misuse has been associated with suicide in older men and women, exacerbating the importance of both treatment and prevention programmes in this population (Waern, 2003). Also of note, Fein and Di Sclafini (2004) found that people who experienced cognitive difficulties due to alcohol misuse early in their lives, even after abstaining for many years and seemingly recovering completely, often re-experienced cognitive problems in later life.

Although there are recommended limits for daily alcohol consumption for men and women in the UK, (three to four, and two to three units respectively) the National Institute on Alcohol Abuse and Alcoholism in the US recommends that people over the age of 65 should consume no more than one drink (not unit) per day. There are no universally recognised alcohol consumption benchmarks for older people in the UK.
Identification of alcohol problems in older adults

The lack of recognition of alcohol problems is a great concern, as not only are older people and their families potentially not receiving the appropriate or optimum care, but alcohol abuse, if undiagnosed, has serious and sometimes fatal implications. Often the effects are subtle and similar to the effects of ageing or physical illnesses common with age, thus resulting in the problem being misdiagnosed (McMahon & Jones, 1993; O’Connell et al., 2003). Symptoms are often misdiagnosed as dementia or depression or as non-specific health problems such as insomnia or gastro-intestinal complaints.

Other difficulties in the identification of alcohol problems include the lack of accuracy in self-reporting alcohol consumption (Hajat et al., 2004; O’Connell et al., 2004). Health care workers are less suspicious of alcohol misuse when assessing older people (Curtis et al., 1989). The difficulties in identifying alcohol use in older people are further confounded by lack of specialist knowledge, attitudes, beliefs and practice protocols by staff working with older people (Ondus et al., 1999).

A survey across professionals working with older people (Wesson, 1992) found that 56 per cent were unaware that recommended limits of alcohol consumption for the general population might be inappropriate for older people. Ninety per cent could not recall ever having seen information related to older people and alcohol and 14 per cent did not know where they could advise someone to go for alcohol-related problems.

The factors outlined above relating to the reporting of alcohol consumption in older people interact to provide a complex and challenging environment in which to identify and work with alcohol misuse. However, the onus falls on services to rise to this challenge in order to provide appropriate and effective care to older people and their families, in line with the NSF.

The present study was conducted within an integrated older people’s service, where there is no specialist service or advice relating to older people and alcohol. This study aimed to determine: (i) the extent to which health care staff perceive alcohol consumption to be a relevant issue within the service; (ii) the staff’s knowledge about alcohol and specialist training; and (iii) the staff’s clinical practice within this area.

Method

Procedure: A list of staff members was acquired from personnel services. A covering letter and the questionnaire were sent to all clinical staff members in the older people service.

Participants: The questionnaire was sent to all 163 staff within an Older People’s Psychiatric Service in the North of England. Sixty-one staff (37 per cent) responded of which 54 per cent were nurses, 20 per cent care assistants, nine per cent professions allied to medicine, seven per cent medical staff, five per cent social workers, and five per cent chaplains.

Materials: Staff were surveyed using a questionnaire developed by the authors for this study. The questionnaire consisted of 14 items and had three sections: demographic information regarding professional and relevant qualifications, questions relating to clinical practice, and questions relating to the service as a whole. The questions were both open and closed. An overview of the content is presented in the results section.

Results

The results from the survey are summarised below.

Extent to which staff perceive alcohol misuse to be an issue with respect to the clients

● 10 per cent of the clients with known or suspected alcohol difficulties were currently receiving treatment for an alcohol-related problem.
● 89 per cent of participants felt that the profile of alcohol misuse needed to be raised within the service.
Specialist knowledge and training

- Participants’ knowledge of the effects of alcohol was patchy: 71 per cent stated that excessive consumption could result in physical and cognitive problems. The most commonly mentioned problems were ‘physical’ problems (malnutrition and falls) and ‘cognitive’ problems (poor memory and confusion). Only 39 per cent noted ‘emotional’ problems (depression, anger and aggression), and 37 per cent recognised ‘social’ problems (isolation, relationship problems and financial problems) to be related to alcohol misuse.

- Fewer than five per cent of participants could correctly identify recommended safe drinking limits for older people.

- 11 per cent of participants felt that they were able to give ‘very good’ or ‘quite a lot of advice’ to colleagues regarding alcohol misuse in older people. The majority felt unable to give ‘any’ or only ‘little advice’.

- 25 per cent of participants had read information on alcohol misuse in the last five years.

- 11 per cent had received training regarding alcohol abuse in older people.

- 69 per cent were aware of which medications were affected by alcohol.

Clinical practice

- 71 per cent of participants knew where to refer to younger clients misusing alcohol.

- 15 per cent did not know whom to consult regarding alcohol problems with respect to one of their older clients.

- 40 per cent routinely asked clients about their drinking behaviour.

Discussion

This survey found that, of the clients in this service who are known, or suspected, to misuse alcohol, only one-in-10 was receiving treatment for alcohol abuse, supporting previous findings that older people rarely receive a primary diagnosis of alcohol misuse (Stinson, 1989). Further, fewer than half of our sample was routinely asking about the client’s drinking as part of their normal assessment. This low proportion perhaps reflects the barriers to detection and treatment highlighted in the introduction.

Our survey suggested that staff who responded recognised that they did not have the right specialist knowledge and required training. Nearly nine-in-10 respondents had received no training on alcohol misuse in older people and three-quarters had not read any material on alcohol misuse in older people in the last five years. This lack of training or information provision may account for the low proportion of respondents who could identify safe drinking limits for older people, and the small percentage of people who were confident they could advise clients on their drinking habits. It is relevant to note that there are currently no UK guidelines related to older people’s alcohol consumption and, without this information in the public domain, there is little chance of it being routinely provided by mental health workers. Our knowledge of safe drinking limits in working age adults is likely to be influenced by information via the media, which is not available specifically for older people. There is a responsibility on the state to ensure that this information disseminated.

A large proportion of respondents was able to identify some of the problems associated with misuse of alcohol such as physical and cognitive problems, and of the possible effects of combining alcohol and medication, which suggests that this information will inform their everyday assessment and interventions. However, the questionnaire did not elicit much information on the way in which this knowledge might be being used in current practice.

This study suggests that respondents do not routinely collect information about alcohol and, even if they did, currently they would struggle to give informed advice to their clients. It may be that their lack of confidence in dealing with a disclosure of alcohol excess could explain why they do not routinely ask about alcohol use.
Clearly, to avoid some of the unpleasant consequences of alcohol misuse in older people, workers in older people’s mental health settings need to gain confidence and skill in asking the right questions and giving the right advice about alcohol consumption. Training in assessment and identification of alcohol misuse is important. This issue should clearly be raised with training agencies within local health trusts. Furthermore, the information available to mental health professionals also needs to be in the public domain in order that it is accessible to clients and their families as well as professionals. Additionally, age discrimination in the use of specialist services for people with drug and alcohol problems needs to be addressed in line with anti-age discrimination guidelines. Then, once difficulties have been identified by care professionals, there is more clarity about the way in which treatment can be obtained.

The potential value of assessment tools was raised in the qualitative section of the questionnaire by a number of the participants in the present study. It is relevant to note, however, that a systematic review of the utility of self report screening instruments for the use of alcohol in older people suggested that the employment of such tools was often problematic (O’Connell et al., 2004). The authors concluded that ‘ease of use, patient acceptability, sensitivity and specificity’ were features that must be considered when selecting a screening tool. They also noted that the clinical characteristics of an older adult population needed to be taken into account. Indeed, in their clinical recommendations, they identified that while some assessment tools, such as the CAGE (Ewing, 1984; Cyr & Wartman, 1988), were useful with general older adult populations, questionnaires such as AUDIT-5 (Philpot et al., 2003) were more appropriate with older people with psychiatric problems.

From the results of this survey, it is evident that the profile of alcohol misuse needs to be raised within the Older People Service. There is a need for further training to provide staff with the competencies to offer clients optimal care. Clear benchmarks for safe drinking limits in older people need to be set.

Acknowledgements
A part of the data set of this project was submitted as an SSRP to the Teesside Doctorate Course in Clinical Psychology. The survey was supervised by Ian James, Newcastle Challenging Behaviour Service.

Correspondence
Malcolm Stephenson (RMN)
Challenging Behaviour Service,
Newcastle General Hospital,
Westgate Road,
Newcastle-upon-Tyne NE4 6BE.

Fiona Fraser
Trainee Clinical Psychologist,
Doctorate in Clinical Psychology,
Teesside University.

Kristina Askew
Assistant Clinical Psychologist,
Challenging Behaviour Service,
Newcastle General Hospital,
Westgate Road,
Newcastle-upon-Tyne NE4 6BE.
References


*Staffs’ perceptions of alcohol misuse in older people*
Cure or contain? Attachment theory as a baseline model to understand resistance to success – or Why people don’t want to get better

Louisa J. Shirley

Attachment theory is a useful model within which to begin to understand some clients’ reluctance to be discharged from mental health services. Bowlby suggests that certain behaviours, such as proximity seeking, or clingingness, designed to elicit/maintain the involvement of an attachment figure are likely to appear at times when a person feels under threat and/or perceives the absence of an attachment figure. In older adulthood, people often experience both the loss of attachment figures, and the perception of threat (to their physical self or to their identities), and we could expect to see the emergence of attachment-seeking behaviour during these crises. For a small number of older people, their early experiences might prompt more extreme or desperate attachment-eliciting behaviour. This article discusses the possibility that people with early attachment difficulties, who become part of mental health services, may form relationships with staff or with the unit that resemble attachment relationships and which prompt attachment-seeking behaviour when the relationship is threatened by discharge from the service. It is suggested that we need to know more about the willingness or reluctance of staff to form meaningful relationships with older people in mental health services, and how such relationships can be supported.

Attachment theory is being increasingly recognised as a useful model within which to understand a variety of phenomena associated with old age. The potential for distressing transition, separation and loss experiences (i.e. retirement, illness, loss of spouse, institutionalisation, death) increase with old age (Bradley & Cafferty, 2001) making it more likely that older people will experience the combination of: (1) actual or perceived threat; and (2) lack of access to an attachment figure which Bowlby (1973) suggests are the specific contexts that activate the attachment system.

Bowlby (1969) proposed that infants are hard wired to seek and maintain safety through an adult figure, usually the main care giver. In infancy, this figure provides actual comfort and security in the face of danger. In doing so, they provide emotional security too, allowing the developing child to explore their environment from a secure physical and emotional base. Over time, the child internalises their attachment experience to form an internal working model on the basis of which they learn to make predictions about their safety and support by others in situations of perceived danger. In threatening situations, we would expect to see attachment-seeking behaviour which has been characterised as ‘any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser’ (Bowlby, 1979, p.129).

Experiences of attachment relationships in childhood are thought to influence relationships and behaviour throughout the individual’s development ‘confidence in the availability of attachment figures, or the lack of it, is built up slowly during the years of immaturity … and whatever expectations are developed during those years tend to persist relatively unchanged throughout the rest of life (Bowlby, 1973, p.202).
Attachment theory offers a developmental perspective to psychological formulations in that it proposes a way in which a pattern of behaviour can be formed in early childhood and perpetuated through experiences in adulthood and older age. It differs from, for example, schema-based perspectives (e.g. Young’s, 1993, early maladaptive schemas) in its emphasis on instinctual processes and has an evolutionary base. Attachment processes are thought to be based in emotion, not cognition, and to be an instinctual behavioural response to perceived danger. Attachment theory recognises the interpersonal aspect of an individual’s problems, and can go some way to describing how patterns of relating emerge and are maintained through further relationships. It is a well developed model which can form a back drop to other psychological models. Thus, we could see someone’s attachment experiences as having been fundamental in the formation of their thinking style, their behavioural challenge, or their interpersonal disputes.

In dementia care settings, specific behaviours such as ‘parent fixation’ (acting as though a deceased parent is still alive), clinginess, and shadowing have been linked with attachment processes (Miesen, 1992, 1993). Attachment theory is also being discussed as a possible explanation for the success of specific psychosocial interventions in dementia such as doll therapy (Marsland, unpublished review) and simulated presence therapy (Woods & Ashley, 1995). In a recent paper, attachment has been proposed as a helpful way to make sense of seemingly ‘manipulative’ or ‘attention-seeking’ behaviours in care home residents without a dementia (Shirley, under review). Attachment has also been used as a framework within which to discuss the importance of early parent-child relationships in the willingness of adult children to provide care, and their perceived burden of care (Cicirelli, 1983, 1991).

Conditions such as Borderline Personality Disorder (BPD) have been linked to early attachment experiences. A survey of BPD service users suggested that a preferred term for some service users to describe this condition was ‘attachment disorder’ (Haigh, 2002) highlighting a need for ‘acceptance and somebody to listen to them.’ Current recommendations for the treatment of BPD attend to attachment-related issues such as consistency of staff and services involved, and consistency of their approach, setting and maintaining boundaries to relationships and behaviour, reciprocal responsibilities and so on (NIMHE, 2003; Bateman & Tyrer, 2002). Although we know that BPD exists among older people, unless a patient arrives into older people’s services with a diagnosis of PD, patients coming into older people’s mental health services rarely attract a diagnosis of BPD, partly because the behaviour associated with BPD may change with age (Young & Bocci, 2005). Attachment-related behaviour occurs along a continuum depending on vulnerability (previous experience of distress) and current experience of distress, and, while the role of attachment in BPD is important, attachment processes need to be given consideration in their own right rather than as an appendage to this diagnosis.

Interventions for attachment-related problems are not well developed, but formulation within an attachment framework would suggest a humanistic approach to intervention, one that allows the client safely to explore alternative behaviours in a context of containing and consistent relationships. This poses a challenge for the way in which we provide mental health services for older people.

With mounting pressure on places in NHS hospitals and day units, and a determination to minimise costs of providing care, admissions have become increasingly goal-directed (NHS Modernisation Agency, 2004), with the ultimate goal being a speedy discharge from NHS services. However, it has long been recognised that some patients, even after an apparently successful discharge, re-present to services with repeti-
tions of acute symptoms of mental ill health such as an expressed desire to self-harm or elevated anxiety symptoms. Common-sense explanations for these readmissions could range from the symptoms of the person's 'illness' having re-emerged, or suggestions that people are being awkward or not being willing to take responsibility for their own lives. However, the idea that a person's distress is somehow held by or situated exclusively in them is a rather unitary view and does not take into account inter-relational factors. Even 'person-centred care', defined in the Older People's NSF as care that 'respects others as individuals and is organised around their needs' (Department of Health, 2001), concentrates on promoting autonomy and independence while neglecting the merits of promoting relationships between staff and patients which could be characterised as 'interdependent' (Nolan et al., 2004).

Ageing is a time when threat of loss is constant and is also characterised by increased not decreased levels of dependence. It seems likely that we will see elevated levels of attachment-seeking behaviour in older people who feel vulnerable through their experience of new or re-emerging mental health problems. Older people who are resistant to moving from mental health services may be demonstrating their need for security in the face of such a threat to their integrity.

Unfortunately, our service structure is unlikely to promote the kinds of relationships that contain and minimise people's distress. Adhead (1998) suggests that relationships between staff and patients in psychiatric units may show the qualities of attachment relationships. She suggests that staff may stimulate secure attachments by spending time in 'active reciprocal interaction' (Rutter, 1988) through therapeutic activities such as counselling or simply 'good professional listening.' Adhead notes that psychiatric units can provide a safe base from which the adult can explore their environment or make a 'series of excursions' (Bowlby, 1979) which, in theory may get longer and longer until the person can exist without anxiety away from the service (attachment figure). However, she goes on to say that the institutional environment can make abnormal attachment behaviour more, rather than less, likely. For example, a service that gives mixed messages about being available to provide support when needed, but which actually operates a policy of short-term interventions might serve more to induce anxiety than alleviate it.

If we accept that attachment provides a helpful model to understand the way in which people's early relationships affect their relationships and behaviour in older adulthood, we can use it to inform service-level interventions for clients who seem to be presenting attachment-related behaviour. The case of Margaret illustrates this type of intervention.

Case study – Margaret

Margaret, now 71, was referred to psychological services four years ago. She had been attending a mental health day unit for eight months. She was depressed, had extremely low self-worth and monitored others closely for approval. She had previously had three months' intervention with another psychologist who had used a CBT approach. Margaret's progress had been haphazard. She said she had enjoyed the sessions but continued to feel worthless. I worked with Margaret over four months during which time I also noticed a pattern of eagerness, compliance and improvement followed by a reported reversal in mood, pessimism for the future, increased alcohol intake and increasing reports of suicidal ideation. She also reported feeling pessimistic about the likelihood of benefiting from psychological therapy and we agreed to a discharge. One week after discharge, Margaret repeatedly hit herself with a hammer causing extensive bruising. Staff working with Margaret seemed frustrated by Margaret's lack of progress. They felt that her behaviour on the unit had indicated recovery but this changed.
as discharge was discussed. There was a feeling that Margaret’s behaviour would become risky if her place were withdrawn. There was a sense that Margaret’s behaviour was intended to protect her placement. A new referral to psychological services was instigated.

Over time, I learned more about Margaret’s history. Margaret was the youngest of five siblings. She reported a childhood environment significantly impoverished both emotionally and materially. Her siblings left home in their early teens to escape her father’s dangerous, bad temper, leaving Margaret the only child at home from 7 years of age. Her mother had been unresponsive to her needs, constantly monitoring her environment for threat from Margaret’s father. Margaret was her mother’s protector when her father was violent. Margaret went on to experience an abusive relationship with her first husband, and felt forced to move away from the North. Margaret’s only contact with mental health services previously was when she took an overdose following the death of her mother when she was around 40 years of age. In recent years, Margaret had experienced an extremely fulfilling relationship with her second husband. She described him treating her like royalty, being entirely loyal to her, and being her ‘rock’ when she was worrying about what other people were saying about her. Margaret became involved with older people’s services shortly after his death, when she became depressed and suicidal.

Margaret described the day unit as being the only place where she felt safe and accepted. She said she felt that she could ‘keep going’ as long as she knew she had these sessions, and that this was the only place she could be herself. Margaret had formed good relationships with her key nurse and with the doctor who both saw her regularly on the unit. Both of these members of staff felt they were often ‘treading on egg shells’ with Margaret, feeling that they could tip the balance of her mental state at any moment. In a review meeting, members of the care team expressed frustration that, although Margaret seemed to be showing no signs of emotional ill-being on the unit, they were unable to discharge her because of the pattern of threats that typically ensued.

Margaret’s history of close family relationships suggested that her needs for physical and emotional safety had not been met by her parents or her siblings. Margaret did not have a good attachment relationship during her childhood. Rather than containing Margaret’s anxieties in the face of threat, Margaret’s mother was more likely to elevate Margaret’s fear. Margaret had become hypervigilant to threat but unable to respond to it appropriately. Margaret’s childhood behaviour had been largely self-regulated using environmental cues, and instinctive self-protective strategies to move through life.

Margaret’s contact with mental health services came at a time when she was facing old age, and having lost the figure in her life she had identified as fulfilling some of her attachment needs – reciprocity, containment of anxiety, and security – circumstances likely to activate the attachment system and prompt attachment-seeking behaviour. Margaret’s need for emotional security at a time when she was also struggling with the symptoms of a depression seems to have been met through her relationship with the day unit, and she improved in mood and function through her attendance. However, Margaret became something of a ‘revolving door’ client. She resisted all attempts at moving on from the day unit and occasionally instigated in-patient admissions with reports of suicidal ideation. Adhead notes that a person’s mental representations of attachment are likely to affect the way in which a person makes use of the help being offered where ‘preoccupied individuals may get stuck, find it difficult to move on, or act ambivalently towards offered care.’

Margaret’s ambivalent response to attempts to resolve her difficulties, and her resistance to discharge could be understood, then, in the context of her attachment expe-
riences in earlier life, and in the context of the mixed messages being provided to her by the system. Her behaviour served the function of keeping the services which kept her secure close at hand in spite of their policy of provision of short term admissions.

During planning meetings, Margaret’s difficulties were reframed in terms of previous and current attachment experiences. We shared the formulation with others involved in her care and negotiated a place for Margaret on the unit that did not depend on short-term review. We agreed to be responsive to her requests for in-patient care so she would not have to use extreme behaviour to elicit a response from services she felt were not recognising her needs.

Summary and concluding comments
Attachment-related difficulties do not seem to respond well to time-limited, goal-directed therapy, and require a more systemic approach with the aim being recognition of distress, containment of high anxiety, and a consistent approach to attachment eliciting behaviour. The way in which our current services are operationalised means that the attachment needs of some patients are left unmet, and staff in services meet with some testing behaviour which is difficult to understand.

Formulations within an attachment framework would suggest that care interventions should be more ‘relationship-centred’ (Tresonlini and the Pew-Fetzer Task Force, 1994), but moving to this framework may not be favoured by all. The case presented here illustrates the ways in which attachment eliciting behaviour can be experienced by staff working in the service. Staff who have formed meaningful relationships with patients experiencing these difficulties can feel upset and unappreciated. Staff can be angry because they feel their actions are being controlled by someone else. Could we expect mental health care staff to embark on these risky relationships with the levels of support they currently receive? If we are to promote relationship-based formulations and interventions, using frameworks like attachment theory, we need to gain a better understanding of the ways in which psychiatric staff currently relate to patients, their willingness to enter into a mutual relationship with them, and why, and the degree to which, they resist this possibility.

Correspondence
Louisa J. Shirley
Psychological Services Directorate, Northumberland Locality, St. George’s Hospital, Morpeth, Northumberland NE61 2NE.
Tel: 01670 501747
E-mail: louisa.shirley@nmht.nhs.uk

References
Cure or contain?


Marsland, L. Unpublished literature review. Older adults with dementia: Can themes derived from the literature on attachment in older adults offer an understanding into the possible benefits of doll therapy in care home settings?


Driving with dementia: In need of an A–Z

Lynne Patience

(on behalf of the North East PSIGE Driving with Dementia Steering Group)

Dementia Steering Group members:
Lynne Patience, Katharina Reichelt, Maire Sharkey, Ian James, Gillian Bowie & Angus Macgregor.

There has been increasing discussion within North East PSIGE over the last year regarding the increase in requests for neuropsychological assessment with a specific query about suitability to drive. While the British Psychological Society’s document on Fitness to Drive and Cognition (1999) clearly laid out the challenges this issue presents to Psychology Services, there is still a largely inconsistent and variable response as to how this is dealt with by different services. A conference on Driving with Dementia was hosted by Scottish PSIGE in Edinburgh on 16 June, 2006, and was well attended by many Psychologists as well as other professionals working in older adult or dementia services across the UK. This suggests that this is not just an issue that is confined to the North East. The Conference covered a range of issues such as service user perspectives on driving with dementia, the DVLA’s viewpoint, the assessment process of the Scottish Driving Assessment Centre and research into whether accident risk is actually increased when someone has dementia. For those of us who attended from the North East, the conference highlighted a need to assess how local services manage this issue currently, and the need to develop a more consistent and co-ordinated response. The aim of this paper is to present some of the questions that we have raised as a group, and hopefully to start a dialogue with other PSIGE members who are also considering this issue.

The general focus of the discussion centred around procedures and assessment, but we also had some ethical dilemmas. The main questions we are considering within the steering group are outlined below.

The DVLA

○ Do we have responsibility for alerting the DVLA or the patient’s GP, and at what point?
○ Are we professionally obliged to do this?
○ Are there other conditions that warrant neuropsychological assessment, for example, chronic obstructive pulmonary disease (COPD), liver disease, post-anaesthesia confusion? What about cognitive function in mental health problems, i.e. severe depression?
○ What information do the DVLA use when making decisions about ability? For example, the current ‘At a glance guide’ from the DVLA states: ‘It is extremely difficult to assess driving ability in those with dementia. Those who have poor short-term memory, disorientation, lack of insight and judgment are almost certainly not fit to drive. The variable presentations and rates of progression are acknowledged. Disorders of attention will also cause impairment. A decision regarding fitness to drive is usually based on medical reports. In early dementia when sufficient skills are retained and progression is slow, a license may be issued subject to annual review. A formal driving assessment may be necessary.’
It then goes on to outline the position on cognitive impairment in general:

1 Editor’s note: A special issue of the PSIGE Newsletter reporting papers from this conference is due out soon.
‘There is no single or simple marker for assessment of impaired cognitive function although the ability to manage day to day living satisfactorily is a possible yardstick of cognitive competence. In-car assessments, on the road with a valids license, are an invaluable method of ensuring that there are no features present liable to cause the patient to be a source of danger, e.g. visual inattention, easy distractibility, and difficulty performing multiple tasks. In addition it is important that reaction time, memory, concentration and confidence are adequate and do not show impairment likely to affect driving performance.’

This is somewhat contradictory and it is unclear on what basis these assertions are made as the research literature is somewhat mixed on these points.

### Driving Assessment Centres
- How does the local Mobility Centre assess ‘driving with dementia’?
- Are we duplicating neuropsychological assessments that they use?
- Should we just refer to the Driving Centre or would it be helpful to screen people locally first?
- How, why and when should we refer someone?

### Assessment and research
- Develop clear guidelines on how to inform patients that an assessment may be used to make a decision about their driving ability, and to routinely ask about driving in assessments;
- What is the current research literature on driving with dementia, in particular the neuropsychological functions which are most implicated in the ability to drive, and which assessments are the most ecologically valid?
- How often should someone be reassessed and what are the cut offs, if any?
- Clinical information is equally valid in contributing to the neuropsychological assessment, what kind of information should we be using to guide our judgement?
- Do other health professionals assess driving ability and how do they do it, i.e. Occupational Therapists?
- Are there other psychologists developing similar protocols in the UK, and can we link up with them?
- If someone is found unsafe to drive, how best can we support them to access alternative modes of transport/support so they do not become socially isolated and depressed?

### Ethical considerations
- Being involved in this decision can be detrimental to any therapeutic relationship and goes against our professional responsibility to provide care, not distress. How do we balance that with keeping people safe and helping them to come to terms with this difficult process?
- The highest rate of severe injury in accidents is in the 20- to 29-year-old age range (Road Accidents Great Britain, 2000) and research on increased risk in dementia is mixed, so are we being unduly ageist?
- Many older people reduce their driving activity significantly. In fact the DVLA recommends this. Are some people good at monitoring their own risk and is there a danger of being overly prescriptive?

Answering some of these questions will inevitably be easier than others, so the aim of the group is to try to research these areas to make informed decisions about how to develop protocols for assessing driving with dementia within our own services. As a group we aim to:
- Review the current processes for assessing and reporting driving and dementia within our own services.
- Review the current research literature on driving in dementia with the possibility of conducting our own research if there are clear gaps.
Contact the DVLA to get up-to-date information and clarify unclear points.

Liaise with our local Driving Assessment Centre to find out what they do and how we can link with them effectively.

Liaise with other health professionals regarding developing protocols and assessment pathways.

Investigate and discuss the ethical issues in more depth.

Liaise with National PSIGE.

We would welcome any feedback or information from groups who may also be tackling these issues within their own localities, and will report back to National PSIGE in the future regarding our progress.

Correspondence
Dr Lynne Patience
Clinical Psychologist,
Older Adult Services, Northumberland.
E-mail: lynne.patience@nmht.nhs.uk

Reference
**Staff's experiences of fearful situations when caring for people with dementia: Will this interfere with the delivery of person-centred care?**

Sylvia Ruttledge & Ian A. James

Staff working in older adult care settings are dealing with people with highly complex clinical presentations. Unfortunately, despite this level of complexity, the staff employed in this area are often poorly trained and ill-prepared emotionally to deal with the challenging situations that are frequent occurrences. The idea for the present research emerged from a series of workshops conducted by the Newcastle Challenging Behaviour Service (NCBS) on ‘Delivering person-centred care’. A common comment from the participants during the training was that it was often difficult to be ‘empathic’ towards a resident when you were fearful of him/her. This was the impetus for this research programme which attempts to examine staffs’ fears, and their impact, in relation to working practices. The current article presents the qualitative data from a 10-item survey, which is serving as a pilot to a larger study to be conducted in Antrim/Ballymena area within the Northern Health & Social Service Board, Northern Ireland (Scott et al., in preparation).

Challenging behaviours are common among elderly persons with middle- to late-stage dementia, in both institutional and community settings (Cohen-Mansfield & Werner, 1998). The reported prevalence rates vary from 30 per cent to upwards of 60 per cent (Aarsland et al., 1996; Brodaty et al., 2003). These behaviours have been shown to increase the care giving burden and to indicate unmet needs (Middleton et al., 1999; Schreiner, 2000). Person-centred care focuses on attempting to understand the poorly communicated need being expressed by the person with dementia, and finding individualised ways of meeting that need (Kitwood, 1997; Stokes, 2000). This view holds that challenging behaviour engaged in by a person with dementia is purposive, and often underpinned by the need to remove a perceived threat. Challenging behaviour often occurs in response to intrusions into the resident’s personal space by staff or other residents or during personal care (Brodaty, 2003; Keene et al., 1999; Cohen-Mansfield, 2000), suggesting that the person misinterprets such care as a personal violation by the staff.

Studies suggest that the approach taken by the staff is a factor in whether the person with dementia responds aggressively (Somboontanont et al., 2004). For example, Skovdahl et al. (2003) found that carers who reported difficulties with aggressive behaviour focused on accomplishing the task in the shortest time, rather than on the process of interacting with the person.

Research shows that the type and quality of care patients receive will depend, in part, on how they are viewed by staff (Tabak & Ozon, 2004). Using a methodology informed by the Theory of Reasoned Action (Ajzen & Fishbein, 1980), McKinlay et al. (2001) found that nurses’ attitudes, and what they believed about the attitudes of others (subjective norms), predicted their behavioural intentions towards patients who had attempted to poison themselves. An understanding of the way nurses intend to behave towards people with dementia and of the attitudes and subjective norms which give rise to these intentions is, therefore, clearly relevant and important.
Challenging behaviour towards staff from people with dementia includes physical assaults such as pushing, kicking, pinching, grabbing, biting and/or psychological violence, e.g. shouting and swearing (Gates et al., 1999; Aström et al., 2004). In some studies (Eastley et al., 1997; Lyketsos et al., 1999) but not in others (Beck et al., 1998), male residents have been found to display more aggressive types of behaviour. Aström and colleagues (2004) found that 11.4 per cent of staff reported being exposed to aggression during the period of investigation; four per cent received wounds and bruises.

Staff attitudes to patient aggression are complex and ambivalent. The reactive and seemingly non-intentional nature of aggressive behaviour by people with dementia, together with the low likelihood of sustaining physical injury, has led to the view that this behaviour should be accepted by staff as ‘part of the job’ (Gates et al., 1999). Some are prepared to accept such fear-provoking behaviour as non-intentional, while others view it as a deliberate act (Oser, 2000; Aström et al., 2004). The predominant responses from staff are fear or anxiety, powerlessness, anger, post-traumatic stress disorder symptoms, guilt, self-blame and shame (Needham et al., 2005). Assaults can affect the carer-patient relationship and lead to behaviours such as less eagerness to spend time with particular residents and less willingness to answer their call lights (Gates et al., 1999) or adopting a passive role (Chambers, 1998). In some cases the emotional toll on staff of repeated assaults may lead them to respond to aggressive behaviour by being aggressive or abusive themselves (Gates et al., 2003). Emotionally depleted staff who find it hard to get in touch with the patients’ points of view, and who feel they lack self-efficacy at work, tend to have difficulties in tolerating aggressive behaviour (Whittington, 2002). A moderately strong correlation has been found between aggression and how ‘emotionally close’ staff reported feeling toward the patient (Bahareethan & Shah, 2000). Cohen-Mansfield and Werner (1998) reported that a poor quality of relationship between staff and patient, along with cognitive impairment, is a chief predictor of physical aggression in people with dementia.

Given the potential impact of staff’s feelings on their attitudes, we decided to examine staffs’ reactions to fear-provoking incidents, and the impact of the events on their attitudes to caring practices for people with dementia.

**Method**

**Participants**

Eighty-two participants were recruited from six care homes (N=69) and one specialist NHS challenging behaviour service (N=13). Of those who completed the demographic details, 35 per cent (N=29) were qualified nurses, and 43 per cent (N=35) were care assistants. Of the 82 care staff, 59 (72 per cent) stated they had experienced an event that had made them fearful, of whom 53 provided details of this event. The data-set discussed in the present article is based on the qualitative responses provided by the latter sub-set of participants.

**Design**

One of the co-researchers (supervisor, IJ) identified potential residential homes. The researcher contacted the homes and arranged a meeting with the manager. These were homes with which the Newcastle Challenging Behaviour Service (NCBS) regularly worked. The project was discussed with the manager and an information sheet describing the study was left. The questionnaires were then given to the carers by a qualified member of staff, together with an envelope. Those willing to participate were asked to return the questionnaire in the envelopes. Staff were encouraged to complete the forms, but no checks were made to improve compliance. Participation varied between care settings (32 to 72 per cent).
**Questionnaire**

Part of the questionnaire included quantitative questions asking for: demographic information (such as profession, gender and number of years working with people with dementia), whether they had ever been fearful for their own safety due to a patient’s/resident’s challenging behaviour, the frequency of such occurrences, whether they had been injured, whether this required time off work, and a series of statements about the aftermath to which the respondent rated their agreement (0 to 5, No – A great deal) e.g. ‘For a short time afterwards I was nervous around the patient/resident involved’. The remaining three questions were qualitative, and designed to obtain more detail about the staff’s individual experiences and coping strategies. The results in this paper focus exclusively on the qualitative questions.

**Results**

**Qualitative data collected from staff**

The participants were asked a number of open-ended questions regarding their thoughts and feelings about their experience of their most fear-provoking incident. Three questions were posed in relation to this incident: firstly a description of the event; secondly the manner in which the person coped with the situation, on reflection; thirdly, the lesson learned from having experienced the fearful incident.

*Question 1: Please describe your most fearful experience, giving as much detail as you feel able to.*

Six themes were extracted from the responses using interpretative phenomenological analysis: nature of the event; use of implements; physical injury; gender of assailant; situation; staff experience. Each theme is discussed below.

**(i) Nature of the incident**

Of the 82 participants, 72 per cent (N=59) indicated they had experienced a fearful event and 65 per cent (N=53) provided specific details. The commonest types of incidents were physical assaults, for example, punching, biting, hitting, lashing-out, kicking, spitting, head-buttng or attempts to do so (total of N=40). Within this group, there were a number of extreme cases; five staff were seized by their throats (by hands or a ligature) and four either by their hair, hand or head. Two others described attempts by residents to stab them.

Seven participants referred to other forms of threatening behaviour, for example, lashing-out at objects in the environment, sexual harassment, and arson. Eight participants described situations of being trapped by a resident, for example, in a toilet, lift, bedroom, or in a room trying to protect themselves from the patient on the other side of the door. Others referred to verbal aggression (N=5) and not having access to an alarm nearby at the time of the incidents (N=2).

**(ii) Implements used**

Twenty-three per cent (N=12) of those describing incidents referred to residents using implements. These included shoes (N=2), walking sticks (N=2), knife/stabbing implement (N=2), a zimmer frame, string (used as a ligature), hot liquid, tables and chairs, surrounding objects and even a hand grenade, which turned out to be a disarmed souvenier.

**(iii) Physical injury**

Nineteen per cent (N=10) of those describing incidents reported being physically injured. The most common injuries were bites (N=4), broken noses (N=2) and head injuries (N=2), including loss of hair. Others included throat/neck and hand injuries.

**(iv) Gender of assailant**

Fifty-nine per cent (N=31) of those describing incidents indicated the gender of the assailant. Of these, male assailants (N=20) outnumbered female assailants (N=11) nearly 2:1.
(v) Situation when incident happened
Forty-nine per cent (N=26) of those describing incidents gave details of the situation in which the event occurred. The most common situations where staff members worked physically close to the residents, followed by when staff members disturbed residents or they encroached on residents’ personal space. We examined the results in terms of Strand’s tripartite framework (Strand et al., 2004): helping situations, situations of reluctance, and situations of molestation. Helping situations (N=12) included carrying out basic care (e.g. toilet/shaving) and providing assistance in daily activities (e.g. dispensing medications). Situations of reluctance (N=9) were described as a way of remonstrating against various kinds of demands residents had to face on a daily basis (e.g. having their leisure time disturbed, being prevented from or trying to prevent staff from leaving a room or unit). Molestation situations (N=5) were when staff appear to have been taken by surprise or when they were caught unawares by, for example, a punch or sexual harassment.

(vi) Experience of the staff
Thirty-four per cent (N=18) of those providing details described their feelings and thoughts at the time of the fear-provoking incident. Most felt vulnerable and uneasy (N=7), and powerless (N=6) in the face of the unpredictability of residents. As a Day Care worker with 10 years’ experience put it, ‘[There was] no warning he was going to attack me. Usually I can see a situation coming’. Another reported, ‘I felt totally out of control’. Others described shock, concern for a bystander-resident’s welfare, and dread in anticipation of an imminent assault. Only one participant reported feeling in control.

The second qualitative question asked the participants to examine their reaction to the event, by giving further descriptive details about the previous question to which they had responded.

Question 2: If you would like to expand upon any of your answers from the previous section [how coped in immediate aftermath of event], please do so below.

Thirty-six per cent (N=19) of those providing details of a fearful event described how they coped. The commonest response was to rationalise the event, and not to over-personalise it. This group tended to try to take into account factors that may have triggered the residents’ behaviour and their own abilities/inabilities to de-escalate the fraught situation (N=8). Some participants, in contrast, coped by using strategies of avoidance/wariness around the residents involved in the event (N=4). Three participants accepted the unpredictable nature of their work, taking a rather fatalistic ‘how can one prevent the unpredictable’ view. A further two participants blamed themselves, taking responsibility for what happened. Two staff looked on the event positively, one deriving job satisfaction from residents’ feedback, the other from comments made by colleagues regarding the manner in which the overall event was handled.

The participants were also asked to reflect on the lessons they had learned from having experienced the stressful incident. We were aware that these lessons could be either negative or positive.

Question 3: Sometimes staff inform us that they learn things from fearful situations – do you think you learned anything helpful from having experienced such episodes? If yes, please describe.

Eighty-six per cent (N=51) of the participants who experienced a fear-provoking event responded. The most common lesson reported was a belief that they had learned to improve their inter-personal skills and strategies in averting or defusing such situations (N=12). Some expressed pride in the value of hands-on experience, ‘I have more experience in dealing with a situation like that. I would not show my fear; I would talk calmly and calm the situation down’.
The next most common response positively reframed the incidents, in terms of taking into account the individual resident’s temperament, needs and context (N=11). For example, ‘I knew the behaviour was not directed at me rather the individual was frustrated […] I was] aware of allowing individual quiet time and space.’

Others learned to be more alert and vigilant around residents (N=10). Eight others erred more on the side of wariness or distrust of residents, and included calling for more back-up staff support as a precautionary measure (N=4). One warned, ‘Never assume you know the capability of a resident.’ For others, there was resignation or apathy towards the unpredictability of residents (N=4), with the attitude ‘It’s part of the job.’ Some learned to obtain more information about a resident of whom they were unsure (N=4). For others there was no lesson or meaning from the incidents (N=2), including one where a resident reportedly attempted to stab a pregnant staff member.

Discussion
Nearly three-quarters of the sample had experienced a fearful event during their work as a carer. In line with previous research (Gates et al., 1999; Aström et al., 2004), the commonest fear-provoking event involved some kind of physical assault, and there were a number of extreme examples of this (e.g. stabbing). A fifth of those reporting a specific event indicated that they had been injured. In situations where gender was reported, males were twice as likely to be the assailant (in agreement with Eastley et al., 1997). In keeping with Cohen-Mansfield’s (2000) findings on ‘triggers for aggression in CB’, we found that the fear provoking events tended to happen during interactive events between the staff and residents. As one might expect, in situations where the staff reported being fearful, experiences of vulnerability and powerlessness were common.

With respect to the second qualitative question that recorded how the staff member dealt with the aftermath of the events, two alternative strategies emerged. The majority were either rationalising or reframing the event positively. A small number of people either became more wary or accepting of the unpredictability of the situations.

In terms of the general lessons learned from situations, we observed a two-way schematic split. Approximately half of the group adopted a person-centred style; more specifically they learned the importance of improving person-centred approaches and adopting a more ‘theory-of-mind’ perspective. The other participants learned to be either more vigilant or wary of the people for whom they care, similar to the findings of Gates et al., 1999. These differing attitudes potentially predict staffs’ ‘behavioural intentions’ towards people with dementia in their care, based on the Theory of Reasoned Action (McKinlay et al., 2001). This study did not attempt to determine the extent to which staffs’ differential behavioural intentions are translated into actual caring behaviour of one sort or another. Nevertheless, suppression of intrusive memories and rumination, for example, can prevent affected staff from seeing the trauma as a negative event as completed and ‘over and done with’, and may maintain this sense of current threat (Clohessey & Ehlers, 1999).

From the literature, there is tentative evidence for the effectiveness of giving care staff training in person-centred care principles and interaction skills for reducing aggressive behaviour (Pulsford & Duxbury, 2006). Such training aims to increase staff understanding of the causes of aggressive behaviour, and their skills in managing such behaviour by responding more individually and creatively to the person’s needs. Training programmes have been criticised for being focused more on awareness raising than on equipping care staff with new skills (James, 2001). Gates et al. (2005) found that a training programme only led to a reduction of aggression against care staff who had previously experienced few assaults, suggest-
ing that some staff, who are frequent recipients of aggression, may be less receptive to considering new ways of interacting with residents. Person centred care, while ethically sound and supported by current policy (NSF, 2001), may be hard to implement and sustain in care settings with fearful staff and high staff turnover (Sheard, 2004, 2006). Staff training and supervision are key issues in the implementation of this psychological approach, with a need in many settings to retain staff so that a consistent approach may be developed. The findings of this pilot study point to the relevance of exploring staff attitudes before implementing training programmes.

The ability to generalise the findings of this study to other populations is limited because of the use of a convenience sample of volunteers. Without randomisation, selection bias could have occurred. Despite the study’s confidentiality, it is possible that those staff members who responded were different in some way than those who did not respond (Gates et al., 1999), leading to either an overestimation or underestimation of the prevalence of fear-provoking behaviour in dementia care. Given the retrospective nature of the study, recall bias on the part of the participants cannot be ruled out.

Finally, the article presents a sub-set of data from the survey. The quantitative sections are currently being analysed, and used to inform a larger study which is presently seeking Ethics Committee approval. The larger study seeks to survey all care staff within a NHS Service catering for people with dementia.

**Correspondence**

**Sylvia Ruttledge**  
Assistant Psychologist,  
Newcastle Challenging Behaviour Service,  
Northumberland, Tyne & Wear  
Mental Health Trust.

**Ian A. James**  
Newcastle Challenging Behaviour Service,  
Northumberland, Tyne & Wear  
Mental Health Trust.

**References**


Integrating psychological formulations into inpatient services

Sarah Dexter-Smith

Tees & North East Yorkshire NHS Trust (now Tees, Esk & Wear Valleys NHS Trust) identified a need to develop a more psychologically-minded workforce across their inpatient mental health settings. My post was created at the beginning of this year to help address this on the two older adult wards (one functional, one organic). There are also, currently, two trainees and two sessions of an assistant who each provide some time to the wards.

As part of the process of engaging with this workforce development, a model of consultation has been underpinned by the use of psychologically-based formulations throughout all stages of care. This provides a coherent framework which enables staff to develop a more meaningful and effective service that responds to individual patient need.

At the start of this process there were a number of features of the ward set-up which facilitated psychology becoming embedded in the system:

- Input to the wards was dedicated rather than having to be fitted into a community psychologist’s week.
- The wards are due to be rebuilt and the Trust is in the process of redesigning both the physical and therapeutic environment with a psychologically minded workforce at the core.
- Full-time Occupational Therapist input had recently been allocated to the wards.
- Staff have generally been open and interested in the work that a psychologist might do on the wards and how this might improve the quality of care that patients receive. In particular, senior staff within the wards and the Trust have been supportive and committed to this new post.
- New nursing managers (including our modern matron) have been keen to change care on the ward and our work is part of this review and development process.

However, there were a number of problems:

- This was the first time that these wards had been allocated psychology input on a regular basis and, therefore, knowledge of psychological approaches was generally low.
- Within the staff team, the medical model dominates in terms of process and hierarchy. This is sometimes at odds with the new ways of working that the trust is trying to implement.
- Although there is now a single set of multidisciplinary notes, care plans are usually profession-specific and independent.
- Nursing shift patterns create problems with passing on changes in care plans, or specific tasks that occur more than once (e.g. as part of a CBT programme).

The process of engaging staff in psychological ways of thinking has been evolving since the post was created.

What didn’t work

During the first few months we tried a number of different approaches to enable staff to work in a more psychologically informed way: attending team meetings to explain the role of a psychologist and the potential work that could be done on the wards; offering to hold supervision/consultation sessions for staff who wanted to think about a particular client, different presentations on the impact of their work on themselves; trying to develop one-off training sessions on material in which the staff were interested.
However, some recurring issues reduced the effectiveness of this work. Nursing shift patterns meant that there was at most only a half-hour period where shifts overlapped and more than one or two staff could be freed up. At this early stage the potential benefits of adopting psychological approaches were not evident to all staff and were, therefore, not prioritised. As such, other jobs frequently overran or prevented attendance.

Despite trying to promote it as different, supervision was bound up in the nursing culture as synonymous with assessment and management, rather than the clinical supervision/consultancy with which clinical psychologists are familiar. Although new learning often occurred within these activities, there were clearly problems in staff taking new ideas and integrating them into the care the client received. New knowledge and understanding was limited to specific staff members and related to specific patients rather than being generalised to other situations.

There was also a sense of some staff feeling that this was something else they were having to take on board with no extra resources, i.e. it was an additional task to work in a psychologically informed way rather than a fundamental change in the way services and care were conceptualised.

Some staff took up these different fora in a positive way, but it was clear that this was patchy at best and was not addressing the wider organisational and cultural issues that impacted on the embedding of psychological approaches within the service.

Reviewing why some of this work had not engaged staff, and spending time developing a set of aims and objectives for our input, has enabled us to develop a more coherent framework for the various pieces of work that we undertake. Formulation is now central to our input and the ways in which we have begun to implement this are described below.

What works – putting formulation at the heart of our input
Our key aim was to enable staff to conceptualise the patient’s current problems and generate meaningful therapeutic interventions in the light of a personal history that extended beyond medical diagnoses. We also wanted to incorporate an understanding of the impact of social and environmental factors including the ward and staff. Rather than trying to address the symptoms of the systemic problems that were occurring throughout a patient’s admission, we decided to try and take a broader look at the cause. The root of the problem was the disjointed process of assessment and intervention carried out by various professional groups that tended to be medically dominated, and symptom or risk focussed. Our key decision was to push for psychologically based formulations underpinning all stages of care in order to:

- bring together the multidisciplinary assessments into a shared, holistic, theory-driven formulation;
- develop a single multidisciplinary care plan that is clear and consistent and directly informed by the formulation;
- establish a clear review and reformulation process;
- develop a shared language for patients, families, and staff;
- challenge the expectation/hope that there was a checklist of answers or set of prescriptive procedures that staff could follow and, therefore, demonstrate that they were ‘being psychological’.

Rather than trying to provide training about formulations as a specific activity (we tried this, but it simply frightened staff and did not change practice) we have decided to take a ‘training in action’ approach. That is, to begin to use formulations in different contexts and to help staff learn by being involved in the process itself.

What type of formulation?
We made a decision initially to run with one style of formulation in the three arenas
described below. A single, shared understanding seemed important in enabling staff to gain confidence in sharing ideas and generalising this skill to other situations. We decided to adopt a CBT-based formulation framework for the initial work based on: its clear structure; consideration of past experiences and current problems; the evidence base; the familiarity of some staff with the model; and its usefulness in helping staff understand how different interventions (e.g. biological or psychological) can impact on the same problem. It was also important that any formulation explicitly acknowledged the medical aspects of some of the patients’ presentations – we are not trying to downplay the importance of the medical side of these patients’ care but to develop a more person-centred/psychological balance. As staff increase in confidence we plan to include work with CAT and psychodynamic colleagues for specific clients, and gradually to introduce more systemic viewpoints in terms of thinking about relationships and systems in which clients and staff operate. Our current framework encompasses:

- Past history (including relationships, losses, physical health, achievements, jobs, personality, interests).
- Beliefs about self, life, others (more emphasis on ‘rules for living’ rather than core beliefs).
- Current/recent situations that have triggered this admission.
- Four groups of ‘symptoms’ – thoughts, behaviour, biology, emotions.

The triggers and ‘symptoms’ are then repeated for discrete incidents on the wards to help build up a pattern of how factors might interact for this person.

Where to begin to include formulations?

We are approaching this from a number of different angles and are currently targeting three different arenas. First, we are piloting a weekly formulation group with one psychiatrist for each of his admissions across both wards. The group consists of clinical psychology, psychiatry, occupational therapy and nursing, runs for an hour, and assimilates everyone’s assessments into a single psychologically-based formulation. From this, gaps in information are identified, a single care plan is drawn up, tasks allocated to professional groups, and a review date set. At present, the information is then shared with the patient and family as appropriate. However, our aim is to include patients in the group as staff become more familiar with the process.

We have also set up a two-session anxiety ‘group’ facilitated by OT and psychology. The sessions cover the basics about the characteristics of anxiety, development and maintenance, but more importantly aim to help the patient to create a formulation of their own problems with anxiety in terms of history, symptoms (behaviour, thoughts, feelings, etc.) and triggers. This is then shared with their named nurse and provides the basis of a shared care plan. A requirement of this group will be that the named nurse also attends, takes part in developing the formulation and care plan and helps the patient to share this with others, as appropriate.

We have also been asked by the senior nurses to provide training on managing challenging behaviour. The intention is that every member of staff will attend and nursing managers have committed to organising shift patterns so that groups of four staff will be able (and expected) to attend all three sessions. The three sessions mirror the process of assessment, formulation and intervention. Session one looks at definitions, examples and the causes of challenging behaviour. Staff are then asked in pairs to identify and describe a recent incident that they have found challenging involving a patient with whom they would like help. Information is generated about possible triggers/causes, specific behaviour of the patient, and how other people/the environment reacted. They are then asked to think beyond the behaviour to the cognitions (both long held beliefs and immediate thoughts) and emotions of the patient and
Integrating psychological formulations into inpatient services

others around them. Between sessions 1 and 2, staff are asked to collect information which is missing from this initial assessment from notes, other staff, family and events. In session 2, the staff pairs develop a formulation together and from this begin to develop ideas for new ways of working with the client and their social and physical environment that might help to reduce the incidence of the behaviour. Session 3 feeds back the results of these interventions, returns to the formulation and, essentially, repeats the process again.

Why it seems to be working
We have identified a number of factors that have enabled us to make this progress:

- Understanding the cultural and systemic pressures that are operating on different professions.
- A proactive psychiatrist prepared to put in the time to trial the approach.
- Support from senior nursing staff who are prepared to change shift patterns in order to enable nursing staff to attend.
- Making better use of the named nurse system and always expecting a nurse to attend with the seniority to implement the care plan with the nursing staff.
- Involving and valuing the input of all staff from managers to domestics.
- Formulations are being adopted consistently in a number of different arenas.
- The formulations reinforce the collaborative approach between psychology and other professions and patients, and do not perpetuate the idea that the psychologists have ‘the answers’ to each specific problem. Instead the emphasis is on providing a framework to enable staff to develop potential interventions that are more meaningful for the patient.
- There is a clear link between the assessment, formulation, and intervention in all the fora in which it is used. The process directly uses psychologists to facilitate transferring this new shared understanding into a meaningful change in care rather than relying on staff to make this leap for themselves.
- The training is also directly related to the problems the staff are experiencing on the wards rather than being an abstract teaching experience.
- Evaluation of whether the proposed interventions have helped is built into the process.

Feedback
Initial feedback on the use of formulations has been very positive, although at this stage the impact is limited to relatively small numbers of staff and patients. Staff report having a greater sense of understanding about patients in the context of their personal history. Interventions have been more focussed with less time wasted in figuring out where one professional’s work fits with the others. Of the staff who have been involved, there is an observable sense of increased confidence in their own ability to solve some of the problems they experience and a clearer understanding of the ways in which they might use clinical psychologists on the ward. We have also observed them becoming more skilled in reflecting on patients’ internal cognitive and emotional experiences, in addition to their existing detailed knowledge of medical and physiological presentations. It has also enabled us to address some complex family dynamics in a clear and non-threatening way that also prevented a multitude of staff becoming over involved in this process.

However, in terms of time commitments the ward rounds use up vast amounts of staff time already and our groups will be seen by some as an increase in workload. Psychological formulations are still new and potentially threatening to some staff who have developed comfortable ways of working over many years, and the approach does not fit with the strict medical model which some staff hold in high regard. It is hoped that over time staff will have the confidence to work with both approaches rather than seeing them as in opposition to one another.
We are now in the early stages of formally evaluating the impact of this work using a variety of indicators such as staff knowledge, self efficacy, incidence reporting and length of stay. We envisage that formulation driven consultancy will become an increasing part of our work and that individual work with patients (other than neuropsychological assessments) will become less intrinsic to our role. We would be interested in other clinicians' views on how clinical psychologists have integrated formulations into older adult inpatient settings.

Correspondence
Sarah Dexter-Smith
Principal Clinical Psychologist,
Tees, Esk & Wear Valleys NHS Trust,
Bath Villa Annexe,
St Luke’s Hospital,
Marton Road,
Middlesbrough TS4 3AF.
E-mail: sarah.dexter-smith@tney.northy.nhs.uk
Introduction and Context

It has been acknowledged by many that people are best and more fully explained using ‘biopsychosocial’ approaches (Knight, 2004). As health care professionals we must be mindful that all patients we meet function biologically (including medical aspects), psychologically and socially. Whether they are experiencing difficulties in one or more of these areas, information about each remains relevant and useful. No one aspect of a person exists in isolation; the presentations we come across are the result of the complex interactions of all aspects of a patient’s bio-, psycho- and, social-world.

This has become an accepted idea and there are several examples of this way of thinking. Rachman and Hodgson (1974) proposed a triangle of three factors: cognition – behaviour – affect (or ‘think – do – feel’), highlighting that each element can influence the others in a positive or a negative way. Williams (2002) developed a five area approach for working to overcome depression. The five areas were: life situation/relationship or practical problems; altered/unhelpful thoughts; physical feelings/symptoms; behaviour; and, emotional feelings. This approach emphasises the links between the five areas and encourages patients to consider the causes of depression and to identify and change the problem areas of their life in order to improve their mood. In their well-known book, Mind Over Mood, Greenberger and Padesky (1995) also illustrate five aspects of a person’s life that should be discussed in order better to understand their problems: thoughts, moods, behaviours, physical reactions, and the environment. They again emphasise the interaction between the five areas, noting that changes in one area of a person’s life can impact on the other areas.

The project in Calderdale

The notion of understanding a patient’s presentation by gathering information about additional areas of their life was the starting point for our work with the stroke and rehabilitation unit at the Calderdale Royal Hospital. Cascading a way of thinking about and working with patients psychologically to multidisciplinary team (MDT) staff, became an efficient way to maximise the psychology time available. This way of working aimed to encourage a shift from sole focus on the medical model, to a consideration of the wider aspects impacting on the patient’s life. Tailoring help and support to the individual’s rehabilitation journey.

Clinical experience highlighted the dominance of the biological aspects when working in an acute medical setting such as a stroke rehabilitation unit. We are all most familiar and, indeed, comfortable with our own area of knowledge and expertise. When working with inpatients it is difficult not to be struck by what is there in front of you; the medical presentation: pain, fatigue, difficulties with mobility, eating, speech, and so on. However, to focus solely on this would miss substantial and important pieces of the picture.
Many factors can contribute to disturbances in mood; not least it being a natural response to an illness event as adjustment begins. Nevertheless, mood can negatively impact upon rehabilitation progress. It is important to consider the other factors in the patient’s life beyond their current diagnosis. Their life outside the hospital and the hospital environment itself may be contributing to their current presentation, and these may be more easily dealt with (Wallace & White, 2006). It is important to see beyond a medical label and remember that this person is an individual with their own likes and dislikes, achievements, worries and so on; as are we.

**Doing a jigsaw to improve psychosocial well-being**

The ‘Jigsaw Model’ aims to encourage staff working on the rehabilitation ward to ‘piece together a fuller picture of a person’, considering other aspects of a person’s life and the potential impact this could have on their presentation. The model utilises an imaginative format to support ease of understanding and use, and employs terms that are meaningful to the staff group. The depiction of this model as a jigsaw, and the notion of piecing together a fuller picture, is intended to facilitate understanding.

The ‘Jigsaw Model’ (see Figure 1 alongside) is made up of six pieces, each of which should be considered when trying to understand a patient’s presenting difficulties. These six pieces are: thoughts, lifestyle (e.g. hobbies, finances, housing, pets, and family) physical sensations, mood, behaviour, and immediate surroundings (e.g. lighting, noise, and temperature on the ward, patients and staff). The six pieces of the jigsaw provide an accessible and user-friendly, biopsychosocial approach. To some extent the pieces can overlap in content and what goes where is less important than having made the observation.

Many factors can contribute to mood and psychological difficulties which can significantly impact on progress in rehabilitation. The ‘Jigsaw Model’ encourages staff to think about what may be contributing to the patient’s current presentation, specifically asking ‘what do we know already’ (e.g. reason for admittance, any history given, current presentation) and ‘what do we not know’ (e.g. social factors: relationships, responsibilities). It is the latter question which this model encourages staff to begin to include in their everyday practice, through familiarisation with the ‘Jigsaw Model’ and developing a psychologically minded way of working.

The ‘Jigsaw Model’ is not a treatment approach, and neither is it a substitute for psychology input. Rather it is a clinical tool which provides a visual image to support thinking around a patient’s presentation, helping staff to think about a person’s current difficulties in an holistic way, and increasing the psychological awareness of staff. This approach may be useful to feed into goal planning, increasing the information available and encouraging goals to be tailored to the patient.

All MDT staff can be empowered and skilled to consider psychosocial issues and can contribute to problem-solving within their own professional role and expertise. Psychologists can support this and, in many cases, working indirectly through MDT staff can yield good results without the need for intensive one-to-one patient contact. The psychologist’s time can be utilised to familiarise staff with this model and way of working, and to see patient’s with more severe and enduring difficulties which need specialised input.

In Calderdale, afternoon workshops have been run to introduce the model and its rationale. Attendees are then required to complete a jigsaw model for a chosen patient with whom they are working, and to attend a 60- to 90-minute session with the psychologist or psychology assistant to discuss this. Part of this session focuses on consideration of how completing the jigsaw impacted upon their knowledge of and work with the patient.
The case study session held with the psychologist is an integral part of facilitating understanding and confidence in the model, ensuring it is utilised to create practical goal planning items, which are meaningful to the patient and make sense to the staff who will implement them.

**Brief illustrated examples**
(See Wallace & White, 2006, for further examples.)
- A 67-year-old male patient was anxious and withdrawn. He was very tired and did not like to come out of his room. Completing the jigsaw helped staff to identify that he was having difficulty sleeping because of the bright lights of the ward, and that loneliness and boredom were contributing to his mood. It was also noted that being in a side room away from others was heightening his anxiety and avoidance of other patients.
- A jigsaw model was completed for a male patient who was low in mood, not sleeping at night, not eating well, too tired for physiotherapy sessions and wanted to go home. Through the structured discussion considering the six pieces of the jigsaw it was discovered that he worked night shifts and was finding it difficult to adjust to the changes in routine.
- A lady with a long-term condition, who was used to managing this at home, was very weary from the noise and activity of the hospital environment. She liked to be alone and, after a disturbed night, she often turned off her light during the day and wore an eye mask. When she had slept well she had a good rapport with staff. She was very independent and liked to keep herself-to-herself. Completing the jigsaw with this lady helped to add context to her presenting poor sleep and withdrawal. She found it very difficult being around food and drink because she had a PEG feed. It was therefore negotiated that she would not be disturbed until 10am allowing her to get enough sleep and for the breakfasts on the ward to have been cleared away.

**Evaluation**
The project in Calderdale has recently undergone initial evaluation. All MDT staff...
who had attended the training workshop were sent a written feedback form and a return envelope. The feedback forms used a three-point scale of ‘yes’, ‘no’, ‘don’t know’, and asked respondents to comment on the workshop in terms of enjoyment, usefulness, relevance, and how practical it was in relation to their work. At this initial stage, 22 evaluation forms were distributed, 13 of which were completed and returned, giving a 59 per cent response rate. Of those responding:

- 92 per cent found the workshop enjoyable;
- 100 per cent found it useful;
- 85 per cent found the workshop relevant;
- 77 per cent found it was practical.

Below are comments about the Jigsaw Model from members of the Calderdale Rehabilitation ward MDT (see Wallace & White, 2006):

- It brings the whole person together.
- Helps me to see the bigger picture.
- Links things together.
- An icebreaker, pointers to start conversations with the patient.
- Makes sure I think about all aspects of a person.

The ward team have reflected that in a busy ward environment it can often feel that there is very little time to ‘chat’ with patients. Staff have commented that the jigsaw is a reminder of areas they can discuss with patients that can be integrated into some of their routine contact with the patient (e.g. medication rounds, bathing, making beds). To complete the ‘Jigsaw Model’ does not require an interview approach, the information can be accessed via more informal conversation and the jigsaw can be pieced together bit-by-bit over a period of time. Information may also come from other sources; family and friends, the referral letter, past medical history and so on.

Summary

In summary the ‘Jigsaw Model’ brings together the factors potentially affecting a patient’s progress and well-being, encouraging the creation of a ‘fuller picture’.

This may then highlight issues which can be formulated and turned into practical goal-planning points. There may be aspects of care or the environment which can be changed which may have a significant impact upon patient wellbeing.

The ‘Jigsaw Model’ is an imaginative and memorable visual representation which encourages a holistic assessment of a patient. It seeks to empower MDT staff that are at the frontline of patient care, making psychological ways of working more accessible.

This like other systems approaches and holistic models promotes the importance of considering the whole person (of which the presenting difficulties are one part) and the wider context (of which the person is one part) (Johnson, 2006).

Correspondence

Victoria Carek
Psychologist in Clinical Training,
University of Sheffield.

David Wallace
Consultant Clinical Psychologist,
Calderdale Royal Hospital,
Halifax.

References


An investigation of the phenomenon of worry in a clinical sample of older adults, using semi-structured interviews

Gillian Bowie, Ian A. James & Mark H. Freeston

Worry is the cardinal feature in Generalised Anxiety Disorder (GAD) and is also prevalent in other anxiety disorders, as well as depression and insomnia. Theoretical accounts have also suggested that the process of worry might play a role in maintaining emotional disturbance through suppressing emotional experience and inhibiting emotional processing (Borkovec, 1994). It is, therefore, not surprising that in recent years worry has emerged as an important research topic.

Research investigating worry in later life has tended to find older adults to be a worry free group (Wisocki, 1988). However, most research has focused primarily on community participants who are generally healthy and active. In addition, the majority of studies has used questionnaire designs, which restrict the amount of detailed information that can be acquired. This study was designed to address some of the shortcomings identified in the current literature, through assessing worry in a clinical sample of older adults using semi-structured interviews.

Aims of study
The primary aim of this study was systematically to describe specific features of the clinical phenomenology of worry among older adults. The areas investigated included; worry content; patterns of worry; and, the function of worry. This article will focus on the results obtained surrounding the content of worry.

Methodology

Design
The study used a cross-sectional, within participants, quantitative, descriptive design. Participants were recruited from clinicians’ caseloads.

Participants
A total of 25 patients were recruited (20 female, five male). The age range of the sample was 67 to 87 years (M=74.7 years, S.D=5.8). Eleven participants were married, 11 widowed, two were single and one was divorced.

Inclusion/exclusion criteria
To be included, participants had to be aged over 65 years and obtain a score above clinical cut-off on the Pennsylvania State Worry Questionnaire (PSWQ). Participants were excluded if they showed signs of psychotic features, organic pathology or recent bereavement.

Measures
The main measure was the semi-structured interview, developed for the study. Additional measures used were the Pennsylvania State Worry Questionnaire (Meyer et al., 1990), Beck Anxiety Inventory (Beck et al., 1988) and the Geriatric Depression Scale (Sheikh & Yesavage, 1986)

Procedure
The semi-structured interview was conducted either at the patients’ homes or site of therapy, after they had consented to take part in the study. The interview took approximately an hour to complete.
Participants were initially asked at the start of the interview to state freely what they worried about. These worries were termed ‘free reports’ and were classified into categories based on a protocol. After this, participants were presented with prompted worry topics identified from the literature, comprising eight areas; (i) health/illness to self (own health), (ii) health/illness to others (others’ health), (iii) family/friends/other people (other people), (iv) relationships, (v) social events, (vi) finances, (vii) future and (viii) minor matters. Participants were asked to state whether they worried about these topics and, if so, the rate, duration and distress level of each ‘prompted worry’ topic.

Results

Features of worry

Length of time
The length of time for which participants had been a worrier ranged from two to 85 years (M=57 years). However, it was common for participants to perceive themselves as ‘born worriers’, with 63 per cent stating that ‘they had been a worrier all their life’.

Interference of worry in everyday life
Sixty-eight per cent of the sample reported that worries interfered with their everyday life.

Duration of worries
Forty-four per cent of participants endorsed very frequent worries, (three to eight hours a day). In addition, 12 per cent reported near constant worries, of more than eight hours a day.

Distress level
Fifty-six per cent believed that their worries were slightly or moderately distressing and 28 per cent reported extreme distress. Whilst, 16 per cent felt that their worries did not cause them any upset.

Content of worry

Free reports
The number of worries freely reported by participants ranged from one to six, (M=3.4 worries, SD=1.4). The topics most freely reported fell into the categories of: (i) other people; (ii) own health; and (iii) minor matters. In contrast, categories least reported were: (i) future; (ii) social events; and (iii) finances.

Prompted worry topics
The worry topics most endorsed when prompted were: (i) others’ health; (ii) other people; and (iii) own health. Those least endorsed were: (i) finances; and (ii) relationships. These results can be seen in Figure 1 alongside.

Duration and distress levels of prompted worry topics
The two worry topics about which participants spent most of their time worrying were others’ health (52 per cent) and own health (48 per cent). The topics that participants worried about least often were finances (eight per cent) and social events (16 per cent). The worry topics that participants rated as being most distressing were own health (40 per cent) and health of others (32 per cent) and other people (32 per cent). Issues to do with finances (four per cent) and the future (eight per cent) were associated with the least distress.

Discussion
Patterns of worry content were examined in a variety of ways. Firstly, worry topics reported freely were compared to those that were endorsed when prompted. Secondly, the prompted worries were examined to determine which worries consumed most of the participants’ time and which were associated with most distress.

A number of similarities exist in the worries that older adults freely report and those that are endorsed when prompted (as can be observed in Figure 1). For example, finances were rarely endorsed either when
freely asked or when prompted. However, this might be attributed to the sample being highly satisfied with their financial status. The most popular worries reported in both forms of elicitation were worry about own health and other people, particularly their health.

Some similarities also exist when comparing the prompted worry topics associated with higher levels of duration and distress. However, the preliminary results obtained from this study would indicate that whilst the health of others is the worry that seems to consume most of participants’ time, the worry that is associated with most distress is their own health. The distinction within this study between worry about own health and worry about the health of others is important as some researchers feel that worrying about oneself and other people differentiates normal worriers from pathological worriers; ‘worrying about others is normative in later life, whereas worrying excessively about oneself may be pathological’ (Wetherell et al., 2003).

Worry about health, albeit one’s own health or others’ health, was the theme most frequently freely reported and endorsed within this study. Previous research has also shown that health is the worry topic most readily endorsed by older adults (e.g. Diefenbach et al., 2001; Hunt et al., 2003). However, comparison studies between younger and older adults have found that older adults do not worry any more about their health than younger age groups (Powers et al., 1992).

Two other worry topics worth mentioning are the future and minor matters, since these topics have been found to be good indicators of excessive worry and distinctive features of GAD (Dugas et al., 1988). This study provides strong support for the notion that older people worry about such issues. Indeed, 44 per cent of the participants freely reported worrying about minor matters and 72 per cent endorsed such a worry when prompted. Common examples provided were associated with household tasks. Likewise, worry about the future was a
relevant concern of the sample, with 56 per cent endorsing it. Themes of autonomy were particularly salient, e.g. a fear of becoming a burden to others or having to go into a nursing home.

Conclusions
This study is the first to date systematically to describe the features of worry in a clinical sample of older adults, through the use of semi-structured interviews. The content of worry reported is consistent with age related developmental changes occurring in later life. Further research is highlighted from this study; the next step would be to explore the content and experience of worry in clinical and non-clinical older adult groups to determine key differences.

It is hoped that this study provides useful information surrounding the characterisation of worry in older adults. Improving the recognition of excessive worry within this client group is important, since older adults themselves will rarely present to medical settings reporting such difficulties.

References

Acknowledgements
This project was submitted as a Large-Scale Research Project to the Teesside Doctorate Course in Clinical Psychology.

The survey was supervised by Mark Freeston and Ian James, as members of Newcastle University Doctorate in Clinical Psychology.

Correspondence
Gillian Bowie
South of Tyne & Wear
Mental Health NHS Trust.

Ian A. James
Newcastle Challenging Behaviour Service,
Northumberland, Tyne & Wear
Mental Health Trust.

Mark H. Freeston
Doctorate in Clinical Psychology,
Newcastle University.

Emotional experiences and complex visual hallucinations

Catherine Andrews, Daniel Collerton, Urs Mosimann & Rob Dudley

SIMPLE (ALSO REFERRED TO AS phosphenes, photopasiae, elementary or unformed) visual hallucinations consists of flashes, stars, sparks or coloured bright lights. Complex visual hallucinations consist of formed images of persons, objects, animals or whole scenes. Both are common in older people.

Though visual hallucinations can occur in individuals without neurological or mental health difficulties, the commonest associations with complex hallucinations are:
- Dementia;
- Eye disease;
- Delirium;
- Psychosis;
- Bereavement.

It is not surprising, therefore, that the greatest number of people who experience visual hallucinations are over the age of 65 years and present within older adult psychology services.

Individuals’ emotional reactions to recurrent complex visual hallucinations are poorly understood. For some individuals the hallucinations are emotionally neutral or comforting experiences (Tein, 1991). For others, they are distressing and disabling aspects of many major illnesses (O’Reilly & Chamberline, 1996). It is rare, if ever, that an individual with either a neutral or positive reaction to their hallucination will be referred to services.

The objective of the research¹ was to investigate why some individuals who experience complex visual hallucinations are distressed while others are not. Therefore, the aims were:

1. To identify common factors in emotional reactions to complex visual hallucinations
2. To explore whether there is a relationship between these factors and distress, as defined by the individual.

Method
A qualitative, phenomenological approach was adopted to elicit detailed accounts of emotional reactions to visual hallucinations from five individuals. The aim of this approach is to seek the psychological meaning of phenomena that are analysed and investigated through the lived experiences of the participants.

The study was approved by Gateshead NHS Local Research Ethics Committee.

Measures
Five participants’ experiences of visual hallucinations were explored using a semi-structured interview. This was designed in collaboration with researchers in the field from different orientations (CBT, psychodynamic and biological) to reduce bias. The interviews were conducted at the participants’ homes and took between 45 to 60 minutes.

Participants
The participants in the study were identified through mental health services. They ranged from 28 years to 84 years old. Participants were diagnosed with: macular degeneration, narcolepsy, dementia with Lewy Bodies, Alzheimer’s disease, or psychosis.

¹ This research project was conducted as part of a Doctorate in Counselling Psychology undertaken by the first author.
Results
The interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA).

In terms of common experiences of visual hallucinations, all of the participants reported fear of the visual hallucination. They suggested that it was the very appearance of a hallucination that was frightening, not the content per se. Participants appraised the occurrence of a hallucination as signifying they were experiencing mental health problems, for example:

So I tended to let my friend turn into a monster. I tended to ignore, ignore that, what he looked like. But, at the same time, it was worrying. I thought I was going out of my mind.

Several factors emerged that cast light on why people had these specific feelings. These were: the influence of other people’s reaction to the visual hallucination; searching for an explanation; coping strategies; and perception of self.

Influence of other people’s reaction
Participants’ emotional reactions were also influenced by how others reacted to them experiencing a hallucination. One of the participants spoke of how she had sought reassurances from professionals and had been left feeling frustrated and misunderstood, for example:

…I’ve been all over the place, but nobody seems to understand what I’m talking about, you see.

Searching for an explanation
All participants searched for an explanation for their visual hallucinations. All suggested that they were symptomatic of physical illness, for example:

As I say, I used to just blame my eyes for everything, you see. I thought that that was the key to it. Just my eyes you see.

All participants sought confirmation and validation of their experience from an external source, although it seemed that this provided them with little reassurance, for example:

And again, I was reluctant to tell them that I was seeing spiders because I thought ‘Well if they haven’t then, there can’t be anything there.’

Coping strategies
All the participants appeared to seek reassurance from others as a way of coping. Several of the participants commented that they used humour as a way of coping. One participant recalled:

Oh, he’ll (husband) just say oh; we’ll get into bed and he’ll say ‘night lads’ (laughter) or ‘have you said goodnight to the lads?’ (laughter). But we just make a joke of it because I think, if we didn’t, I couldn’t handle it. I couldn’t handle it.

Another participant said:

He just sometimes makes a little joke about which I don’t get offended by but sometimes and it sometimes it helps – because everybody like, I say, treats it seriously all the time and bit more bearable and bit more easy to cope with.

It would seem that how other people react to the presence of the hallucination might either reinforce or reduce the distress that the hallucinator might experience.

Perception of self
It would seem that all participants felt that their experiences of having visual hallucinations had challenged their view of themselves and what ‘type’ of person experienced visual hallucinations. The main theme of the participants’ accounts was that their hallucinations were a sign of mental illness, although all were keen to emphasise that this was not true in their case, for example:

I really don’t know because, I mean I know I’m not sick in the mind I know that.

Clinical implications
The results of this piece of qualitative research suggested that there was a strong association between how the individual appraised the appearance of a hallucination and the amount of distress that they experienced. The individuals’ reaction were also influenced by other people’s reactions when
they talked of their experiences. Participants who appeared to understand that the hallucinations were not real, through a variety of coping strategies (reality testing, confirmation/validation from an external source) reported less distress over time. Thus, potential interventions to reduce emotional distress might be targeted to achieve these ends.

For example, a combination of the acceptance of the reality of the subjective hallucinatory experience with psycho-education regarding the origins of visual hallucinations might be effective. For example, Barta et al. (1997) reported that patients experience some relief when they were told their hallucinations were a recognised feature of eye disease, as opposed to the hallucinations being indicative of an underlying psychological disorder.

Conclusion
There were a number of common factors that resulted in participants experiencing emotional distress in reaction to their visual hallucinations. It is apparent that there is not one single factor that causes an emotional reaction and that there is not one single type of emotional reaction.

It is clear that the traditional conceptualisation of visual hallucinations as symptomatic of psychopathology or reaction to trauma needs to be challenged. Rather, a process model that acknowledges multiple factors and the dynamic nature of the individual is required. Similarly treatment interventions should also reflect the complexities of these phenomena.

Acknowledgement
We would like to thank Allan Winthrop, Consultant Counselling Psychologist and Course Director, Doctorate in Counselling Psychology, Teesside University for his support with this project.

Correspondence
Catherine Andrews
Counselling Psychologist,
Bensham Hospital,
Gateshead NE8 4YL.
E-mail: kate.andrews@ghnt.nhs.uk

Daniel Collerton
Consultant Clinical Psychologist,
Bensham Hospital,
Gateshead NE8 4YL.

Urs Mosimann
Senior Clinical Lecturer in
Old Age Psychiatry,
Institute for Ageing and Health,
Newcastle General Hospital,
Newcastle-upon-Tyne NE4 6BE.

Rob Dudley
Consultant Clinical Psychologist,
South of Tyne Early Interventions in
Psychosis Service,
Monkwearmouth Hospital,
Newcastle Road,
Sunderland SR5 1NB.

References


Members’ updates

Subscription policy – important notice to current members
If you have underpaid your membership or it has lapsed you will be sent one reminder – after that, however, you will be removed from the database on 1 July, 2007. It is your responsibility to ensure you are paying the appropriate standing order or cheque. It is also your responsibility to keep your contact details up-to-date through Ange Brown at:

Ange Brown,
2 Earnslaw Farm Cottages,
Coldstream, Berwickshire TD12 4JS.
You can download a standing order mandate form at: http://www.psige.org/join-us.htm

Evaluation of models of respite care – NEW project
The NHS Service Delivery Organisation has recently funded a two-year project to develop tools to evaluate the extent to which different models of respite care for people with dementia are person- and carer-centred. The project is based at the Universities of Newcastle and York.

The initial part of the study involves identifying the range of models of respite care in the UK. By respite care we mean all services whose primary purpose is to provide a break from usual routine for the person with dementia and/or the carer. This includes day care and short term breaks as well as more traditional forms of respite care. A telephone scoping survey will be the main approach used to identify models of respite care. However, to try to ensure the inclusion of as many models as possible, we would like to invite readers to contact us with information on innovative models of respite care.

Further information about the project is available at:
http://www.ncl.ac.uk/ihs/research/dementia/project/1304
Please send information to:
Claire Bamford,
Senior Research Associate,
Institute of Health and Society,
Newcastle University,
21 Claremont Place,
Newcastle-upon-Tyne NE2 4AA.
E-mail: c.h.bamford@ncl.ac.uk

Relaunch of North Thames PSIGE
All (members, non-members, trainees) are welcome to come to the following quarterly meetings held between 3.00 p.m. to 4.30 p.m. in 2007.

Friday 19 January – Value and status of work other than face-to-face contacts, in the context of payment by results.
Venue: UCL, 188 Tottenham Court Road, Rockefeller 337.

Wednesday 25 April – Hoarding and Diogenes Syndrome.
Venue: UCL, 188 Tottenham Court Road, Rockefeller 339.

Venue: UCL, Tottenham Court Road, Rockefeller 339.

Tuesday 16 October – Clinical case presentation.
Venue: To be arranged.

For further information, please contact:
geraint.price@nhs.net or
Ruth.Lukeman@wlmht.nhs.uk
Launch of the British Council for Ageing

Jane Fossey and Steve Boddington attended the launch of the British Council for Ageing at the House of Lords on 12 October, 2006. This is an attempt by three learned societies (British Geriatrics Society, British Society of Gerontology and the British Society for Research on Ageing) to establish a unified voice with which to provide informed opinion and influence policy making with respect to older people, and to promote research into the ageing process. The BCA intends to establish links with organisations representing older people, or involved in the study of ageing. We were invited to the launch in this capacity, as the BCA is keen to ensure that there is representation from organisations with expertise in a wide range of areas affecting older people, including psychological well-being.

Apart from the fascinating experience of sipping drinks and nibbling canapés on the terrace of the House of Lords, we believe that this organisation is one with which we should endeavour to forge links. We would be particularly interested to hear from any of our members with a strong academic background and interest, who might be willing to further this link on behalf of PSIGE.

You may also be interested to check out the website for SPARC (Strategic Promotion of Ageing Research Capacity): www.sparc.ac.uk. This organisation aims to facilitate research into ageing through it’s links to research funding councils and through it’s workshops.

****************

Updates to the PSIGE website – NEW Links

If you have not looked recently, please go to www.psige.org to see the new look website.

In particular, take a look at the links pages which have recently been updated. If there are any documents that you have found useful, please share them with the membership by e-mailing Patrick Mcguinness at Patrick.Mcguinness@slam.nhs.uk who will post the links on the website.

REMEMBER, this website is your website, so please contribute to it.
My dear PSIGE Members

Happy New Year.

It is some years since I have been in touch, however, now I have some thoughts that I hope may prove of relevance to you. Don’t dismiss them by thinking ‘Oh I know all that’, you don’t, unless you have experienced these things for yourself.

Until a few years ago I felt that my age was my business and I was unwilling to admit to it. Then I realised that I had achieved something reasonably impressive: I had survived to reach the state of ‘a good old age’, whatever that is! In view of the fact that I have no grey hairs and look fairly intact I began to admit my age with some silly pride. At 76, I find that although my lungs leave a lot to be desired (thanks to smoking and genes) my old brain is functioning more or less as well as ever. As I am now a potential guinea pig for age research I prefer, if you please, to offer my own insight and experience regarding this popularly described condition of senility, disintegration, deterioration and approaching demise.

Well, there is a minor degree of truth in the general beliefs. It is certainly not a glorious, free existence, but then, what age is? Obviously the situation varies from person to person. Much depends on physical fitness, health problems, mental functioning, the degree of intelligence, cultural and occupational levels, previous and present environments, family and friends, and by far not least, finances. To be alone deprived of family and social contacts must be intolerable. I am very fortunate in having a close and loving family – with sadly one exception. My children and grandchildren play a massive role in providing me with reasons for living. Those of us who have physical disabilities and poor health have almost as much unhappiness as those in isolation. These are the elderly who need the most support and understanding from others. I wonder how well this is achieved today.

It is frequently supposed that depression plays a common role in age; here I find my own experience relevant and the reason for this letter. The form of depression requiring serious medication is not as common as Reactive Depression. The latter is the real problem for older people. It is irrelevant how intelligent or active a person may be, depressive episodes occur – admittedly the frequency depends on circumstances. The cause of these episodes? Quite simply, LOSS.

Without much warning the ability to do ordinary day-to-day things is increasingly impaired and usually lost. Running, jumping, digging in the garden, dancing to wonderful Latin-American music, carrying heavy objects including shopping, climbing hills and mountains – all these are subject to loss. These day to day changes are recognised as the usual changes related to age, but what is not recognised or understood is how an older person feels about these losses. To have to admit to an inability to correctly perform ordinary actions or tasks is acutely frustrating and angry-making, but the loss of status is devastating. After years of being in work, contributing to society, each and everyone to a greater or lesser degree, it all comes to an abrupt end. Within weeks of retirement his or her place is taken by another, the ranks close and a whole new system installed. The individual is forgotten – for instance, I wonder just how many, if any, of the new Membership have the vaguest idea of who I am? Even the ex-factory worker in the same factory for 40 to 50 years on returning to the workplace is often met with vague welcome or even indifference and in a flash the person is made to feel redundant and unwanted, even an embarrassment. Where is the respect once given, who remembers the contribution, the expertise and the achievements? For a few weeks it is great not to have to get up at a certain time, go to work regularly, not to have to perform some duties, not to have to
work with, advise, direct or oversee other people, but that feeling ceases to exist after a while. The realisation that time will be in their hands for the rest of their lives is not a particularly welcome promise of boredom for retired people. This realisation is the precursor of depressive episodes.

The episodes are not just about frustration, but are much more shattering. Worthlessness, redundancy as a person, hopelessness all play their part. The person asks ‘What is left? Nothing. There is no future to look forward to; I am not contributing; there is no reason to live. Why am I surviving? What’s the point?’

These are genuine, deeply felt emotions to which there appears to be no answer. Admitting to them seems to some people a sign of weakness and is never disclosed, but the episodes do exist. Fortunately usually it will pass, particularly if something interesting happens to alleviate it, but it will return in time.

What can be done to cope with these episodes? First and foremost all older people need to beware apathy which all too easily becomes inertia. Those with good functioning brains need to continue to keep them oiled and find something of use or significance. Those with retained physical ability also need outlets of satisfaction and meaningfulness.

Of course, it is not possible to retrace steps to that previous status with its personal significance, but many older people find remarkable ways to either avoid the Loss or to minimise it. Actors, e.g. Sir John Mills, Writers, e.g. PD James, politicians, e.g. Churchill, even Popes are examples of those often able to continue in their professional work until amazing ages, even up to death itself. Others take part in marathons, learn to fly, take up painting and astound everybody – probably including themselves! Even curiosity regarding certain things in the future can act as encouragement to continue to seek out value in life. Perhaps these examples can provide us with guidelines as to what we can do, not only ourselves, but in order to help others floundering in these episodes of depression. Here I am sure PSIGE can play a big part in seeking out the alternatives for individuals in order that they may regain self-esteem and satisfaction.

On a personal basis, of course I suffer occasionally from depressive episodes. It is most unpleasant and I have wracked my still working brain to find an answer for myself. I think I have found it in continuing to write – something I have always found enjoyable and rewarding – my only trouble is trying to find something to write about that has nothing whatever to do with my precious profession!

Una Holden
Calle Limoneros 22,
Capistrano Village,
Nerja, Malaga 29780,
Spain.
E-mail: upcosgrove@hotmail.com
PSIGE Committee 2006/2007

CHAIR
Steve Boddington
Felix Post Unit, Maudsley Hospital, Denmark Hill, London SE5 8AZ.
Tel: 020 7919 2832 Fax: 020 7919 2109
E-mail: steve.boddington@slam.nhs.uk

VICE-CHAIR
Sinclair Lough
Psychology Service, North Dorset PCT, 10 Cornwall Road, Dorchester, Dorset DT1 1RT.
Tel: 01305 266011 Fax: 01305 266720
E-mail: Sinclair.lough@northdorset-pct.nhs.uk

HONORARY SECRETARY
Don Brechin
Leeds Mental Health Teaching NHS Trust, 17 Blenheim Terrace, Leeds LS2 9HN.
Tel: 0113 343 1949 (Secretary) Fax: 0113 343 1961
E-mail: Donald.brechin@leedsmh.nhs.uk

TREASURER/MEMBERSHIP SECRETARY
Alice Campbell Reay
Dept. of Older Adult Psychology, Lea Hurst Day Unit, Walton Hospital, Whitecotes Lane,
Chesterfield S40 3HW. Tel: 01246 515576
E-mail: alice.reay@chesterfieldpct.nhs.uk

MEDIA OFFICER
Chris Allen
The John Hampden Unit, Stoke Mandeville Hospital, Mandeville Road, Aylesbury,
Buckinghamshire HP21 8AL. Tel: 01296 565016 Fax: 01296 399791 Mobile: 07766 763245
E-mail: chris.allen@bmh-tr.nhs.uk

NEWSLETTER EDITOR
Romola Bucks
University of Southampton.
E-mail: romola.bucks@soton.ac.uk

COMMITTEE MEMBER
Penny Fooks
Winchester CMHT for Older People, St. Waleric Park Road, Winchester SO23 7BE.
Tel: 01962 841941
E-mail: penny.fooks@weht.swest.nhs.uk

GEOGRAPHICAL GROUPS LIAISON AND WEBSITE CO-ORDINATOR
Patrick McGuinness
Psychological Therapies Service, Morland Lodge, 4 Morland Road, Croydon CR0 6NA.
Tel: 020 8663 8137
E-mail: Patrick.mcguinness@slam.nhs.uk
CHAIR OF TRAINING SUB-COMMITTEE
Catherine Dooley
Barnes Hospital, South Worple Way, London SW14 8SU.
Tel: 020 8878 4981 ext. 8327 Fax: 020 8876 5471
E-mail: catherine.dooley@swlstg-tr.nhs.uk

SCOTLAND REPRESENTATIVE
TBC

WALES REPRESENTATIVE
Janice Rees
Ty Dafydd Day Hospital, Ystrad Mynach Hospital, Ystrad Mynach, Gwent CF82 7XU.
Tel: 014438 11457
E-mail: Janice.Rees@gwent.wales.nhs.uk

COMMITTEE MEMBER
Polly Kaiser
312–314 Oldham Road, Royton, Oldham. Tel: 0161 909 8200
E-mail: pollykaiser@f2s.com

COMMITTEE MEMBER
Cath Burley
The Bungalow, Gables Drive, Peterborough District Hospital, Thorpe Road,
Peterborough PE3 6DA. Tel: 01733 318186 Fax: 01733 318180
E-mail: cath.burley@cambsmh.nhs.uk

COMMITTEE MEMBER
Sarah Dexter-Smith
Older Adult Inpatient Services, Wells Villa, St Luke’s Hospital, Marton Road,
Middlesbrough TS4 3AF. Tel: 01642 516135, Fax: 01642 852822
E-mail: Sarah.Dexter-Smith@tney.northy.nhs.uk

CO-OPTED MEMBER (NATIONAL COUNCIL OF AGEING)
Lyndsay Royan
The Petersfield Centre, Petersfield Avenue, Harold Hill, Essex RM3 9PB.
Tel: 01708 796476 Mobile: 07958 699871
E-mail: lyndsay.royan@haveringpct.nhs.uk

CO-OPTED MEMBER (DCP FINANCE COMMITTEE)
Nicky Bradbury
Psychology Services, Harry Walton House, 97 Church Lane, Aston, Birmingham B6 5UG.
Tel: 0121 685 6420, Fax: 0121 685 6421
E-mail: nicola.bradbury@bsmht.nhs.uk
Geographical Group Convenors
as at October 2006

EAST ANGLIA
Kathryn Sams
Chatterton House, Goodwins Road, King’s Lynn, Norfolk PE30 5PD.
Tel: 01553 815117 Fax: 01553 815181
E-mail: Kathryn.sams@westnorfolk-pct.nhs.uk

Cath Burley
Older People’s Mental Health Services, The Bungalow, Gables Drive,
Peterborough District Hospital, Thorpe Road, Peterborough PE3 6DA.
Tel: 01733 318186 Fax: 01733 318180
E-mail: cath.burley@cambsmh.nhs.uk
or
E-mail: Samantha.wilson@cambsmh.nhs.uk

ESSEX & HERTS.
Sara Banks
Department of Psychology and Psychotherapy, Derwent Centre, Princess Alexandra Hospital,
Hamstel Road, Harlow, Essex CM20 1QX.
Tel: 01279 827276 Fax: 01279 827282
E-mail: Sara.Banks@nemhpt.nhs.uk

NORTHERN
Louisa Shirley
Psychological Services Directorate, Northumberland Locality, St. George’s Hospital,
Morpeth, Northumberland NE61 2NE.
Tel: 01670 501747
E-mail: louisa.shirley@nmht.nhs.uk

NORTH THAMES
Geraint Price
Older Adults Psychology, Chamberlain House, St. Charles Hospital, London W10 6DZ.
Tel: 020 8206 7140
E-mail: geraint.price@nhs.net

NORTH WALES
Fiona Sanders
Glan Traeth Day Hospital, Royal Alexandra Hospital, Marine Drive, Rhyl,
North Wales LL18 3EA.
Tel: 01745 443384 Fax: 01745 330250
E-mail: Fiona.Sanders@cd-tr.wales.nhs.uk
NORTH WESTERN
Sylvia Dillon
Senior Clinical Tutor – Older People, Clinical Psychology, Community and Behavioural Sciences, University of Liverpool, The Whelan Building, The Quadrangle, Brownlow Hill, Liverpool L69 3GB.
Tel: 0151 794 5534
E-mail: s.c.dillon@liverpool.ac.uk

Polly Kaiser (from Summer 2007)
E-mail: pollykaiser@f2s.com

NORTHERN IRELAND
Brenda Carney-Gallagher
Consultant Clinical Psychologist, Department of Elderly Medicine, Lagan Valley Hospital, Hillsborough Road, Lisburn, Northern Ireland.
Tel: 028 906 69475 (Home); 028 926 65141 x 2639 (Work)
E-mail: mandbgall@aol.com

OXFORD
Candy Stone
Moorview, 2–8 Moorland Road, Witney, Oxon OX28 6LF.
Tel: 01993 202100
E-mail: candy.stone@obmh.nhs.uk

SCOTLAND
Liz Baikie
Consultant Clinical Psychologist, Royal Victoria Hospital, 13 Craigleith Road, Edinburgh EH4 2DN.
Tel: 0131 537 5096/7 Fax: 0131 537 5141/0
E-mail: elizabeth.baikie@luht.scot.nhs.uk

SOUTH THAMES
Marina Palomo
North Maidstone & Malling CMHT for Older People, Priority House, Hermitage Lane, Maidstone, Kent ME16 9PH.
Tel: 01622 722173
E-mail: Marina.Palomo@icc.wkentmht.nhs.uk

SOUTH WALES
Sarah Morgan
Resource Centre, Tonna Hospital, Neath SA11 3LX.
Tel: 01639 862869
E-mail: Sarah.Morgan@bromor-tr.wales.nhs.uk
E-mail: psychology.tonna@bromor-tr.wales.nhs.uk
Geographical Group Convenors

SOUTH WESTERN
Philippa Wilson
Poplar Unit, The Coppice, Callington Road Hospital, Brislington, Bristol BS4 5BJ.
Tel: 0117 919 5800 Fax: 0117 919 5809
E-mail: Philippa.Wilson@awp.nhs.uk

P.F. Joyce
Templer House CMHT, Newton Abbot Hospital, 62–64 East Street, Newton Abbot,
Devon TQ12 4PT.
Tel: 01626 362179
E-mail: pf.joyce@nhs.net

TRENT
Rhona Nicol (Convenor)
West Leics CMHT, Hynca Lodge, Tudor Road, Hinckley, Leics. LE10 0EW.
Tel: 01455 443600 Fax: 01455 443636
E-mail: rhona.nicol@leicspart.nhs.uk

Catherine Nicholl (Secretary)
11/12 Keresford Close, Off Broadway, Barnsley S70 6RS.
E-mail: catherine.nicoll@barnsleypct.nhs.uk

WESSEX
Paul Whitby
CMHT, 2nd Floor, Bewley House, Marshfield Road, Chippenham SN15 1JW.
Tel: 01249 707987
E-mail: paul.whitby@awp.nhs.uk

WEST MIDLANDS
Caroline Sincock
Department of Psychology, Rowan House, Osborne Road, Malvern Link,
Worcestershire WR14 1JE.
Tel: 01684 612763 Fax: 01684 612790
E-mail: Caroline.Sincock@worcs-mht.nhs.uk

Ian James (from January 2007)

YORKSHIRE/HUMBERSIDE
Michael Jubb
Clinical Psychologist, Leeds Older People’s Psychology and Therapies Service,
The Mount, 44 Hyde Terrace, Leeds LS2 9LN.
Tel: 0113 305 5587 Fax: 0113 305 5659
E-mail: Michael.Jubb@leedsmh.nhs.uk
The best psychology, to your inbox - free!

Sign up for The British Psychological Society’s free, fortnightly e-mail: a vital resource for students, lecturers...in fact, anyone interested in psychology.

www.researchdigest.org.uk
WRITE for The Psychologist: We publish general ‘overview’ articles of published research, debates, interviews, news analyses, ‘Why I study...’ pieces and a wide range of other formats. For free online sample issues, a full searchable archive for members, and a guide to writing and submitting your article see www.thepsychologist.org.uk.

‘I’ve read this before, but only when I’d experienced it myself did I really believe it...writing for The Psychologist helped me to reach people my usual publications don’t reach. Several of them supplied me, spontaneously, with useful sources, information and examples of real-world applications.’

Professor Miles Hewstone

ADVERTISE in The Psychologist: Want to tell over 44,000 psychologists about your course, conference or organisation? Colour display adverts start from under £100 – contact psyadvert@bps.org.uk for further details.

SUBSCRIBE to The Psychologist: All members of The British Psychological Society receive The Psychologist free, but non-members can also subscribe for just £50 per year (£60 overseas). Contact Sarah Stainton on sarsta@bps.org.uk, or see the website.

For more of the best that psychology has to offer, subscribe to the Society’s free Research Digest e-mail service www.researchdigest.org.uk
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
Contents

1 Guest Editorial
Louisa J. Shirley & Ian A. James

3 Letter from the Editor
Romola Bucks

4 Letter from the Chair
Steve Boddington

5 Politics, money, death and dying
Tim Prescott

7 Meditation is everywhere
Neil Sabin

11 Promoting attitude change: Staff training programme on continence care
Ian A. James, Petra Carlsson-Mitchell, Jenny Ellingford & Lorna Mackenzie

17 Staffs’ perceptions of alcohol misuse in older people
Malcolm Stephenson, Fiona Fraser & Kristina Askew

22 Cure or contain? Attachment theory as a baseline model to understand resistance to success – or Why people don’t want to get better
Louisa J. Shirley

28 Driving with dementia: In need of an A–Z
Lynne Patience

31 Staff’s experiences of fearful situations when caring for people with dementia: Will this interfere with the delivery of person-centred care?
Sylvia Ruttledge & Ian A. James

38 Integrating psychological formulations into inpatient services
Sarah Dexter-Smith

43 Piecing together a fuller picture of the patient: Can doing a jigsaw help to improve the psychosocial well-being of stroke and rehabilitation patients?
Victoria Carek & David Wallace

47 An investigation of the phenomenon of worry in a clinical sample of older adults, using semi-structured interviews
Gillian Bowie, Ian A. James & Mark H. Freeston

51 Emotional experiences and complex visual hallucinations
Catherine Andrews, Daniel Collerton, Urs Mosimann & Rob Dudley

54 Members’ updates

56 Letter to the Editor
Una Holden

58 PSIGE Committee 2006/2007

60 Geographical Group Convenors as at October 2006