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Working With Older People

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Psychology Specialists Working With Older People

AIMS

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

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Letter from the Editor

Louisa Shirley

THE FIRST PAPER in which I appeared as first author was published in the first ever edition of a journal specialising in the psychology of sex differences. The editor was a friend and colleague of my PhD supervisor. I have about 25 copies left.................... if anyone wants one. I had several other peer-reviewed papers accepted from this series of studies where I appeared as second or third author to my supervisor (who was also grant holder for the study from which I derived my PhD data). The bulk of the paper would be written by my supervisor (who has an international reputation in this field) and I contributed the methodology and results sections.

My first attempt at writing solo was was a far less pleasant experience. It was harshly reviewed both in style of the review and in the fierceness of the rebuke of my argument.

Not to be perturbed, I tried again to submit to a peer-reviewed journal after I graduated from my clinical doctorate, and received another firm and caustic rejection. Finally, my first post-qualification paper appeared in the *Forum*, the editor of which treated the paper with seriousness and respect.

In acknowledgement of the contribution of psychologists at the beginnings of their career to psychological understanding of and intervention with older people, and in recognition of the need for people to have early positive experiences of submitting papers, the committee agreed to produce this 'Early Careers' edition of the *Newsletter*. In this issue, we present a series of papers written by assistants, trainees and newly qualified clinical and counselling psychologists offering a mixture of experimental design and service evaluations which have direct and practical relevance to our field.

Before introducing this group, we begin the edition with a paper from Ian James, Consultant Clinical Psychologist and Newcastle Challenging Behaviour Service Lead. Ian's prominence in supervising good quality small- and large-scale research projects for trainees at Teesside and Newcastle Clinical doctorate courses is well recognised. In this role, Ian has skilled up assistants, trainees, and nurses to become curious about psychological phenomenon and to translate their curiosity into hypotheses and research projects. In this paper, he comments on the change in tide at some universities where trainees opt for joining programmatic research that reflect the university's interests, leaving a gap in the available 'rookie' researchers who have traditionally provided time and energy to allow clinical psychologists in the field to remain research active.

Our first early career paper is, in fact, authored by a trainee who was placed with Ian and co-authored by other members of the Newcastle Challenging Behaviour Service. Daley and colleagues note the problem for older people in mental health services in having their sexual needs recognised, despite research suggesting that older people continue to find sex an important part of their lives. This research project asks important questions with minimal resources, and, in doing so, raises awareness of the need to research these issues further.

In our second paper, Fisk and Domone look at mis-scoring and score discrepancies when clinicians have used the ACE-R for cognitive screening in their department. Their results suggest need for some further training and continuing audit for accuracy.

Buckingham, Appleton and Collerton gather the perspectives of service users on their experience of the assessment process

for suspected dementia. Their data is a powerful description of the complexity inherent in receiving this devastating diagnosis and they use their findings to highlight the role of health professionals in particular in supporting the person in learning of their diagnosis.

In our fourth paper, Heath describes a grounded theory analysis of people's experience of group therapy. Heath argues that previous research has found direct links between specific therapeutic factors and outcomes but that more qualitative research is required to identify the processes that make group work therapeutic in order to encapsulate the constructs of the participants.

Mulholland gives the results of a service user satisfaction study in Tayside combining qualitative and quantitative data. The data supports the case for current good practice such as enabling people to be seen in their own homes and has led to the service reviewing its information-giving practice. The study also raises questions about why information-giving practice can differ between referrers.

In our final paper, Alexander and Evans describe a comparative study looking at the differing needs of younger and older people with dementia around diagnosis and support. This type of comparative study is essential in the on-going argument for services recognising the different needs of these two groups which is often only supported with anecdotal evidence from clinicians.

Thank you to those who have let us know details of your recent publications. This will form a regular feature in the *Newsletter* (though it will not necessarily appear every one unless you are really prolific). The intention of this page is to share with colleagues within PSIGE the fruits of your labours. Some members may have limited access to study time or materials and this can be a helpful way to guide the PSIGE community's reading, and may even lead to future collaborations.

Continued thanks to those who are sending me papers.

Louisa

PS: Don's commitments to maintaining the national profile of the PSIGE group have meant he has needed to send apologies for not being able to send us a letter this edition. In the meantime, we will keep you up-dated as always through your geographical groups.

Conducting research in clinical settings: The vital role played by trainees and assistants

Ian A. James

P AYMENT BY RESULTS may have put paid to the scientist-practitioner model that many of us have aspired to in the past. Indeed, unless one has dedicated research time specified in one's job description, one may now find it hard to convince managers of the benefits of conducting and supervising research projects. One might marvel at the folly of this managerial myopia, but we must be careful that our own disenchantment does not mean we passively accept such a situation.

This short article looks at some of the factors that have allowed me to maintain a steady research output over the last decade without funding. It also highlights the role that unqualified psychologists (trainees, assistants) have had in ensuring that clinicians like me have remained research active. It further illustrates the importance of crediting our junior colleagues for the valuable work they do, so that everyone ends-up feeling a 'research' winner.

Finally, the article raises a concern about the increasing difficulties that many of us 'jobbing' clinicians have in getting the chance to work with trainee psychologists on our 'home-grown' projects. This is in part due to reorganisations within some doctorate courses that now encourage trainees to con-duct Large-Scale Research Projects (LSRPs) within themed programmatic areas that match University tutors' expertise. The resulting problem is that many clinicians are feeling that without the excellent resources provided by a trainee their own research becomes impossible. Further, over time it seems inevitable that these clinicians will start to feel deskilled and become research 'inactive'.

Research activity

Table 1 shows a breakdown of the published research projects I have helped supervise over the last 10 years. Most of this work has been done while I have been a full-time clinician in either the Newcastle Older People's Psychology Service or a member of the Challenging Behaviour Team.

Publishing at a mean rate of six supervised projects per year has developed its own momentum and also a local reputation that attracts people who are keen to be published. In order to maintain this level of activity, any potential supervisees are always informed at the outset that an aim of our collaboration will be to conduct a project worthy of publication. This overt statement helps to set standards and clarity expectations.

It is my general policy that if a study is to be written-up for publication, all of the contributors should be authors. I think this is particularly important for the junior members of a research team because as well as helping directly in terms of their CVs, it also gives them an experience of what it takes to get published: the submission process; initial rejections; re-submissions; re-writing; patience and perseverance.

As one can see from Table 1 a lot of the published material has been undertaken with the help of trainees and assistants. The standards have been fairly high with many of them co-authoring projects in peer-reviewed journals. Also, in 32 per cent (N=12 out of 38) of the total projects, first authorship was credited to either a trainee or an assistant (see Appendix).

Table 1: Projects supervised and published during the last 10 years.

Group*	Published Studies			
	Total projects	Experimental	Reviews/ Case studies	Peer–reviewed publications
Trainee psychologist	21	13	8	14
Assistant	17	10	7	8
Nurse colleague	17	5	12	4
PhD student	5	1	4	4
	60	29	31	30

* Where there was multiple authorship, only one study has been recorded. The preferential order for accreditation is: Trainee, Assistant, Nurse colleague, PhD student. See Appendix for examples of peer-reviewed articles in which a trainee or assistant has been the first author.

Key variables: Boosters, Barriers and Brakes

Figure 1 presents some of the variables that have influenced my ability to conduct research as part of my clinical work (i.e. the boosters). At the centre of the diagram are three interlocking spheres: Motivation, Ideas, Competence. These features are labelled clinician-centred items because they reflect the attitude, knowledge and skills of the clinician undertaking the research.

Motivation: this aspect concerns the attitudinal beliefs of the clinician that influence him/her to put time aside to plan, execute, supervise and disseminate research as an extra-curricular activity. For most NHS clinicians there will be few external drivers, particularly for those of us who are not contracted to a university. Hence, the motivation may come from a desire to develop issues in a particular field, to criticise perceived injustices, to maintain or build a clinical reputation, to relieve the drudgery of clinical work, etc. Whatever the motivation(s), it is evident that along with the appropriate attitude, a deal of perseverance is required to give steel to one's drive.

Ideas: the clinical researcher needs to routinely produce appropriate ideas that can be empirically examined within the available resources. He/she also needs to be able to develop other people's ideas (e.g. those of the unqualified psycho-logists) into viable projects. Having a good 'research-eye' is a key skill in this endeavour, as it permits a particular idea or an observation to be assessed and then developed into a project. A good example of this was the work undertaken on the 'therapeutic use of dolls in dementia'. This programme of work began with observations made by a nurse colleague about a resident's use of a teddy bear (Mackenzie, Wood-Mitchell & James, 2007).

Competence: the clinician requires the skills and confidence to work with a range of methodologies, both qualitative and quantitative. Skills in statistics and report writing are obviously helpful. Further, if working with others, the ability to supervise them is a relevant skill, and an capacity to contain project-related anxieties is important; particularly when working with doctorate trainees engaged in their LSRPs.

Circling this clinician-centred core in Figure 1 are the vital ingredients of Support and Resources, which permit the research to actually happen and to progress along an appropriate path. The latter features also assist the research to move over barriers that may lie in its path. It is in these areas that the trainees and assistants have played a vital role in my work.

Figure 1: Boosters, Barriers and Brakes Model of Research.
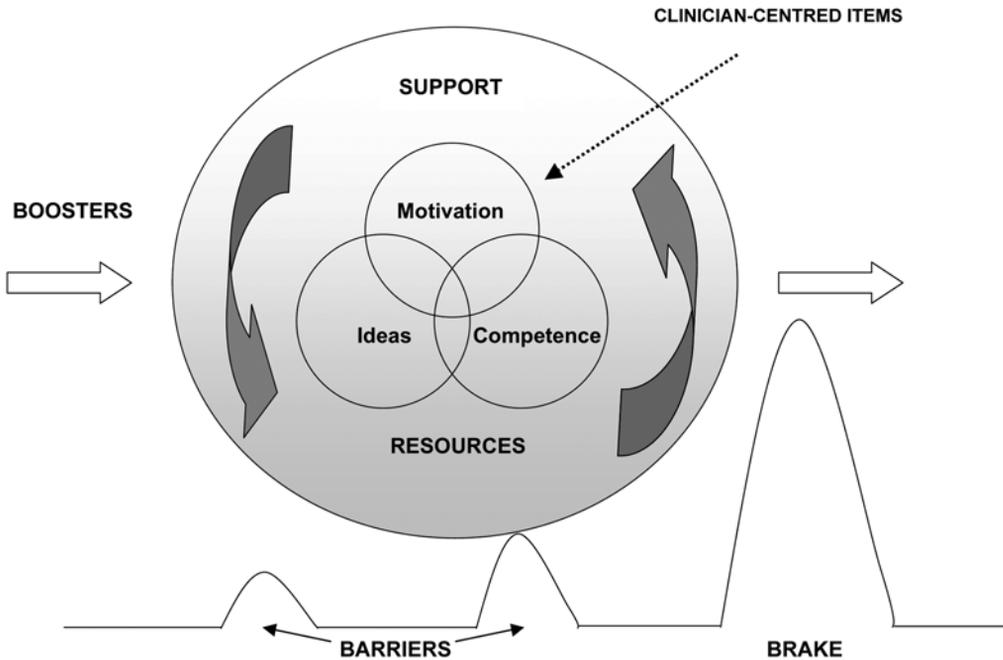
Support: when seeking to do research without a budget, the support of organisations and key people are essential. Typically, the main organisations involved are the NHS, universities, charities and the private sector (e.g. care homes). These groups often provide personnel in the form of researchers, co-supervisors and access to participants free of charge. In order to provide such assistance, the organisations and personnel usually need to feel they are getting something from participating. Examples might include: free supervision, consultancy and/or training; co-authorship; the raising of the profile of the organisation, etc.

Resources: besides funding, the most precious resources are time and energy. This is where the services of the trainees and assistants often prove extremely important. Their abilities to engage in literature reviews, to correspond with other researchers, to liaise with experts in statistics, to perform the statistics under guidance, to format questionnaires, to write protocols and drafts of papers, etc., have been critical in sustaining a regular research output.

As can be seen in Figure 1, barriers and obstacles commonly arise when conducting research, and occasionally a more serious barrier may put the 'brakes' on a study all-together. While the research activity in my department has remained at a high level, in recent years three issues have started to curtail my research output: (i) the devaluing of research by NHS managers and by potential commissioners; (ii) the difficulties of obtaining ethical approval for even the 'simplest' of studies; and (iii) the rise of programmatic research groups on doctorate courses, which has served to filter trainees away from clinicians and towards established researchers.

In the context of the changing NHS, GP consortia are unlikely to commission research as part of a purchasing package.

Thus people tendering for services are unlikely to include research and service development projects within their bids. Even if they did, the barriers introduced by some over-zealous ethics committees towards even the most basic research/audits makes many potential service-related projects unviable (particularly within the timescale required of a doctorate trainee). While both of these issues are highly influential in relation to research output, it is the rise of programmatic research groups that has posed one of the greatest threats because, unlike the other two items, it is a matter that I have no control over. The problem has arisen due to a reorganisation within some of the local universities regarding LSRPs. The preferred model of the research tutors on these courses is for their trainees to choose projects from within themed programmes of study, which match the tutors' areas of expertise. While I understand the various benefits of this system (improved supervision, development of greater expertise, continuity, better quality of projects, publications, etc.), the system creates a barrier between University and clinical placements. Indeed, the system tends to reduce the opportunities of 'jobbing' clinicians to utilse the 'support and resources' of the energetic trainees, and prevents the clinicians exploring phenomena that is clinically relevant for them. Over time I think that this system will also reduce the confidence and competence of clinicians to develop and supervise projects.

Conclusion

Over many years a symbiotic relationship has developed between qualified and unqualified psychologists with respect to research. Both groups have brought different skills and activities to the table, and overall the system has worked well. In this article, my own practice has been used to demonstrate important variables and their relationships to each other, and has provided an example of a mutually beneficial system with a high research output. However, the final section of the article strikes a word of caution about potential research barriers for jobbing psychologists, and suggests that these feature may in the future apply the brakes with respect to our abilities to undertake meaningful studies within our own settings.

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Appendix: Peer-reviewed publications by trainees and assistants
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Sexuality and older adults in care settings: Staff attitudes

Kate Daley, Elizabeth Shipley, Lorna McKenzie & Amy Wood-Mitchell

SEXUALITY is a complex and multi-dimensional concept covering the desire for sex, sexual activity, orientation, values and beliefs, in addition to a person's self-concept and self-esteem (Kaiser, 1996; Penhollow, Young & Denny, 2009). Sexuality has been linked to both psychological and physical wellbeing, and is thought to indirectly contribute to mental health, and life satisfaction (Penhollow et al., 2009). Within the older adult population, sexuality has also been shown to play a vital role, making a substantial contribution to quality of life (Penhollow et al., 2009).

Despite these findings, it appears that sexuality within an older adult population is often difficult for staff to contemplate. A recent study found only 10 per cent of older adults indicated that their health care provider had asked them about sexual behaviour or performed a sexual risk assessment (Penhollow et al., 2009). This is despite sexuality being considered by the majority of older people to be a lifelong need, and most reporting to have had physical and sexual experiences within the past year (Ginsberg, Pomerantz & Kramer-Feeley, 2005).

Society appears to have failed to consider sexual needs within the older adult population, with the National Service Framework for Older People (Department of Health, 2001) making no reference to sexuality or sexual health issues. In fact, the expression of sexuality by people in long-term care is often regarded as problematic, and seldom as a positive aspect of a person's life. This may be particularly pertinent in those with dementia, with one study finding 54 per cent of patients with severe dementia displayed what was deemed 'inappropriate sexual behaviour' (Alagiakrishnan, 2005).

Physical health, social environment, and staff attitude, are frequently cited as barriers to the recognition of sexual needs in an older adult population (Béphage, 2008). Physical conditions may make the expression of sexuality more difficult, and a lack of partner or privacy in care homes are also likely to play a role (Ginsberg et al., 2005). In addition, there may be patient reluctance (Andrews & Piterman, 2007), with older people finding it difficult to discuss their sexual needs, having been brought up in an era where sex was taboo. Care staff may also avoid discussing these issues, many perceiving older patients to be less sexual due to their physical and psychological dependency (Bouman, 2007). There appears a common misperception that sexual activity ceases after middle age (Hodson, 1994), with societal stereotypes leading to an underestimation of the sexuality issues in older adults (Andrews & Piterman, 2007).

This study aimed to investigate the attitudes of mental health professionals working in a local older adult in-patient service, looking at whether sexuality is considered by staff, and how comfortable and confident they feel in addressing such issues with their patients.

Method

Questionnaires were administered to 28 staff working into a local older adult mental health service; this included registered mental health nurses, community psychiatric nurses, and nursing and occupational therapy students. This asked questions

around sexuality in older adults, in terms of their attitudes and experience.

Case notes for all patients residing on two older adult mental health in-patient wards were also audited, which included a total of 38 case files. Case notes contain an initial assessment that is completed for all in-patients on admission, this is completed routinely and contains a section entitled 'expressing sexuality'.

Results

Participants were initially asked whether sexuality was an issue they would address in their assessments with a patient, to which only eight people (29 per cent) responded that they would. Participants were then asked what they would record on an assessment form with a section entitled 'sexuality'. A summary of the themes are detailed in Table 1.

Case notes from all patients on the in-patient units were then audited to examine the type of information that was recorded under the 'sexuality' section within the patient files. The themes gathered from this audit are detailed in Table 2.

Less than a third of staff reported that they would address sexuality in an assessment with older patients, and only half of the patient sample had something recorded in the sexuality section of their notes. Although staff identified that they would be most likely to record themes such as sexual orientation, gender and sexual activity; in practice, clothing, marital status and physical appearance were most frequently cited.

Table 1: Themes given by participants to the question 'What would you record in the sexuality section of older adults' in-patient notes?' (*N*=28)

|	Number of responses
Sexual orientation	8
Gender	7
Sexual activity	7
Marital status	4
Relationships	4
Clothing	4
Attitudes towards sex	4
Sexual consent	2
Reactions to the opposite sex (patients)	2
Reactions to male/female carers	2
Nothing	2
Sexual behaviour	1
Sexual problems	1
Appearance	1
Sexual history	1
Defining masculinity/femininity	1
Libido	1

Table 2: Themes recorded in the 'expressing sexuality' section of the older adults' in-patient notes. (*N*=38)

	Number of responses
Not completed	19
Clothing	8
Marital status	6
Physical appearance	4
Reactions towards staff	3
Has children	2
No apparent difficulties	2
Attitudes towards personal care	2
Sexual orientation	1
Social life	1

Despite only a few staff noting that they would address sexuality issues with their patients, most were able to identify instances when they had experienced problems of a sexual nature from clients. Themes of which are illustrated in Table 3.

Table 3: Responses to the question 'Have you experienced any problems of a sexual nature from clients?'
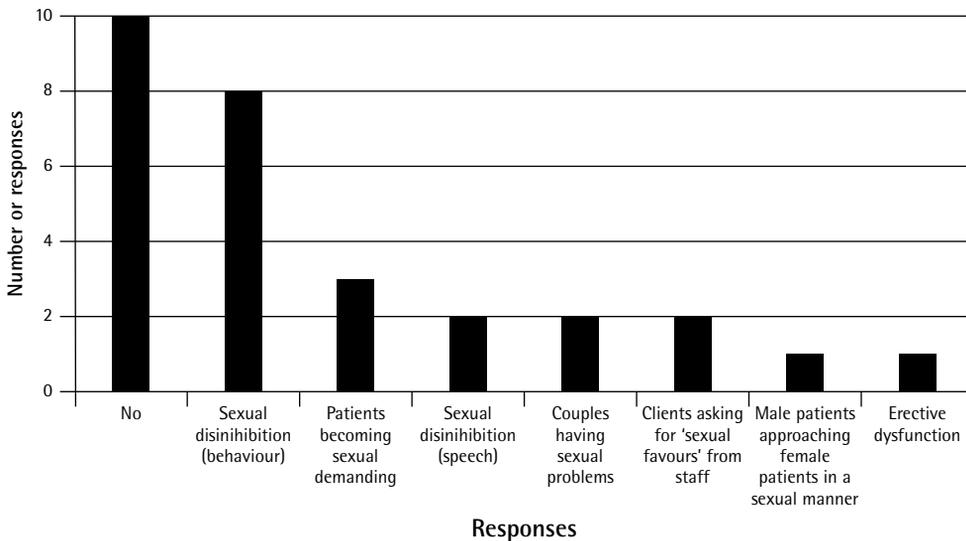
Staff were also asked how comfortable they would feel discussing issues surrounding sexuality with their patients, rating this on a scale of 1 to 7 (Very uncomfortable to Very comfortable). Staff were found to range in their level of comfort, with only two feeling very comfortable discussing sexuality with patients. Findings are detailed in Table 4.

Table 4: Responses to the question 'How comfortable would you feel discussing issues surrounding sexuality with your clients?'
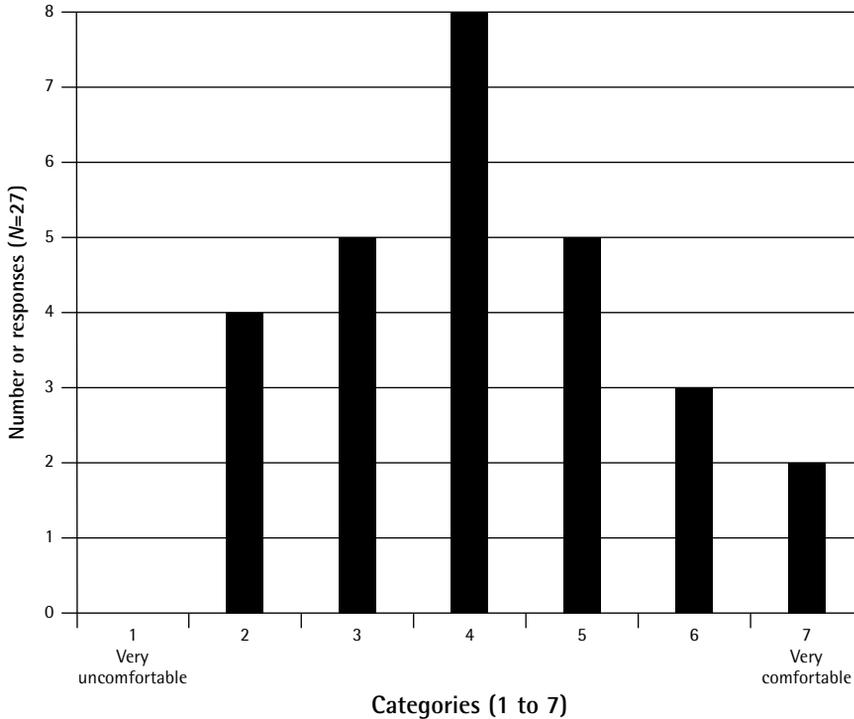
Participants were then asked how competent they would feel assessing issues to do with sexuality; again this was rated on a scale of 1 to 7 (Very incompetent to Very competent). Again, there was a range of perceived competence expressed, with few feeling competent in this area. Findings are illustrated in Table 5.

In terms of training and guidelines, only one person (four per cent) reported having received training in addressing issues of sexuality in older adults, and only two (seven per cent) were aware of any guidelines surrounding sexuality when caring for this population. This lack of training may impact significantly on levels of competence and confidence, impairing the ability of staff to broach this subject with their patients.

Table 5: Responses to the question 'How competent would you feel assessing issues to do with sexuality?'
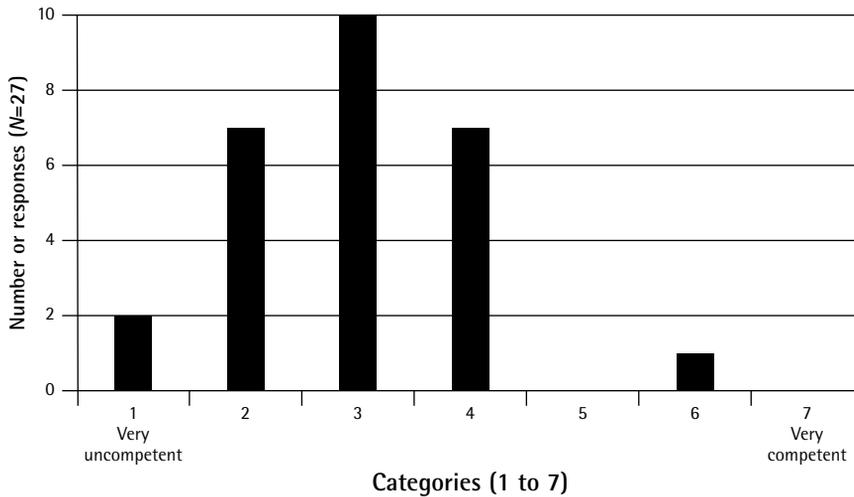
Discussion

The aim of this study was to investigate the attitudes of mental health professionals working in older adult in-patient service, looking at whether sexuality is something they consider, and how comfortable and confident they feel in doing so. The study found less than a third of staff currently address sexuality issues with their patients, with few feeling competent in this area. Staff had received minimal training on this topic, despite many experiencing problems of a sexual nature from their patients.

It was positive that staff were able to cite themes such as sexual orientation and sexual activity as relevant things to record in terms of patient sexuality, however, in practice only half of the case notes had anything recorded in this section, with type of clothing and marital status appearing most frequently. This would suggest that the sexual needs of this group are often not being acknowledged within the in-patient setting, with a restricted definition of 'sexuality' being employed.

The failure to acknowledge such issues may be a reflection of the attitudes and beliefs held by care staff or the wider team. Comments such as 'I didn't think they would

have sexual needs' and 'I didn't even think they would think about it' were prevalent. This is consistent with the literature and confirmed a general lack of awareness around sexuality issues within an older adult population. This finding may, however, also reflect the assessment being completed within the first two days of hospital admission; staff perhaps did not feel they had built enough rapport to ask what they perceive to be sensitive questions. In addition, family members are often present during the assessment, which may effect how much both staff and patient discuss at this stage.

Society often views sexuality to be something of the young, many seeing older adults as asexual (Pangman & Seguire, 2000); it is likely that a lack of awareness, training, documentation and government policy will only serve to reinforce such beliefs. It is worth noting that as we move to a paperless system (on our case RIO), the sexuality section is no longer included, highlighting this as a systemic issue, and not just a ward oversight. Low et al. (2005) suggests staff awareness should be raised through education and training, there should be a tolerant environment for sexual expression, and research

conducted to conceptualise the meaning of sexuality from an older persons' perspective. In addition, policy should be examined in light of research evidence.

These findings are particularly relevant in dementia care. Of the case files audited, 55 per cent of patients had a diagnosis of dementia. Those with dementia are noted to become more sexually disinhibited as their cognitive deficits progress (Alagiakrishnan, 2005), and within this study, the majority of staff cited this as the biggest problem they encounter when working with this group. Sexuality has been cited as a significant cause of challenging behaviour in older adults (Alagiakrishnan, 2005), with sexual behaviour often being construed as a behaviour problem rather than expression of love and intimacy (Miles & Parker, 1999). Increasing staff awareness is likely to allow sexuality and sexual needs to be explored, leading to suitable interventions implemented.

There were some limitations of this study. In terms of sampling, it would have been useful to administer the questionnaire to other groups of staff, including those working directly with older adults on in-patient wards and also members of the general public, to get a wider response. It would also be useful to sample other older adult in-patient wards to see whether there are cultural biases, as the current study was limited by this. In addition, by carrying out the questionnaire in a group environment with colleagues, staff may have given desirable responses which would have created some response bias. Future studies may sample participants using an interview format in order to gain richer information, however, due to limited resources and time constraints of the current study this was not possible.

Conclusion
Further staff training and psycho-education is needed to help ensure that sexuality does not continue to be an overlooked aspect of older adults care. It is crucial that belief and attitudes are addressed alongside the physical aspects of care, with the aim of promoting quality of life within this population.

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An audit of scoring practice in the Addenbrooke's Cognitive Examination (Revised) practice within a Memory Assessment Service

Laura Fisk & Rachel Domone

An audit of scoring accuracy for a routinely-used cognitive screen for dementia by staff in a Memory Assessment Service in East Lancashire found low levels of errors, but evidence that adjustments to guidelines and further training could improve scoring accuracy.

THE ADVENT of treatments for cognitive decline in dementia and the rapid increase in the number of memory clinics (Mathuranath et al., 2000) has created a need for a quick and simple but accurate measure of cognitive functioning. Various tools including the CamCog (Roth et al., 1986) and the Addenbrooke's Cognitive Examination (Revised) (ACE-R; Mioshi et al., 2006) have demonstrated potential to fulfil this role. After consideration of appropriate options, Lancashire Care NHS Foundation Trust has adopted the ACE-R as the measure of choice across all of its Memory Assessment Services.

The ACE and its revised version (ACE-R: Mioshi et al., 2006), are brief cognitive assessment tools used in the detection of dementia in a clinical population. It proposes some ability to classify a profile as more typical of a fronto-temporal dementia (FTD) or of Alzheimer's disease. The Addenbrooke's Examinations incorporate the older, shorter Mini-Mental State Examination (MMSE: Folstein, Folstein & McHugh, 1975). The MMSE has long demonstrated popularity among clinicians, and is referenced in the National Institute for Clinical Excellence (NICE) guidance for determining appropriateness of 'cognitive enhancing' medications (NICE, 2001). However, the MMSE has been found to have serious limitations (Mathuranath et al.,

2000) such as insensitivity to impairments in executive functioning and visuospatial ability (e.g. Naugle & Kawczak, 1989). Crucially, some assessment has been made of inter-rater reliability for the MMSE, which showed significant differences in scoring practice (Davey & Jamieson, 2004). It was for this reason that the ACE was originally developed (Mathuranath et al., 2000).

The Addenbrooke's Examinations build on previous attempts to increase the clinical efficacy of the MMSE for dementia screening. Additional items have been incorporated, creating a total of 100 available points. However, the examination is still intended to function as a relatively quick 'bedside' instrument (Bak & Mioshi, 2007). The ACE was shown to have good internal reliability, with a Cronbach's alpha value for internal consistency at 0.78, where 0.7 is considered good (Mathuranath et al., 2000). For the ACE-R, the alpha coefficient was 0.80; no measure of test – retest reliability was reported. Thus, in development, the ACE and ACE-R were shown to be strong candidates for an effective cognitive screen for dementia. However, the authors of the ACE-R note that, although developed in a 'real-life' clinic, the normative sample was biased towards younger clients with FTD attending a university-based clinic (Mioshi et al., 2006).

A specific problem for cognitive assessment in everyday clinical settings is that a large

team of staff may be involved, commonly administering cognitive screens without appropriate training or supervision. This can lead to variation in administrative procedures and deviance from given scoring criteria. The ACE and ACE-R have been subject to audit in everyday clinical settings (e.g. Larner, 2005, 2007), although the focus was on evaluating cut-offs for impairment rather than as an evaluation of clinical practice.

The consistent and accurate scoring of cognitive assessments is crucial in clinical settings, especially where results are used to aid diagnosis, yet there appears to be minimal extant literature that has assessed clinicians' use of these tests in everyday practice. In Lancashire Care, all appropriate staff must undergo training in the administration and scoring of the ACE-R, but the 'success' of this in terms of the resulting accuracy of staff members scoring had not been established. Consequently, the aim of the present study was to conduct a small-scale audit of the accuracy with which ACE-R assessments are scored by members of a multi-disciplinary memory assessment service.

Method

A sample of ACE-Rs (*N*=40) from a list of clients seen by the consultant psychiatrist since the official opening of the East Lancashire Memory Assessment Service (*N*=320) were randomly selected, in subsamples for each member of the team.

Two copies of each original ACE-R were made. One set was retained for later use and the other set was anonymised. Re-scoring was conducted by the assistant psychologist in the team, using strict adherence to the published scoring criteria. To avoid any bias created by recall of the original scores, a week was left before commencement of re-scoring. Four tests were unavailable for analysis. Re-scoring was conducted by an assistant psychologist new to the team and who had Masters' level of education in psychology.

The data from the re-scoring were entered into a Microsoft Excel database. The original scores were subsequently entered.

The main part of the audit consisted of a comparison between scores given in 'original' scoring by staff and the 're-score'; differences between these scores are henceforth called 'discrepancies'.

Results

Sample Characteristics

Three staff groups were represented: Registered Mental Health Nurses (RMNs: *N*=6), Occupational Therapists (OTs: *N*=4), and Assistant Practitioners (APs: *N*=1). All staff had undergone initial training, delivered by a clinical psychologist, in the administration and scoring of the ACE-R. 23 ACE-Rs were analysed for the RMNs, 13 for OTs and four for APs. Slightly fewer ACE-Rs were gained for the OT staff group relative to the other groups because it was only possible to gain three tests for three staff members.

Errors in summing

A total of 12 errors were made in summing scores of the subscales and the overall total. Seven errors arose due to inconsistencies in the way marks were recorded. Five errors were made in summing MMSE scores.

Discrepancies

This is the proxy measure for the 'accuracy' with which ACE-Rs were scored. In total, 63 questions were subject to discrepancies across 40 tests, constituting an average of 1.6 marks difference for each individual test, reflecting 6.6 per cent of the total number of questions for which scores were given across the 40 ACE-Rs. For 143 questions, the lack of information given meant that an effective rescore could not be completed. Consequently, there is a possibility this is an underestimation of discrepant scores.

Discrepancies according to cognitive domain

In the ACE-R, the scores of individual questions are summed to give a value for each 'cognitive domain' or subscale. There are five domains, each contributed to by a different number of questions and offering different total available scores: attention and orienta-

tion has four questions and 18 available marks; memory has 26 marks over five questions; fluency has 14 over two; language has 26 over 10, and visuospatial has 16 over five.

The highest number of discrepancies was found for the visuospatial domain (N=19); the fewest for memory (N=7). To at least some degree, the re-score of the tests provided a different distribution of scores, i.e. a difference in the 'cognitive profile', in 18 instances. The client would have been re-scored as above cut-off on some domains (N=2; both fluency), or below cut-off in others (N=3; twice for attention and orientation and once for memory). Other changes were more subtle, for example, bringing a profile closer to cut-offs or emphasising strengths in a domain.

Discussion

The purpose of this audit was to evaluate the accuracy with which memory assessment service staff score the ACE-R, a brief cognitive screening tool. Results can help to improve staff performance in scoring ACE-Rs by providing insight into the areas resulting in the greatest discrepancy from scoring criteria. The results can also act as a baseline against which to compare rates of accuracy of future scoring, following any changes in the training offered, for example.

Two main areas for focus are indicated by the results: errors in summing and 'true' discrepancies in which opinions differed about appropriate scores for different items. Slightly different approaches will be required to minimise scoring errors for each area.

The 12 summing errors made over a total of 40 tests represent only 4.3 per cent of the 280 sums that were required in this sample. Thus, it would appear that the accuracy of testers' summing is actually quite high. However, suggestions can be made for improving accuracy even further; for example, by involving another person in double-checking calculations or by re-scoring every test.

The key area of interest for the audit was the rate of discrepancies between scores given by the original tester and by the re-scorer. Overall, there were generally only small differences between original and re-test scores, so although discrepant scores occurred over a number of items, the impact on actual scores for individual questions was relatively small. Again, however, the fact that changes in subscale interpretation (i.e. above or below cut-off) could emerge in response to only small discrepancies indicates that efforts to improve accuracy are warranted.

The audit provides information about staff difficulties at individual question level. For a single question, the highest total number of discrepant scores was found to be nine, for clock drawing. This was closely followed by letter fluency (eight marks difference), naming pictures of animals and objects (seven marks difference) and cube drawing (seven marks difference). For example, on the clock drawing item, judgements must be made regarding how evenly spaced the numbers are, and the relative length of the hands. Similarly, for other items, misunderstanding of, or very severe interpretations of the guidelines seem likely to have been the main factor in discrepant scores. Intuitively, it might be expected that the visuospatial domain (to which both cube and clock drawing belong) would be subject to greater variation between staff members' scoring as it requires most judgement and interpretation from the scorer. This is reflected in the fact that the visuospatial domain was subject to the greatest number of discrepancies. The fluency domain also created a high number of errors. As this is often interpreted as the main indication of executive functioning ability, scoring errors here have important clinical significance. While recognising the limitations in scoring detail that can reasonably be expected from a screening tool, clearer guidelines and further examples may be warranted.

Results of this audit indicate that relatively few discrepancies in ACE-R scoring can result in inaccurate interpretations of a client's performance, particularly in relation to the cut-offs for individual subscales.

As these ultimately contribute to clinical diagnosis, it is crucial that services strive to ensure accuracy of scoring practices. This audit has suggested that greater attention should be given to the use and design of the scoring guideline and possibly the training currently offered by the clinical psychology team. Further clarification is required when scoring visuospatial items in particular, but also when scoring fluency items and relating them to the scaled scores on the response sheet. The findings and recommendations from this audit have been incorporated into the 'refresher' ACE-R training, which is undertaken by all staff administering the ACE-R on a regular basis. Further research will be required to evaluate the impact of these adjustments. The authors are also mindful that this audit focused on the scoring of the ACE-R. Whilst accurate and person-centred administration of the ACE-R is emphasised in the training provided, this was not evaluated in the current study. Arguably, the quality of the administration of the ACE-R can have even greater impact on the performance of the client and consequently, the scores given, and is therefore, worthy of further attention.

Overall, it can be concluded that staff in the Memory Assessment Service are generally accurate in scoring ACE-Rs. However, continued attention to best practice in the administration and scoring of cognitive tools should be an ongoing focus for quality memory services.

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'I think they mostly tell you, don't they?': The perspectives of people with dementia on the process of diagnostic assessment

Jocelyn Buckingham, Claire Appleton & Daniel Collerton

Disclosure of a dementia diagnosis
The disclosure of a dementia diagnosis has been recognised as a major psychosocial intervention (Vernooij-Dassen et al., 2006). A systematic review of disclosure in dementia (Bamford et al., 2004) found evidence of both positive and negative psychological consequences of disclosure.

Pratt and Wilkinson (2003) have proposed a psychosocial model of understanding the experience of receiving a diagnosis of dementia. The model has two axes: the individual's desire and ability to know their diagnosis, and the social context. The latter axis emphasises the importance of aspects such as social stigma, social support and the practice of health professionals in adjustment to a dementia diagnosis. The model proposes that an individual's experience is a function of the combined effect of their desire and ability to know the diagnosis and their social context.

A recent report by the National Audit Office (2007) has identified that there is scope for improving the process of disclosing diagnoses of dementia, in particular, communication around the diagnosis, and the support and information offered by professionals.

Diagnostic assessment for dementia and informed consent
The ethical issues related to gaining informed consent for diagnostic assessment for dementia, including neuropsychological testing, have been the subject of increasing professional debate (e.g. Kapp, 2006; Williams, 2002, 2004; Woods & Pratt, 2005). Kapp (2006) argues that the principle of informed consent applies to diagnosis and assessment in the area of dementia as well as therapy, intervention and research. This is supported by the British Psychological Society (BPS, 1995). Valid consent is a key priority for implementation in the National Institute for Health and Clinical Excellence (NICE) guidelines on dementia (NICE, 2006). Valid informed consent has three elements: the person's decision-making must be voluntary, informed and competent (Department of Health, 2001; Kapp, 2006). The National Academy for Neuropsychology in the US has identified that informed consent procedures should involve: '(a) an explanation of the nature and purpose of the assessment; (b) fees; (c) involvement of third parties; and (d) limits of confidentiality. The patient/client should also be provided with sufficient opportunity to ask questions and receive answers' (Johnson-Greene, 2005, p.336). Pre-diagnostic counselling, or informational care provided prior to a diagnostic assessment for dementia, such as neuropsychological testing, is also seen as good practice (Williams, 2002, 2004). This might include: a description of the possible diagnoses that could be the outcome of the assessment, for example, Alzheimer's disease or vascular dementia; an explanation of the advantages and disadvantages of completing the assessment, for example, the implications the results might have for driving; and, a discussion about the client's preferences for being told the test results and diagnosis (Williams, 2002, 2004).

Background to the project and aims

Neuropsychological testing – as part of the process of multi-disciplinary diagnostic assessment for dementia – is a service that is provided in Gateshead by the Department of Clinical Psychology for Older Adults at Bensham Hospital.

There was recognition from clinicians within the department that individual practices varied with regard to informed consent procedures and informational care, and that best practice had not been agreed upon, despite increasing professional literature on the subject. In particular, it was identified that the perspectives of service users on this aspect of the service were largely unknown.

The overall aim of the project was to improve the process of gaining informed consent for neuropsychological assessment, and the provision of pre-diagnostic informational care, for service users with suspected dementia, by developing informed consent procedures. This article will focus on one of the main objectives of the project: to gather the perspectives of service users on their experience of the process of assessment for suspected dementia, in order to inform the development of informed consent procedures.

Method

Participants

Six members of a local Living with Dementia (LwD) Group participated in the project. The sample comprised four males and two females. The mean age of the participants was 73 years, with a range between 56 and 85 years. The diagnostic category composition was: 66.7 per cent Alzheimer's disease; 16.7 per cent mixed Alzheimer's disease/vascular dementia; 16.7 per cent dementia with Lewy bodies. This sample was chosen because all participants had been assessed for, and diagnosed with, dementia, and told this diagnosis.

Measures

The project used a focus group with semi-structured interview questions to elicit the participants' own experience of being assessed for suspected dementia, and to identify factors that they considered important elements of health care during this process. Of particular interest were their perspectives on informed consent procedures during diagnostic assessment.

Focus groups have been recognised as one effective qualitative method of understanding health service users experiences (Kitzinger, 1995), and, in particular, one way of involving people with dementia in meaningful consultation about health services (Alzheimer's Disease International, 2003, April; Bamford & Bruce, 2002; Care Services Improvement Partnership, 2007).

The focus group questions were based upon the psychosocial model of understanding the experience of receiving a dementia diagnosis (Pratt & Wilkinson, 2003), and also from the professional literature on good practice for informed consent procedures (adapted from BPS Division of Clinical Psychology Professional Practice Guidelines (1995), Johnson-Greene (2005) and Williams (2002, 2004)).

Ethical considerations and recruitment

The project was registered with the Research and Clinical Effectiveness Department of Northumberland, Tyne and Wear NHS Trust, as service development work. Permission to approach participants was given by staff at the local branch of the Alzheimer's Society, which hosts the LwD Group from which participants were recruited.

In order to ensure that participants' consent to take part was informed and voluntary, information on the nature and purpose of the focus group was provided on two occasions and members were facilitated to discuss their participation by Alzheimer's Society staff who were independent of the project team. The LwD Group is designed for people who are in the early stages of dementia and, therefore, the members were deemed to be capable of giving informed consent.

Procedure

Two members of the project team attended a regular meeting of the LwD Group to conduct the focus group. This was held at the usual location of the LwD Group to make the situation more comfortable (McKillop & Wilkinson, 2004). Two members of staff who ran the LwD Group also attended to provide a sense of familiarity and reduce anxiety (Bamford & Bruce, 2002).

Participants were given a topic guide in order to facilitate them following the discussion (Bamford & Bruce, 2002). This was also written-up on a flipchart. Participants were given a 15-minute break half-way through the discussion. The focus group lasted approximately 75 minutes. The focus group was recorded and one member of the project team took notes to support data analysis.

Analyses

The transcript of the focus group was qualitatively analysed using the method of thematic analysis described by Braun and Clarke (2006). Thematic analysis involves 'identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail' (Braun & Clarke, 2006, p.79). This method is widely used within the field of psychology (e.g. Frith & Gleeson, 2004), and has the advantage that it is useful for producing results suitable for informing policy development (Braun & Clarke, 2006). The analysis was conducted to provide a thematic description of the whole data set, took an inductive approach, and themes were identified at the semantic (rather than latent) level.

Results

Four themes were derived from the focus group data:

1. Recognising problems is difficult;
2. Individual processes of adjustment;
3. Other people; and,
4. Trust in health professionals.

Each of these themes included a number of sub-themes. See Figure 1 for the Thematic Map.

Theme 1: Recognising problems is difficult

This theme describes the difficulties (particularly psychological, but also social and practical) that the participants had in recognising their symptoms of dementia, obtaining a diagnosis of dementia, and accepting this diagnosis. The theme comprises four sub-themes.

Feeling that something is wrong

A number of participants described a process of realising that something was wrong cognitively but being unable to identify the problem, leading them to seek help from health professionals.

'Last year, the early part of last year I just knew there was something wrong with me. I couldn't put my finger on it, and and I went to see my GP'.

Others first recognise problems

Some participants described how others first pointed out to them that they were experiencing cognitive problems, and how this was very difficult to take in.

'He (husband) sat us down, and he says 'You do realise' he says, 'What's wrong with you, don't you?' I says 'Well, there's nothing wrong with us.''

*Dissatisfaction with assessment process*

A number of participants described how obtaining a dementia diagnosis involved disagreements with health professionals, lengthy waiting times, and being seen by a number of professionals. This was felt to have had a negative emotional impact.

'I went to see him (GP) and he didn't agree with me that, that I had anything wrong with me…the early stage there I went through quite a bit.'

Difficulty accepting the diagnosis

Participants described how they did not consider themselves as identified with the characteristics of dementia or thought their cognitive problems were similar to those of other people, and could not accept the diagnosis at first.

Figure 1: Thematic Map.
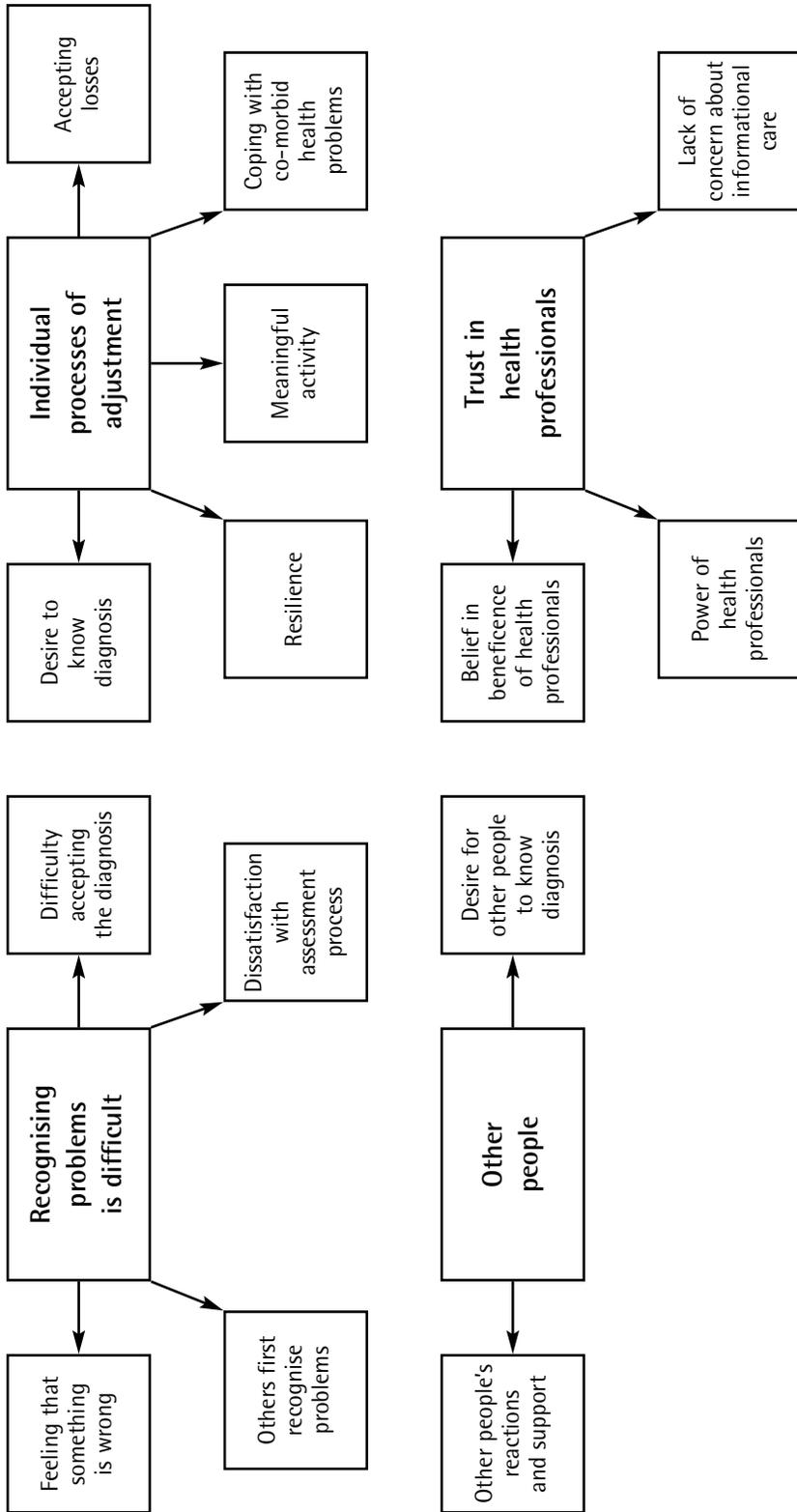
'I mean I'm as fit as a lop in here, you know, but when people try to talk to us like that (about dementia), you know, I think what the hell's the matter with them, there's something the matter with them, 'cause it's not me, it cannot be me because I'm not stupid.'

Theme 2: Individual processes of adjustment
This theme describes the different individual factors that impact both positively and negatively on participants' adjustment to a dementia diagnosis. The theme comprises five sub-themes.

Desire to know diagnosis
The majority of participants reported that they had wanted to know their diagnosis and believed that other people would too, although there was some recognition that people's preferences might vary with regard to this.
'Different people are different ways, you know. I'm sure. They told me I was ill, or whatever, I'd rather know.'

Resilience
Participants described a resilient attitude to coping with dementia and their difficulties, which involved not letting dementia stop them from living and taking things as they are.
'I don't worry about things, I just take things as they are.'

Meaningful activity
The majority of participants described continuing to engage in activities of daily living and pursuing other interests, including trying new experiences.
'Everything I did before this happened I still do it. I probably do it a bit more. Instead of having one, of getting one pint I have two.'

Coping with co-morbid health problems
Participants described how a combination of co-morbid physical health problems and dementia made it a lot harder to cope.
'Me eyes are shot to pieces. You know that's bad enough without this (dementia).'

Accepting losses
Participants identified losses that accompanied the condition, which they had had to accept. The most prevalent of these was giving up driving, and many people described this as a significant loss.
'What I hate is not being able to drive a car again.'

Theme 3: Other people
This theme describes the elements of participants' social context that influence their adjustment to living with dementia. The theme comprises two sub-themes.

Other people's reactions and support
Participants described both positive and negative reactions to their disclosure of a dementia diagnosis, and varying levels of support from family, friends, acquaintances and health professionals. Levels of continuing support from health professionals varied although the majority were satisfied with the help they had received. A prevalent response was that the LwD Group – both staff and members – was one of the most helpful sources of social support. The social stigma attached to dementia was also a significant meaning.
'Mind, a lot of my friends tend to, well some of them, tend to give me a wide berth. I think they don't know what to say.'

Desire for other people to know diagnosis
Participants described differences in whether or not they had told family, friends and acquaintances about having dementia.
'I thought well I'm not saying anything (about diagnosis), you know, because I mean it's got nothing to do with them'.'
'I've told just about everybody I know.'

Theme 4: Trust in health professionals
This theme describes the trusting attitude that participants had towards health professionals and services. The theme comprises three sub-themes.

Belief in beneficence of health professionals
A number of participants described their belief that health professionals act in a person's best interests and, in particular, provide information about assessment and diagnosis.
'I think they mostly tell you (diagnosis), don't they?'

Power of health professionals
A number of participants described how they would not question the decisions of health professionals.
'I wouldn't challenge them (health professionals) on anything.'

Lack of concern about informational care
Participants expressed few opinions on information provided by health services. A number of participants described indifference towards what pre-diagnostic information should be provided or said that they had not considered this matter.
'What do you think about people being given information about the advantages and disadvantages of taking part in the assessment?' 'I don't think it would bother me actually.'

Discussion
Summary and discussion of findings
The findings from the thematic analysis describe participants' experience of the process of recognising symptoms, undergoing assessment for suspected dementia, and adjusting to a diagnosis within a social context that includes ongoing relationships with health professionals. The four themes – 'Recognising problems is difficult', 'Individual processes of adjustment', 'Other people', and 'Trust in health professionals' – are largely consistent with previous empirical evidence on understanding the disclosure of a dementia diagnosis (e.g. Pratt & Wilkinson, 2001; Robinson, Clare & Evans, 2005) and, in particular, Pratt and Wilkinson's (2003) psychosocial model. However, the findings also provide new insights into the specific role of health care practices during diagnostic assessment beyond that of the power of health professionals to withhold a diagnosis of dementia (Bamford et al., 2004; Pratt & Wilkinson, 2003). These will be explored further.

Previous research has emphasised that the majority of people experience a gradual process of noticing difficulties themselves (e.g. Pratt & Wilkinson, 2003; Robinson et al., 2005), which is consistent with the sub-theme 'Feeling that something is wrong'. However, the sub-theme 'Others first recognise problems' suggests that when gaining informed consent health professionals should consider that some people using services may not have noticed or admitted to themselves symptoms, and may be on a different stage of the 'journey' (Pratt & Wilkinson, 2001, p.26) towards adjustment to a dementia diagnosis.

The sub-theme 'Coping with co-morbid health problems' suggests that physical health problems may be a priority for people with suspected dementia, and, therefore, health professionals should consider this during assessment and avoid a diagnostic overshadowing bias.

The theme 'Trust in health professionals' develops our understanding of the relationship between health professionals and people with dementia identified by Pratt and Wilkinson's (2003) psychosocial model. The sub-themes 'Power of health professionals' and 'Lack of concern about informational care' have important implications for clinical practice involving informed consent procedures as they identify the power of health professionals during the assessment process even where services were dissatisfactory, and suggest that information and choice are not prioritised by (some) people with dementia. This implication for the wider process of assessment for suspected dementia will be discussed further.

Clinical implications and limitations
One of the wider clinical implications of the findings of the focus group is that factors important for clients' positive experience of

assessment for suspected dementia may not be elements associated with informed consent (voluntary decision-making, information, choice) within a traditional medical model of consent to intervention. Instead, psychosocial features of the assessment environment may be significant, such as feeling listened to about difficulties by health professionals, having co-morbid physical health problems acknowledged and cared for, and reducing stigma and increasing social support during and after the diagnostic process. Maximising adjustment to a dementia diagnosis may be as important a service-process outcome as gaining informed consent.

However, it is important to examine alternative interpretations of these findings. The concern for psychosocial factors over informational care amongst the focus group may be the result of some members' difficulties understanding the somewhat abstract concept of informed consent, and their memory problems limiting discussion to concrete experiences of the assessment process and feelings about this rather than exploring possible alternatives to the service they received. It is also important to consider that the sample were a very selective and small group of users of services for assessment for suspected dementia.

The participants in the current project might also be expected to have adjusted to the diagnosis better than the wider population of people with dementia given that they have chosen to attend a LwD Group, which is designed to support this process. As such these findings may not generalise to other users of dementia services.

Conclusion

The aim of this project was to improve the process of gaining informed consent for neuropsychological assessment, and the provision of pre-diagnostic informational care, with service users with suspected dementia. The findings suggested that maximising adjustment through considering psychosocial factors during neuropsychological assessment may be as important a service-process outcome as gaining informed consent.

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A process of counteracting forces: A grounded theory investigation of group therapy with older adults

Julia Heath

There is a scarcity of research into group therapy with older adults that explores participants' experiences and underlying processes. This study aimed to investigate and explore participants' experiences of group therapy and the processes occurring, with a view to producing a localised theory. A grounded theory methodology was used and semi-structured interviews were conducted with eight older adults who had previously participated in group therapy. The data were subjected to grounded theory analysis that produced a core category of 'Counteracting Forces'. Within this, the three main sub-categories were Group Process, Individual Process, and Societal Process. For each process a counteracting force is believed to operate. Overall the findings add new insight by incorporating participants' outside experiences into the group processes, highlighting how group processes lead to individual change and specifically focusing on emotions. By incorporating societal processes, the findings are also given a contextual basis.
Keywords: older adults; group processes; grounded theory.

THE EXPLORATION and understanding of group processes is important because it contributes to our understanding of why group therapy is efficacious. There are significant clinical implications in identifying the processes that make group work therapeutic, as research has found a direct link between therapeutic factors and outcomes (Castonguay et al., 1996; Corey & Corey, 2002; Oei & Browne, 2006). The group process can be considered comparable to the relationship in individual therapy, which has been found to be the best predictor of outcome (Mearns & Cooper, 2005).

To date, there has been very little research specifically on the processes in group therapy with older adults (people aged 65 years and above). Research on group effectiveness with older adults by Thomas and Martin (1992) highlighted three areas of therapeutic processes. They proposed that groups provided opportunities for restoring and maintaining meaningful social interaction. Secondly groups provide increased opportunity for intimacy and friendships. Finally they offer support for sharing common losses, concerns and experiences.

Existential group therapy with older adults was explored by Garrow and Walker (2001). They found that the group provided a sense of community and belonging, which helped participants to develop new ways of coping. Similar findings by Weiss (1994) found that therapy groups in a long-term care setting provided participants with a sense of meaning and purpose.

The research above has originated from researchers' observations of these groups, or by the participants using quantitative measures. Arguably, what is missing from the literature is an account of what is occurring in the group which originates from the participant's perspective. Thus, this research will hopefully re-address the imbalance by asking: What processes in group therapy with older adults lead to change? The research aims to use the participants accounts to develop a localised theory of the experiences of older adults in group therapy, as a previously constructed theory was absent from the literature.

Method

Participants

Prior to recruitment, ethical approval for the research was obtained from and NHS research ethics committee. The participants were people over the age of 65 who had attended group psychotherapy within the last three months and had attended at least half of the sessions. They were recruited from a Community Mental Health Team by a clinical psychologist who also conducted an initial screening. Overall 28 people were asked to participate, out of which eight agreed to be interviewed. The participants were from three eight-week groups, two which used Cognitive Behavioural Therapy (CBT) and one which used Narrative Therapy (NT). See Table 1 for characteristics of the sample. All the participants were female, and their ages ranged from 69 to 83 (Mean age=75.4). They were all white and all but one was British. Pseudonyms have been used.

Interview schedule

Following theoretical sampling (Charmaz, 2006), the schedules were subjected to two amendments through the data collection process. The first included a question regarding connecting to others in the group. The second focused on understanding how the experience of the group changes over time, and how individuals changed as a result of being in the group.

Analysis

The grounded theory method of Charmaz (2006) was employed to analyse the data. For each transcript the process of 'Initial Coding' was conducted whereby codes were generated which describe the data. A process of 'Focused Coding' was employed which developed more conceptual codes. A further three interviews were conducted, and the coding processes repeated. From the six interviews, 'Axial Coding' was employed, whereby the initial codes were combined and linked. A further interview was conducted, with seven transcripts the process of 'Theoretical Coding' was started, whereby theoretical codes were generated and the relationships between them were developed. This led to theoretical categories and a tentative theory emerged. As the final interview did not identify any new theoretical insights, theoretical saturation was deemed to have been achieved (Charmaz, 2006, Stern, 2008).

Table 1: Participant details.

Participant	Age	Relationships	Therapy Group	Ethnicity
Valerie	69	Single	CBT	White – British
Jill	77	Divorced	NT	White – British
Dierdre	79	Widowed	CBT	White – Other
Rita	75	Widowed	NT	White – British
Sheila	70	Single	CBT	White – British
Lilly	83	Widowed	CBT	White – British
Rose	82	Married	NT	White – British
Barbara	68	Married	CBT	White – British

Results

One single core category emerged from the data: the process of counteracting forces, which encompasses the sub-categories of group, individual and societal processes. For clarity a visual representation is presented in Figure 1.

Core category: Counteracting Forces

The core category of counteracting forces was developed from an exploration into why the change described by individuals was happening. It arose from the participants' discussions about how the group provided a place to learn new skills, be listened to, and accepted by others, compared to the difficulties they experienced outside the group. Many participants mentioned how they experienced a change within themselves, as a direct consequence of being in the group. The extract from Sheila illustrates how individuals experienced a change within themselves, as a direct consequence of being in the group.

> *Sheila: I know since being on the group that I can change. Now I can act more positively because of the things I have learnt in the group.*

Participants also reported seeing other group member's change.

> *Barbara: We could actually see quite a change in one of the gentlemen. The first time he came he was so on edge that he would have to walk around every five minutes. Over the weeks he got a lot better, and he was able to sit still and listen.*

Sub-category: A Group Process

Changes in the participants are best understood by considering what the group was providing compared to what the individual was experiencing in their lives. In a simplistic way it can be seen as a 'see saw' effect, with the overall positive experiences of the group, balancing out the negative experiences outside the group, a positive counteracting force.

Figure 1
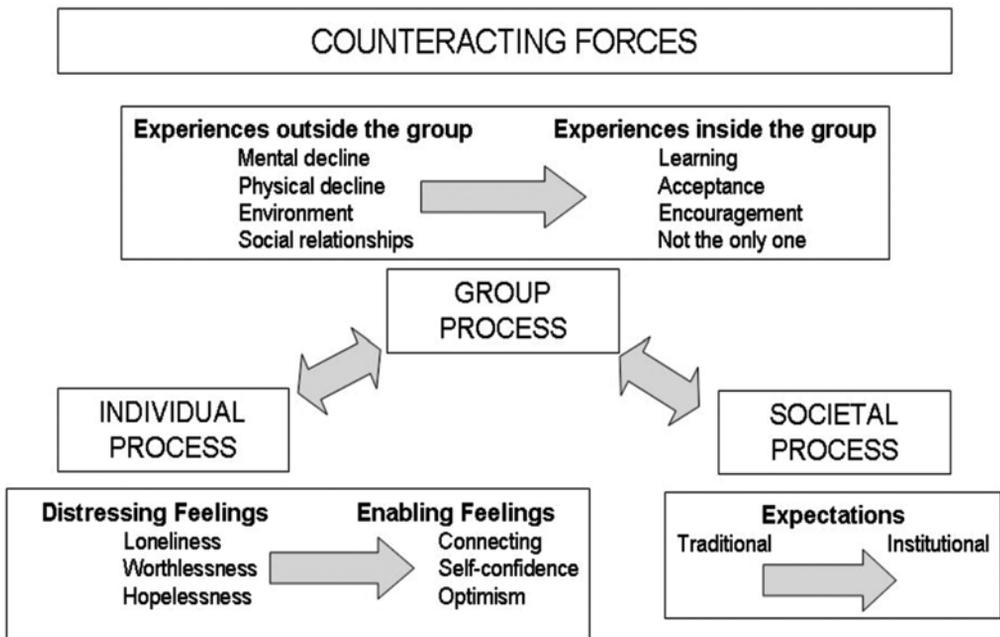
Experiences outside the group

Experiences of the participants outside the group have been divided into mental decline, physical decline, environment, and social others.

Mental decline

All participants mentioned a problem affecting their mental well being or a decline in their mental ability. Some had suffered from what they had termed 'breakdowns', whereas others specifically mentioned either depression or anxiety.

Valerie: All the stress caused me to have a breakdown.

Physical decline

In addition, participants were also experiencing a decline in their physical health, either due to a gradual deterioration, or through chronic disease.

Rose: I have had a very bad time because of my back. I am having trouble walking.

Environment

A couple of participants mentioned having problems where they live.

Sheila: Since I moved here, there is a small council estate at the back, I have had horrendous problems with youngsters, and we had to get police involved.

Social others

Relationship difficulties also affected a number of the participants, including single, co-habiting and married participants. Participants spoke about tensions with children and siblings, some of which were long-standing.

Lilly: My sister had upset me by writing nasty letters. It didn't cause my depression, but it didn't help at all.

Experiences inside the group

In contrast, participants spoke about how the group provided learning, acceptance, encouragement and a feeling of being 'not the only one'.

Learning

All participants spoke about what they had learnt in the group. This included understanding about their experiences, concepts, explanations and origins. Also included were tools and techniques, which many described as 'coping strategies'. Valerie's comments illustrated how this was experienced as very helpful and beneficial.

Valerie: It taught me a lot of things that would help, not to be quite so anxious. It taught me that when I panic, to slow my breathing down, and how to think things through and not to be so frightened of everything. The person who was talking said how they coped with it, and then you think I can use that coping mechanism for myself.

The learning aspect of the group seemed to provide a purpose for the group, which allowed for other group process to operate and in turn, these processes were instrumental to the learning of the content.

Acceptance

Nearly all participants spoke about how accepted they felt in the group. They valued the fact that other members respected and did not judge them. For many, the group provided a new experience of being able to listen to others, and also having the opportunity to be listened to. This was added to by the therapeutic frame of confidentiality and mutual respect. The extract below from Rose illustrates how being open about an attempted suicide, and the subsequent acceptance was very powerful.

Rose: Because they didn't judge me for what I had done, they understood. I mean I couldn't understand it myself.

In addition, the acceptance from the group decreased her worry about talking.

Rose: They were really kind. I discovered that it is good to talk, to get it out in the open, and that's what I was doing towards the end

Encouragement

Acceptance by others can be viewed as an implicit process which contrasts to the explicit process of encouragement. Partici-

pants described others as kind, and offering praise, encouragement, and congratulating each other on achievements. For Sheila the group provided a different experience to that outside the group.

> *Sheila: I think one of the biggest things I found was the encouragement from the other people in the group. I was always told you are no good at anything, you will never do anything. And for someone to say you are a nice person, or the ideas that you have are good, thank you for contributing to the group, was quite an eye opener for me.*

It appears that the nearness of the group, with the acceptance and encouragement from others provided a positive contrast to other social relationships outside in the group, either current or past.

Not the only one

The phrase 'Not the only one' was mentioned by the majority of participants. At first the group was normalising, however, the experience of sharing and disclosure added a deeper dimension of being able to feel for other people and to acknowledge that their own experiences had affected them. This experience also reduced the shame and stigma the participants felt with 'being ill'. The extract below illustrates how for one participant, the group interaction, and sharing of personal information helped her to feel less alone in the world.

> *Jill: There were one or two, one of them seemed to be quite a lot like myself and when we were expressing things, she would refer to what I said. I always felt that I'm the only one with this. Then you suddenly realise that you are not the only one. That helps you. It was a bit of a comfort to see that you are not alone.*

Sub-category: An Individual Process

There appeared to be a counteracting force of positive, more enabling emotions within the individual, resulting from the group experience, which balanced the distressing feelings felt before starting the group.

Distressing feelings within the self

Participants described how they felt before they started the group and they linked it to the experiences encountered outside the group. The feelings can be categorised into loneliness, worthlessness, and hopelessness.

Loneliness

For the majority, the problems in their environment and difficulties in relationships led the participants to feel lonely. Some participants who did have partners or close family relationships spoke about how they did not feel able to talk about their problems, as illustrated below:

> *Sheila: There are friends you can share things with and friends that you wouldn't. If you are feeling a bit down, I never 'phone anyone and say I am feeling really rough, I'm in a lot of pain and I can't cope today.*

Worthlessness

The analysis suggested that many participants experienced feelings of worthlessness or uselessness. For Barbara these had emerged from her decreased ability.

> *Barbara: At one stage I couldn't write a shopping list or think straight enough to think about what I would need, so I was pretty useless for a while.*

For Jill, it a long standing feeling which had affected her throughout her life.

> *Jill: I would do anything for anybody else but nothing for me. A worthless feeling I suppose.*

Hopelessness

For many participants, there was a feeling of being overwhelmed, or not seeing an end to their problems. This came over as a feeling of hopelessness. For some it was about not being able to do the activities they had previously enjoyed. Interestingly, for Rose the group had helped lift her mood, but then her continued disability after an operation again altered her perception about her situation.

> *Rose: I got on so well, and everything was looking up, and then I had the treatment, and I thought I would be fine and pick up the pieces again, but I can't.*

This illustrates the dynamic nature of the counteracting forces at work for an individual, and how even if there is change from being in a group, the external forces can still add pressure on an individual.

Enabling feelings within the self

The group therapy was reported by participants to change the feelings they had about themselves and their situations. These enabling feelings include connectedness, self confidence and optimism.

Connectedness

A feeling of connectedness, both to others in the group due to its social nature and also to themselves, appears to be counteracting the feeling of loneliness and isolation.

> Lilly: When you are that bad you can't get interested in things. I like being with other people. I missed seeing people.

The opportunity of the group to meet and connect with others was valued by the group. Participants spoke about how the group 'gelled'. Some considered others in the group to be newly formed friends. Overall being with others who had similar concerns in an intimate way, provided an enriching experience. For many the process of connecting to others was a gradual change, as they were often cautious at the beginning of therapy.

> Rose: It was good as I keep things to myself a lot. I am not a very outgoing person. I was surprised as I felt very relaxed about being in the group, talking to them about myself. They all took an interest in me. We all sort of took an interest in each other. We got to know each other very well in such a short space of time.

Self-confidence

All but one of the participants mentioned an increase in self confidence, and they related it to an increased feeling of control over their symptoms, with new coping tools, or through finding their own voice.

> Valerie: I think it has changed me and given me more confidence in myself because I have always regarded this mental illness that I have

got as something to be ashamed of and now I don't get that anymore, as now I can see that a lot of people have it as well.

This quote illustrates how Valerie's confidence has grown through the group situation, but in addition that connecting to others has helped decrease the shame she felt related to her 'mental illness'. For Lilly her confidence grew directly from seeing that she was not by herself.

> Lilly: It gave me more confidence to think that you are not on your own.

Therefore, there appears to be a link between 'self-confidence' and 'not the only one'.

Optimism

The group therapy also seemed to foster a sense of optimism in the future, probably intrinsically linked to the change and the increase in self confidence.

> Sheila: I think it has made me feel a lot more positive, and it has given me a new way of coping with different situation, and actually whereas in the past I might not have bothered, now I will tackle something.

Overall it appears that the positive enabling feelings counteract the negative feelings, with a shift from isolation to connectedness, from worthlessness to self confidence, and from hopelessness to optimism.

Sub-category: A Societal Process

This third layer of a counteracting force materialised with less precedence than the other two layers, but provides a contextual understanding of the counteracting forces that exist on a societal level.

Traditional versus Current Social Influences

There were many cultural and societal beliefs about not talking to others, not burdening others.

> Dierdre: These people have enough problems of their own, and you don't go there and tell them your problems.

Participants also spoke about their history of 'mental illness' and how their previous experiences of treatment were focused on

medication or Electric Convulsive Therapy. The traditional medical model of the participant's distress seemed to mirror the cultural expectations of not talking about problems. In comparison, the therapy group appeared to counteract this, with a psychological explanation of human distress and a belief in the curative power of talking. Rita summarised this eloquently.

> *Rita: I feel that it was the first time that people tried to discover what the causes were, rather than just giving out pills. Being holistic, dealing with the whole person. I felt (the therapy) had much more of an aim, rather than just heaping out pills.*

The participants began to talk about themselves, and they came to believe in the benefit of this. They moved away from their cultural beliefs towards the beliefs based on the positive experiences within the group.

Discussion

This study was carried out in order to understand older adults' experiences of group therapy and to examine the processes within the group. The emergent results can be constructed into a localised theory which proposes that counteracting forces occur on three levels of process: the group, the individual and societal. Furthermore, the participants spoke about how elements of these processes interacted and led them to experience a change.

The theory is also an important consideration to aid group therapists to conceptualise the processes that lead to change. It might alter therapists' interventions that stress support and acceptance and feedback from the other participants on progress and alternative strategies. It can facilitate the development of creating a positive environment within the group, by focusing on the features of learning, acceptance and encouragement. In this way, it will encourage therapists to think beyond what is being 'discussed' in the theoretical perspective. Overall group therapy seems to be an appropriate intervention on two levels. The first considers cost effectiveness (Leung & Orrell, 1993). But more importantly, the format of the group itself appears to provide additional benefits, especially considering the range of concerns such as physical and mental decline, social relations and hostile environments.

The research has produced a tentative and localised theory that reflects the accounts of eight older white women. It cannot be transferred to other groups, especially those with differences in participants' characteristics, service provision or type of therapy. It is possible, however, that this research could form part of a wider 'survey of voices' (Steibbins, 2006), with research being conducted with different samples to produce a more detailed account.

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Service user satisfaction questionnaire of NHS Tayside Psychological Therapies Services for Older People

Paula Mulholland

This paper describes a small-scale research project conducted to evaluate the level of service user's satisfaction with the NHS Tayside Psychological Therapies Services for Older People across. Views and opinions were gathered by postal questionnaire in order to aid service provision development. Service users, particularly older people, are not regularly involved in the development of the NHS, as is now recommended. This study offers insight into the experiences of this population, highlighting older people's positive experiences of having such a service and their concerns that more resource is provided to it.

SERVICE USER involvement is regarded as essential in the development and provision of National Health Service (NHS). This has recently been highlighted by the Patient Focus and Public Involvement Framework (PFPI) (2006–2009), provided by NHS Quality Improvement Scotland (NHS QIS). The PFPI aims to ensure that there is partnership between patients and the public with the NHS.

The PFPI offers four explicit aims of this partnership. They are to:

1. Improve the quality of health services in Scotland by ensuring that these are sensitive to the needs and preferences of patients.
2. Promote openness and transparency by enabling the public to review the quality of the NHS and be involved in our processes.
3. Learn from the experiences of patients and carers and gain an improved understanding of their needs and preferences.
4. Focus our work on patients and encourage public accountability by providing an essential complement to the expertise from health professionals and information from scientific literature and research.
   (NHS QIS, 2006)

The PFPI represents the accumulating recognition within the NHS that service users should and need to have a voice within its development. Within the PFPI framework document it suggests that the above aims are achieved through 'listening to the needs and preferences of the patients'.

When specifically examining the provision of the Mental Health Services, government policies have also strongly endorsed the need to include service users (Department of Health, 2004). Similarly the National Service Framework (NSF) for Older People (Department of Health, 2001) promotes the inclusion of patients in 'advising and providing feedback' on NHS planning. The NSF for Older People also highlighted that statistically this population represent the highest number of users of the NHS. This would make older people an important and vital population to target for involvement.

Aims

1. An older people population has been identified as potentially more difficult to involve in choices and decisions in the NHS due to lack of knowledge, disability and being housebound (Kennelly & Bowling, 2001). There has also been some resistance to seeking user involvement due to perceived fear of increasing expectation and increased

work pressure (Poulton, 1999). There-fore, this study aimed to make a genuine attempt to include older people, who had recently accessed psychological services, in the provision and development of their NHS care.

2. More specifically, the study also aimed to identify if the Older People (OP) population accessing psychological services across Tayside were given enough information about clinical psychology, and its role, both at time of referral and on meeting with a Clinical Psychologist. The need for clearly communicated, user focused informa-tion is central to the NHS. This was a particularly important area to examine as it could be argued that OP may be particularly unaware of the range of specialist services available to them and are, therefore, in most need of informa-tion. It has also been suggested that OPs need for information is often under-estimated (Followfield, Ford & Lewis, 1994). Although this need for information may not be fully realised, the level of information given has been found to be correlated with patient satisfaction (Bond & Thomas, 1992).

3. This study also aimed to highlight areas of current good practice while also allowing for less helpful areas to be highlighted, in order to inform service provision and development.

Methods
Participants
A total of 53 participants were included from across Tayside.

Recruitment
Participants were recently discharged service users of the Older People Psychological Therapies Service. They had been discharged no longer than six months previ-ously, to help limit the risks of dramatic change in abilities to consent due to cogni-tive deterioration (as many individuals were seen for neuropsychological assessment).

Once identified the participants' details were given to the clinical psychologist's secretary who sent out the covering letter, questionnaire and stamped addressed enve-lope (SAE). Alternatively, where appro-priate, participants were handed this pack by their clinical psychologist during their final appointment. These participants also returned their questionnaires in the SAE if they choose to participate. The envelopes were addressed to the author, who was unknown to the participants.

Exclusion criteria
1. If deemed incapable of providing consent due to cognitive decline or if the appropriate clinical psychologist believed that they would become distressed by such a request.
2. If living in a nursing care home, due to issues of consent.

Questionnaire and Information Sheet
Information was treated as confidential and all responses were voluntary and anony-mous. Participants were also reassured that their access to future services would not be affected, a concern previously highlighted in similar research.

The questionnaire consisted of five closed questions and three open-ended questions.

Ethical considerations
NHS ethical advice was sought, as partici-pants were NHS service users. It was advised that no NHS ethical approval was required as the author did not access patient details directly and participant responses were fully anonymous and confidential.

Results
A total of 53 questionnaires were given out to participants, with 29 of these being returned (55 per cent).

In summary, the majority of responders reported satisfaction with the level of infor-mation provided by both the referrer and the clinical psychologist. Although it is of

Table 1. Responses to closed questions.

Questions	Responses		
	Yes	*Somewhat*	*No*
Before you saw a clinical psychologist did you know that you had been referred to clinical psychology?	27	N/A	2
Did you receive adequate information from the referrer (e.g. your doctor) about clinical psychology?	20	6	3
Did you receive adequate information from the clinical psychologist about their role?	25	3	1
Were you satisfied with the quality of care you received from your clinical psychologist?	27	0	1

note that nine participants were not fully satisfied with the amount of information provided by their referrer. In terms quality of care, all but one participant were satisfied.

Open-ended questions

An inductive thematic qualitative analysis was used to interpret the three open-ended questions, which involved the sorting of the open-ended responses into themes (Hayes, 2000).

What were the most helpful aspects of your contact with a clinical psychologist?

Of the questionnaires returned, twenty-four responses were provided in response to the above question (83 per cent).

Theme 1

Psycho-education: Nine of the participants indicated that their level of understanding had increased following sessions with their clinical psychologist. This increase in understanding was often associated with positive attributes, such as increased confidence.

> *'just explaining things to the patient.'*
> *'giving back my confidence and helping me understand my problem.'*

Theme 2

Communication: The majority of responders indicated how important they viewed the opportunity to talk openly and be listened to without judgement.

> *'to be listened to and notice being taken of the problems experienced, without being told, 'it's your age' and 'we all develop memory problems.'*
> *'just being able to talk about things from the past that has been a cause of my depression...'*

Theme 3

Therapeutic Manner: Six participants made reference to the therapists' qualities, such as their kindness, caring and sensitive manner.

> *'kindness, understanding, positive approach.'*
> *'easy to speak with psychologist, a very sympathetic manner...'*

Theme 4

Practical Issues: A number of more practical issues were also raised as helpful, such as the service being provided at their home (3), being provided with physical resources, that is, relaxation tapes (1), being set homework tasks (1) and receiving a diagnosis(1).

> *'being able to discuss issues in the privacy of my own home.'*
> *'the tape I was given to help me relax.'*
> *'that she confirmed my own diagnosis.'*

Theme 5

Negative feedback: It should also be highlighted that there was also a small number of negative qualitative answers given to this question.

> *'I can't think of anything helpful. I was put through a lot of ridiculous tests...'*

'The other two seemingly negative responses were more ambiguous, 'none, but that would depend on illness' and 'none, as I had medical problems at the time.''

Were there any unhelpful aspects of your contact with a clinical psychologist?
Only two participants reported unhelpful aspects of their care. One participant found the outcome of their neuropsychological assessment as unhelpful and the other was unhappy that there 'was nothing she (the clinical psychologist) could do while medical problems continued'.

Do you have any further comments or suggestions regarding the service?

Theme 1
Overall Positive Experience: Many of the responders felt they had no comments to offer, however all but two participants who did respond reported positive experiences.
'highly recommended and necessary service.'
'I can only thank you for the time I was given was excellent and I really congratulate you for your service.'

Theme 2
Resources: The recognition to both maintain standards and build on the current provision of the service was explicitly highlighted.
'…I hope more resources are made available.'
'there is the obvious point that the NHS desperately needs more clinical psychologists.'

Although there were no discontentment themes, as such, from the responders, again two participants felt that their input had been inadequate.
'I still feel unhappy and have lots of stress and unwanted thoughts and fears.'

Conclusions
Service User Inclusion
The first aim of this study was to act on a vast number of policy recommendations highlighting the need to include service users in service provision and development of the NHS (PFPI, 2006–2009; Department of Health, 2001). As the average return rate was a relatively high 46 per cent, it is hoped that this study is representative of the OP population accessing psychological services in Tayside.

The relatively high return rate may have been due to the familiar nature of questionnaires in today's society, while also allowing for the participant to complete it in their own time.

Information
All but two participants had been aware that they had been referred to clinical psychology, indicating that there is good communication between the original referrer and the patient at time of referral. However, the referrer did not always provide satisfactory information about clinical psychology at this time of referral. This was highlighted by nine of the participants responding 'somewhat' or 'no' to the closed question, 'Did you receive adequate information from the referrer (e.g. your doctor) about clinical psychology?'

One of the aims of this study was to examine if OP were receiving enough information as it has been highlighted that this need for information is often under-estimated but essential for good quality care. The current findings would suggest that although the majority of participants did receive adequate information, this was not always the case. By providing information the patient gains a sense of control that potentially reduces their anxiety about accessing new services. These results may highlight a reluctance of some referrers to discuss the role of the clinical psychologist as the referral may be in relation to a neuropsychological assessment of possible dementia. The referrer may feel they may cause more distress to discuss the role and possible assessment outcomes of the neuropsychological assessments. However, most OP patients have been reported to want to know about possible outcomes, even for feared conditions such as Alzheimer's disease (Pratt &

Wilkinson, 2001). Unfortunately the current study did not gather information on the referral reason to examine this further.

Another possible reason for this decrease in information giving may be that the referring professionals have varying understanding of the role of the clinical psychologist. Alternatively the patient may not remember the information given due to anxiety or memory difficulties. Participants may have rated this question more poorly as they may value the face-to-face discussions.

In relation to the information provided by the clinical psychologist about their role ('did you receive adequate information from the clinical psychologist about their role?'), the numbers not fully satisfied reduced to four, from the 29 responders, with three being 'somewhat' satisfied. Although a small percentage (16 per cent) of participants were not fully satisfied, it again highlights the need to improve information provision. In response to the finding thus far, information booklets are being developed to give to patients to take home and read in their own time, alongside the usual discussions in session. This is to promote good practice, which suggests using various means of information sharing. It is also a relatively inexpensive way to provide information that could increase participation and reduce anxiety and distress. To be effective and applicable, the size of text and readability has also been taken into consideration.

Encouragingly all bar one participant responded that they were satisfied with the quality of service they had received. Similarly many of the themes identified by the open-ended questions were positive, such as the therapeutic methods used and their development of understanding. The high value placed on approachability has long been associated with patient satisfaction.

Throughout the open-ended responses only a small minority offered grievances, which may not therefore be representative of the general view of the care offered. The participants identified that clinical psychology is a small resource but one which they

highly valued, providing yet more evidence for the use of psychological approaches in this population. Practical considerations were highlighted as positive, such as being seen at home and being provided with resources.

Further research and limitations
Only the opinions of individuals who responded were represented in these findings. Potentially those who were most dissatisfied could have felt disempowered and subsequently did not voice their opinions. It has been argued that satisfaction cannot be measured but only dissatisfaction as measured by complaints. However, if an individual is so passive or disempowered not to fill in a questionnaire then they may be as unlikely to follow through a complaints procedure either.

The overall ratings of satisfaction have been very positive, however, caution most also be exercised when using satisfaction questionnaires as it has been argued that OP report more satisfaction in services than younger adults (Bowling, 2002). Bowling suggests that this may be a result of OP being more 'grateful' for their services in comparison with what their parents had access to. Calnan (2003) has also suggested that OP may report higher levels of satisfaction as they are frequent users of the NHS they have developed more realistic expectations of it. In response to these limitations it may be helpful to run a focus group to further understand these experiences and to attempt to engage the most disempowered by specifically identifying these individuals to encourage their inclusion.

This study has highlighted areas of good practice such as providing the service within the individual's own home, which may have an impact on the departments views on moving to a clinic-based model. It has also increased awareness of the importance of information provision, resulting in multidisciplinary discussion and action, such as information leaflets. It may be helpful in the future to examine why some referrers may

provide less information to the patient, for example, investigating if there is discrepancy of knowledge about the role of the clinical psychologist within the referring groups. This study also indicates that the psychological services are a highly valued commodity to this population, who request more resource to expand the service. This awareness of the limited nature of their psychological service could be a reflection of this population becoming more aware of their rights to a high quality NHS.

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A grounded theory approach to investigating the differing needs of Young Onset Dementia clients attending a memory clinic

Thomas Alexander & Andrea Evans

The present study aimed to explore the needs of clients and carers attending a memory clinic in Pembrokeshire, Wales. It hoped to explore whether the clients and carers of those with Young Onset Dementia (<65 years of age) had any differing needs to those of an older adult group of clients and carers (>65 years of age). The interviews of each of the participant's (N=14) diagnostic experience within the memory clinic was conducted and analysed using a grounded theory methodology. The core category of 'Contact' with the memory clinic service was identified. Contact was demonstrated in relation to the categories of Regularity of contact, Community contact, Social contact, Awareness of service, and Specialist intervention. Differing themes between groups arose on the following; anxiety about clinic (clients >65, clients <65), unawareness of service provision (carers <65, clients >65), positive experiences of post diagnosis group intervention for the client (carers >65, clients >65) and unsuitability for post-diagnosis group intervention (carers <65, clients <65). The findings supported the notion that prior education around memory clinic needs to be improved upon, and that regular specialist contact for those going through the diagnostic and post-diagnostic phases is of high importance. Differences were highlighted in the needs of post-diagnosis intervention for those <65, and recommendations and practical advice were suggested with regard to this.

MEMORY CLINICS were first developed in the US in the 1970s and were introduced to the UK some 10 years later. Initially the memory clinics' role primarily involved research, however, the roles and responsibilities of the memory clinics soon expanded and with it their numbers throughout the UK. In 1993 only 20 memory clinics were in existence in the UK, with numbers rising to over 100 in 2000 (Lindsey et al., 2000). More recently numbers have been estimated to exceed 200 (*Daily Mail*, 2005).

There is no one agreed definition for the term 'memory clinic' in the UK, as it represents a broad ranging service. Functions can involve psychometric testing, counselling, intervention and monitoring, information dissemination, research, and education and training services to the public and to professionals. Individual differences within these are often dictated by resource, or theoretical standpoints of the professionals involved. However, one common goal all memory clinics share is the early diagnosis of dementia for clients and support for the carers.

With the diagnosis rates of dementia seemingly increasing in recent years and predictions of prevalence estimating continued rises (Alzheimer's Society, 2009) the result has been an increase in memory clinics and the provision offered. It is perhaps unsurprising then that increased political and media attention has been afforded to services involved in the diagnosis and intervention of dementia. The Government recently rolled out a five-year strategy for the rising problem of dementia, famously saying that soon there would be a memory clinic in every town (*BBC News*, 2009). Perhaps what is more surprising is that despite this attention, comparatively little research has been carried out on the memory clinics themselves.

The majority of investigation that has been completed on memory clinics tends to be directed more toward clinical features of those attending memory clinics and success in terms of diagnostic value (Van Der Cammen et al., 1987; Almeida et al., 1993). Only a handful of studies identified have concerned themselves with patient and carer experience directly. Logiudice et al. (1999) investigated whether memory clinics improved quality of life for carers of those with dementia. Measures were taken before and after memory clinic intervention to assess carer burden, psychological morbidity and psychosocial health, and the results highlighted significant improvements for all of the measures taken. A qualitative/questionnaire approach was also taken by Van-Hout et al. (2001). Their study concentrated on the opinion of memory clinic 'users' (patients and their relatives) and GPs involved. Again positive results were found, particularly with regard to the diagnostic value of memory clinics. Although representing a positive step toward client and carer involvement in memory clinic research these studies only took into account pre-determined, or structured information – such as questionnaire or scaled data.

The only research to date found concerning an unstructured and qualitative approach to clients attending a memory clinic was that of Keady (2005). The study employed a grounded theory approach, using practitioner-research principles (Reed & Procter, 1995). Their goal was similar to that of the present research, in that it was hoped investigation may inform practice development within a memory clinic. In taking each individual's narrative account of their experiences within the memory clinic it did just this, and led eventually to the establishment new assessment and diagnostic sharing practices. The method of involving client and carer opinion directly then is one that has shown favourable results, and one that can contribute to the body of knowledge on dementia as a possible disease process and aid clinical practice (Voss, 1999). It is on this basis the present research is put forward: to inform and aid clinical practice but also specifically incorporating a population of young onset dementia clients, a population not well researched within memory clinic settings to date.

Pembrokeshire memory clinic is pioneering a young onset dementia service, and is set to undergo a structural change. As such an ideal opportunity for research to inform changes and improve clinical practice came about, and investigate whether differences in need existed between clients and carers in the traditional older adult memory clinic service (65 years and over) and those in the young onset service (under 65 years).

A qualitative approach and more specifically, grounded theory methodology, was thought most suited for the research aims. The approach is documented as successful in generating theory in largely unexplored areas, is person-centred and can generate theory or attempt to understand the experience of groups effectively (Strauss & Corbin, 1990; Symon & Assell, 1998; Charmaz, 2000).

Method
Grounded theory analysis
'Iterative analysis is a process where the researcher moves back and forth through the data in order to find, compare, and verify the patterns, concepts, categories, properties and dimensions of the phenomena. Having gained the insight of the emerging patterns, categories and dimensions the following interviews can be focused on filling out those patterns, categories and dimensions to the point of saturation.'
Kwortnik (2003)

Strict grounded theory (GT) methodology recommends a no pre-research literature review approach, as it is thought studying the literature of the area under study would give preconceptions about what to find and will desensitise the researcher with borrowed concepts (Straus, 1990). However, Glaser (1965) and Dick (2005) do recommend prior background reading on a limited basis.

They argue that this helps to make sense of the data in the wider sense, but warn to avoid in-depth reading of closely related research in the area one plans to work. As such, a limited literature search was carried out in order avoid any influences that may affect the direction of the proposed research

Interviewing process

Semi-structured interviews were conducted on an individual basis at a Day Hospital. After each interview a debriefing was offered, and participants were invited to ask questions on anything they had misunderstood.

Each interview was taped and during each encounter detailed theoretical memos were taken. At the end of each interview these notes were checked against the tape recording and information that was missed was added to the notes. Constant comparison was at the heart of the analysis, and notes were compared throughout the research.

The transcriptions and process notes were subjected to the analysis, following the 'long table approach' (Krueger & Casey, 2000), which is an effective way of letting themes emerge visually. Key themes and categories were cut up and arranged in groups, in order to visually organise concepts and aid in the finding of a core category.

The method of not completing full transcriptions is one that is becoming increasingly recognised and recommended in grounded theory, and has clear economic and qualitative advantages over full transcription (Glaser, 1964; Dick, 2005). Dick (2005) is of the opinion that more understanding comes from the extra interviews that could be completed in the time it would take to undertake full transcriptions. Additionally, this method was thought advantageous in working with dementia sufferers, who can be repetitive/ruminative/forgetful and can lose the thread of conversation.

Sample

Following GT methodology, theoretical sampling was employed throughout, whereby the researcher chooses participants who have experienced or are experiencing the phenomena under study. The researcher can thus choose 'experts' in the phenomena, and is able to provide the best data available (Corbin & Strauss, 1998; Glaser & Strauss, 1967).

A total sample of 14 individuals was used. Participants came from the following groups.

- Individuals 65 of years age or over with diagnosis, or suspected diagnosis, of cognitive decline (over 65 service user).
- Carers of those 65 years of age or over with diagnosis, or suspected diagnosis, of cognitive decline (over 65 carer).
- Individuals under 65 years of age with diagnosis, or suspected diagnosis, of cognitive decline (under 65 service user).
- Carers of those under 65 years of age with diagnosis, or suspected diagnosis, of cognitive decline (under 65 carer).

Inclusion and exclusion criteria
Exclusion

Criteria included for this population will be those who are deemed not to possess capacity to consent to the study or who had specific language difficulties. Participants were selected from the memory clinic database, by the clinic nurse and clinical psychologist.

Inclusion

If the individual with a diagnosis of dementia had gone through the full memory clinic pathway (CPN visit, psychiatry assessment, psychology assessment, MRI, feedback) and this had happened within the past four years.

Validity and reliability

All of the information gathered was cross checked by the co-author. Any differences in coding, or information that was felt to be overlooked, was then discussed and checked against notes and recordings. To ensure high

face validity a focus group meeting was held for individuals who had experienced the same process but were not included in the investigation, as well as informal conversations with professionals working within the memory clinic. This gauged whether the results and conclusion of the study fitted with the experiences and observations of those involved.

Ethical considerations

Participant information sheets and consent forms were given to each potential subject. This process helped dispel any of the myths around the study and informed participants better on what was being asked of them and why. It was also reiterated to participants on the day of the interview, that they were be able to leave the interview process at any time. Interviews were conducted by the author who, although working within the memory clinic, was not known to the participants. This not only addressed ethical issues it also had the aim of receiving – it was hoped – less bias from the participant's responses. Data was stored according to current policy and practice on confidentiality and Data Protection.

A favourable ethical opinion for the present analysis was granted by the Dyfed Powys Ethics Committee.

Results

The main theme or the core category that arose was that of 'Contact'. This was related to the under-arching categories of 'Regularity of contact', 'Community contact', 'Social contact', 'Awareness of service' and 'Specialist intervention'.

Within these sub-categories clear similarities and differences in opinions between the groups began to emerge in the areas of importance of regular contact with the memory clinic service, unawareness of memory clinic service, positive experiences of post-diagnosis group intervention for the client, and unsuitability of post-diagnosis group intervention for the client.

Regularity of contact

This sub-category referred to regular contact from the professionals working within the memory clinic service and all four of the groups mentioned the importance of regular contact. The fact that people were contacted regularly, and the feeling that client/carers could contact on a need basis, led to a sense of reassurance from all of the groups.

Community contact

Community contact referred to the community visits the professionals within the service made to clients and carers. The narratives of all four groups reflected importance of community contact, usually referring to positive experiences of the specialist nurse and other professionals involved. It was also conveyed that contact within the home environment eased stress and worry for carers and clients of both age groups.

Social

Participants mentioned their experiences within the social and informal meetings with other clients and carers within the memory clinic. Service users are encouraged to meet and share their experiences of dementia, and group outings as well as informal informational days are run by the service.

This sub-category brought differing themes amongst service users, with the under 65 group (clients and carers) explaining feelings of unsuitability for the social side of memory clinic, in meeting with other clients and carers, and the over 65 having more positive experiences.

The over 65 group explained how they gained from social interactions, in terms of exchange of information, and explained positive feelings around reassurance of not being alone and not being in as bad a situation as others.

Clients and carers in the under 65 group mentioned feeling unsuitable for the social side of the memory clinic. Statements from this centred around being anxious about meeting other individuals affected dementia, and not feeling comfortable.

Awareness of service

This sub-category represented how aware, prior to clinic involvement, service users and carers were of the memory clinic, the support/intervention offered and with regard to the dementia itself. Narratives revealed that the under 65 carers and the over 65 clients were unaware as to service and the disease itself prior to memory clinic involvement.

Specialist intervention

Specialist intervention was mentioned in terms of the varying professional roles involved in the team and the clients and carers recognition of the importance of specialist advice and support. Specialist advice is also sourced from outside of the team, in terms of speakers that are organised for the memory clinic and again was mentioned in discourse in all of the groups.

Discussion

'The back up was very important; we know that we are not completely alone now.'

What are the needs of individuals going through the memory clinic pathway up to and including the point of diagnosis or suspected diagnosis?

Contact with service

'(Nurse) and (OT) visit often'
(Carer, under 65 group)

The core category of 'contact with service' was identified, and within this positive and negative aspects were apparent. The analysis highlighted that all four of the groups found the aspects of regular, specialist and community contact important in the memory clinic service. This is a finding that has implications for the present service and for memory clinics nationwide.

The current economic climate dictates that the justifications of NHS resources have to be increasingly argued for. The findings of this investigation would certainly add to the argument that the needs of service users within a memory clinic are far reaching, and

that a range of specialist support is needed for both working age and older age groups.

Pembrokeshire has a geographically wide ranging community of clients and is very rural and isolated in places. The importance of contact, particularly community could be a reflection of this. Many clients and carers reported feeling isolated and the community support offered was of great help. The over 65 group often have more transportation needs than those under 65 due to driving restrictions, physical health difficulties, etc., and is a potential constraint for newly emerging memory clinics in rural areas.

Awareness

'Didn't know anything existed, I knew nothing about it.'
(Carer, under 65 group)

Awareness of service provision was another category that arose from analysis. Analysis of the narratives of the over 65 client group and the under 65 carer group revealed that they were unsure of what the service offered in terms of assessment and intervention.

Worry generated around lack of awareness is an important point that has far reaching connotations for service provision and client well-being. It is probable that increased awareness of the service and towards dementia itself will lead to more individuals approaching memory clinics. The economic advantages of getting those with dementia into service at an early stage are well documented. The current research has demonstrated that in Pembrokeshire the two groups in particular (over 65 client and the under 65 carer groups) have shown low levels of awareness with regard to service provision. Possible reasons for this discrepancy could be further investigated, with a view to increasing awareness in these groups.

Do younger adults with suspected dementia have differing needs to those in the over 65 population during this process?

'Didn't feel it (group sessions post-diagnosis) was giving me anything. There were people there

further down the line and I was listening to people worse than me. I didn't feel it was helpful being with people worse than me.'
(Client under 65 group)

'Meeting people who were in similar circumstances who were similar was most important…better to compare, compare notes from each other.'
(Client over 65 group)

Analysis found that one clear difference existed between the groups – that of benefit gained from social interaction with other clients/carers provided through memory clinic. The over 65 clients/carers found these interactions to be valuable with regard to informal information sharing, and it was revealed that a sense of relief came about from not being alone in their difficulties. The under 65 clients/carers felt they were unsuitable for the groups, and maybe not being at the stages of being ready for this. This raises valuable questions such as:
Is this finding clinically significant, and if so what are the reasons for differences of opinion?
Would a specialist YOD support group be beneficial?
Is it more of a reflection of the degree of impairment, rather than age differences?

Analysis issues
There are of course limitations to the findings from the study, and there is an awareness of cultural bias (for example, feelings of isolation may not be so prolific in urban areas), and issues around sample size and generalisation and representation. However, aspects of reliability and validity were covered comprehensively and it is felt that the research offers valuable insight into service user's views. It would be interesting to replicate this study in an urban setting to compare possible geographical or cultural biases.

Conclusion
It is hoped developing clinics may take into account the findings of this study; the importance of regular, specialist and community contact, service promotion and adapting services to actively encourage the differing needs of the under 65 population.

It also highlights the need for further qualitative and quantitative study into the most helpful and effective way to run a memory group. This may go some way to creating an agreed format taking into account the needs of these two potentially quite different client groups. If there is to be a memory clinic in every town it is hoped that this research can contribute to the creation of these and help to raise the profile of research within these.

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We would like to thank the participants of this project and our colleagues within the Memory Clinic Team in Pembrokeshire.

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Obituary:
Dr Ann D.M. Davies FBPsS
## 28 November 1938 – 22 December 2010

David Powell & John Downes

I T WAS WITH enormous sadness and a great sense of personal and professional loss that friends and colleagues received the news of the death of Dr Ann Davies just before Christmas 2010. She died on the 22nd December after a two-year battle with cancer and the courage with which she faced the challenges of her illness was inspirational to many. She let it interfere as little as possible with her preferred lifestyle. She continued to work full time as a consultant clinical psychologist until just a few weeks before her death, and still managed to combine this with a rich family and social life.

Ann has been a leading light in Psychology of Ageing nationally and internationally since the 1970s. She had a massively distinguished reputation as a researcher, particularly into those health issues that affect older people and their families. She was a true scientist-practitioner, finding the time while an academic to qualify as a clinical psychologist, conducting applied research capable of making a difference to older people's lives, and bridging the gap that too often exists between academia and clinical practice

Ann's qualifications and memberships give an indication of her multiple talents and continuing curiosity: Chartered Clinical Psychologist, Chartered Health Psychologist, member of the British Psychological Society's Division of Neuropsychology, accredited Cognitive Behavioural Therapist, member of the UK Council for Psychotherapy. At the time of her death she was studying for a further Diploma in Neuropsychology.

Ann's academic career began after qualifying with a first-class honours degree at the University of Liverpool in 1961. It was at that time that a life-long interest in the psychology of ageing was formed when she joined the prestigious MRC supported Research Institute for Studies on Occupational Aspects of Ageing, in Liverpool, where she worked with several eminent psychologists. Her studies at the Institute led to a doctoral thesis and her career progressed: She was appointed a lecturer in the School of Psychology in 1967, later becoming senior lecturer until she retired from University work, to pursue full-time work in the NHS in 2002, during which time she had accumulated an impressive list of more than 150 publications. Her contribution to the psychological studies on ageing was recognised by the granting of the status of Fellow of the BPS as early as 1977. Undergraduate and postgraduate students who worked on research projects with her during this time will remember the initial trepidation upon realising the high standards and attention to detail which were required of them; but all would eventually be swayed by the genuine care Ann invested in developing their academic thinking styles, most particularly an appreciation of the multi-factorial complexities involved in studies of the psychology of ageing.

On retiring from the University of Liverpool, Ann became a full-time consultant clinical psychologist split between older people's mental health services and stroke services. She continued in this role, mainly with Merseycare NHS Trust, until her death. She didn't believe that chronological age
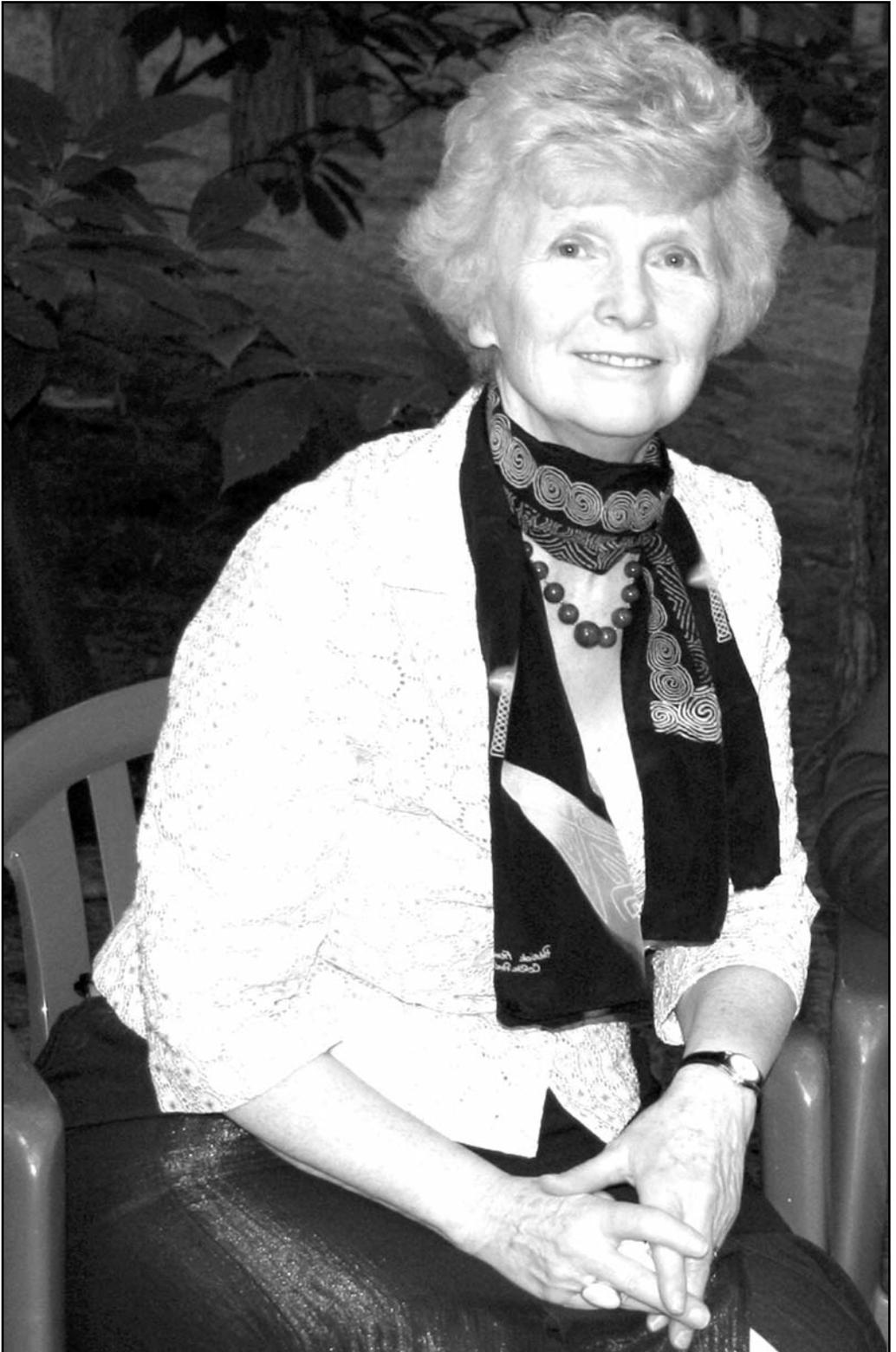
had any relationship to what an individual could contribute. As a consultant clinical psychologist she engaged brilliantly in all potential roles: clinician, teacher, supervisor, mentor, inspirer and dogged service developer. Many would say that she was the hardest working person they have known, putting in many hours more than she was contracted for. She also ensured she had one day a week ring-fenced for research but in reality she expanded this by doing research activity in her own time

Ann knew what psychological approaches could offer to her client groups and was frustrated by the severe under-resourcing with which we are all familiar. Aside from working overly long hours personally her approach to this deficit was innovative, rigorous and persistent. In the Stroke Services she created what is one of the best available examples of an Honorary Psychology Assistant scheme which served to increase the presence of psychology in the Stroke Service as well as to help many excellent graduates get a foot on the career ladder. She wrote elegant, persuasive and rigorous cases for service expansion which universally impressed others even though they did not immediately attract extra resources. She attended the grand medical rounds often very early in the morning and so generally elevated the profile of psychology. She was a great ambassador for the profession. More recently she was invited onto the Stroke Board at Aintree and was becoming a little more optimistic about getting more posts.

In her last year it is satisfying that Ann's persistence paid off, and resulted in the development of new psychology posts in older adult mental health services in Merseycare, the goal she had been fighting for over many years. Thankfully she lived to see that. Although some of these posts may be temporary, I know that her next goal would have been to ensure they would be extended and to lobby hard for them becoming permanent. She left a clear vision for how these could be used and how evidence could be collected to demonstrate their contribution to the service.

As a clinician, Ann imported the keen, analytical, empirical, knowledgeable, rigorous and deeply inquisitive mind of a researcher. Crucially, on an interpersonal level, she also had a really good way of being with service users. She had empathy, warmth, commitment, the capacity to actively listen, the ability to get to the heart of the matter quickly. Often the heart of the matter involved acknowledgement that many people with major health and transitional problems are working through very difficult, complex issues for which there is no easy fix or answer.

She was tenacious with such complex cases. She often discussed them and it felt as though she refused to be discouraged – she would give 100 per cent, even when there seemed to be but slim chance of any change. Ann's clients could be assured of her absolute commitment to try to help them. She had a rich appreciation of the interweaving factors influencing ageing and she applied this to her clinical formulations. In her last year she wrote, 'My style of therapeutic intervention is broad-based, but rooted in life-span developmental, intergenerational, cognitive, behavioural and neuropsychology.'

I'm sure all who benefitted from her work will grieve her death. She was dedicated to the wellbeing of people and her work was of an excellent standard, not just in quantity but also quality – she expected a lot of others but always much more of herself.

As a consultant clinical psychologist Ann did not let up on research. Over the last few years her research focussed on care-giving in Parkinson's disease, heart failure, stroke and depression. She conceptualised care-giving as a complex dynamic, dyadic process, and paid attention to both positive and negative interactions. She disseminated her views and observations to a broad field, including a range of medical specialties and other disciplines, through conference presentations, academic articles and workshops.

All of us have a legacy – it's our only achievable form of immortality. For Ann, most important of all it is the way she will live

on in the hearts of her family and friends, but more widely it rests with all the people she taught, influenced, inspired, and in her massive contribution to what she called 'the literature' – the corpus of research papers and book chapters.

She is survived by her husband, three-children and five grandchildren and will be greatly missed.

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Independent Practitioner Forum

The Society's Professional Practice Board has set up an electronic forum for independent and private practitioners.

If you are interested in joining, please send an email to Nigel Atter at the Leicester office:
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European Congress of Community Psychology

York, 15–16 September 2011

Second Announcement and
Call for Papers

Conference website:
http://bit.ly/dF5Fzu

PSIGE National Committee

as at January, 2010

Don Brechin – *Chair*

Cath Burley – *Vice Chair & CPD Lead*

Polly Kaiser – *Policy & Diversity Lead*

Sarah Dexter-Smith – *Secretary*

Louisa Shirley – *Newsletter Editor*

Mhairi Donaldson – *Membership Liaison and Website*

Cerys MacGillivray – *Conference Liaison*

Liz Baikie – *Scottish Representative and Dementia Lead*

Lyn Sutcliffe – *Dementia Lead*

Julia Boot – *IAPT Lead*

Becci Dow – *Treasurer and Welsh Representative*

Louise Bergin – *IAPT and Newsletter support*

Recent journal articles or books by PSIGE members

Craven-Staines, S., Dexter-Smith, S., Murphy, G. & Ferrier, L. (2011). Psychological therapy networks in older people's secondary care services. *Clinical Psychology Forum, 220*, 43–47.

Milne, D. & Dunkerley, C. (2010). Towards evidence-based clinical supervision: The development and evaluation of four CBT guidelines. *The Cognitive Behaviour Therapist, 3*, 43–57.

Milne, D., Reiser, R., Aylott, H., Dunkerley, C., Fitzpatrick, H. & Wharton, S. (2010). The Systematic Review as an Empirical Approach to Improving CBT Supervision. *International Journal of Cognitive Therapy, 3*, 278–294.

Ndukwe, N., Borowski, D., Lee, A., Orr, A., Dexter-Smith, S. & Agarwal, A (2010). The 'two-week rule' for suspected colorectal cancer: Patient experience and psychological impact. Accepted for publication in the *International Journal of Health Care Quality Assurance.*

Sells, D. & Shirley, L. (2010). Person-centred care planning: The traffic light approach. *Journal of Dementia Care, 18*(5), 21–23.

Stirling, E. (2010). *Valuing Older People: Positive Psychological Practice.* Wiley-Blackwell.

Weatherhead, S.J. & Jones, G.M. (2008). Measuring the narrative: The challenge of evidencing change in narrative therapy. *Clinical Psychology Forum, 118*, 38–41.

Weatherhead, S.J. & Jones, G.M. (2010). Dilemmas in evidencing narrative: Reflections from workshop conversations. The Institute of Narrative Therapy. Available at: www.theinstituteofnarrativetherapy.com/Papers%20and%20resources.html

Weatherhead, S.J. & Flaherty-Jones, G.M. (In Press). *The Pocket Guide to Therapy: An Introduction to 10 Models of Therapy.* London: Sage.

If you would like to keep PSIGE members informed about your current publications, please let me have an update.

Louisa

PSIGE National Conference 2011: Enhancing Knowledge and Skills for working with a Diverse Older Adult Population

T HE PSIGE NATIONAL CONFERENCE 2011 is being hosted in Scotland's 'other' capital city, Glasgow (www.seeglasgow.com). This event is taking place in the Lorne Hotel (www.lornehotelglasgow.com) conveniently located between Glasgow's lively and bohemian West End and its vibrant city centre (both Queen Street and Central Station are 10 minutes away by taxi). The Lorne Hotel is five minutes away from the renowned Kelvingrove Art Gallery and Museum, and across the road is leafy Kelvingrove Park where delegates may enjoy a lunchtime, or late evening stroll; it will be light (and hopefully sunny!) until 10.00 p.m. at the time of year.

A delegate overnight rate of £55 per room has been agreed with the hotel (£65 for bed & breakfast) and there is an award-winning Indian restaurant (main dishes around £10 to £12) situated within the hotel. Bar meals are also available in the Bilbery Bar in the hotel. There is a range of accommodation and dining options (Greek, Thai, Italian, Seafood) within yards of the hotel and many, many pubs including the Ben Nevis with its famous gantry of fine malt whiskies! For those who wish to stay longer, Loch Lomond and The Trossachs National Park are a mere 40 minutes' drive and Glencoe and beyond for those whom the mountains beckon not much further!

Workshops:
- Professor Andrés Losada (Universidad Rey Juan Carlos, Madrid) and Professor Maria Marquez (Universidad Auntonoma de Madrid, Madrid). Title: 'ACT for Dementia Caregivers'.
- Dr Deborah Lee, Consultant Clinical Psychologist. Title: 'Compassion focussed therapy to work with shame and self-attack: a transdiagnositic approach'.

For further information about the workshops please contact Dr Cerys MacGillivray (cerys.macgillivray@ggc.scot.nhs.uk) and an abstract will be forwarded to you.

Keynote Speakers:
- Dr Ken Laidlaw, Consultant Clinical Psychologist.
- Professor Linda Clare, Consultant Clinical Psychologist.

Conference Speakers include:
- Professor Kate Davidson, Consultant Clinical Psychologist (NHS Greater Glasgow & Clyde/ Director of Glasgow Institute of Psycho-Social Interventions) will talk about personality disorders and older people.
- Professor Keith Millar, Consultant Clinical Psychologist (NHS Greater Glasgow & Clyde/ Senior Lecturer, University of Glasgow) will present a talk titled: 'Cognitive impairment in older adults after general anaesthesia and surgery: Why?'

● Dr Daniel Collerton, Consultant Clinical Psychologist (Northumberland, Tyne and Wear NHS Foundation Trust/Honorary Teacher in Clinical Psychology, University of Newcastle-upon-Tyne) will talk about working psychologically with hallucinations in later life.
● Dr Donna Gilroy, Clinical Psychologist (NHS Lothian) will discuss recent research into dyadic CBT for depression in people with dementia and their caregivers.
● Dr Stephanie Crawford, Clinical Psychologist (NHS Greater Glasgow & Clyde) will discuss her recent research project 'An Investigation of the Reliability of the Addenbrooke's Cognitive Examination-Revised (ACE-R)'

Please note, places for workshops will be limited. Applications will be taken on a first-come first-served basis.

To attend the workshop and/or conference please contact:
Frances Free, PSIGE, 20 Fleet Street, Beaminster, Dorset DT8 3EF,
or email to: **frances@academictype.co.uk**

GLASGOW CATHOLIC CATHEDRAL

Developments in the Neuropsychology of Neuro-degenerative Disorders

A joint study day organised by the BPS Division of Neuropsychology and the BPS Division of Clinical Psychology Old Age Faculty, Psychology Specialists working with Older People (PSIGE)

Convenors: Cath Burley & Phil Yates

Friday 10 June 2011 – 9.30 a.m. to 4.30 p.m.

Venue: The London Voluntary Resource Centre, 35b Holloway Road, London, N7 6PA (www.theresourcecentre.org.uk)

Outline of the day:
This post-qualification training day is an opportunity to bring together psychologists for an update on developments in neuropsychological research on neuro-degenerative disorders. The day will cover a range of recent neuropsychological research on multiple sclerosis, Parkinson's disease, motor neurone disease, Alzheimer's disease and dementia. It is anticipated that learning outcomes from the day will include a greater awareness of current research in neuro-developmental disorders, and an understanding of it's application in relation to clinical practice.

Cost:
£100 (DON/PSIGE member);
£120 (BPS member but non-DON/PSIGE member);
 £75 (Trainee/Assistant/student BPS Member but non-member of DON/PSIGE);
£150 (non-BPS/DON/PSIGE Member)

Register online for this event at: www.kc-jones.co.uk/neurodegenerative

For all registration enquiries: Tel: 01332 227773; email: bps@kc-jones.co.uk

For further general information about this and other PQT events contact:
Phil Yates (DoN CPD/PQT Co-ordinator), Tel: 01392 208585; email: p.j.yates@ex.ac.uk

Developments in the Neuropsychology of Neuro-degenerative Disorders – Provisional Programme

9.00–9.30   **Registration** *(with coffee and biscuits)*

9.30   **Introductions**

9.40   **Atypical presentations in a typical memory clinic:**
      The possibilities for rehabilitation
      Dr Rebecca Poz, (Suffolk Mental Health Partnership NHS Trust)

10.30   **Cognition in Motor Neurone Disease**
      Dr Sharon Abrahams (Euan MacDonald Centre for MND Research & Centre
      for Cognitive Aging and Cognitive Epidemiology, University of Edinburgh)

11.30   Coffee

12.00   **Dual tasking and executive functioning in healthy ageing, Alzheimer's and**
      Parkinson's disease
      Dr. Jennifer Foley (Human Cognitive Neurosciences, University of Edinburgh)

13.00   Lunch

13.45   **Using neuropsychological assessment to predict everyday functioning in**
      Alzheimer's dementia
      Dr Linda Monaci (Wolfson Neuro-rehabilitation Centre,
      St George's NHS Healthcare Trust).

14.30   **When is progressive not progressive?**
      A consideration of vascular dementia vs. stroke
      Dr Dons Coleston-Shields

15.15   Tea

15.45   **MND and Parkinson's Disease**
      Dr Steven Meldrum (University of Glasgow)

16.30   End

Notes for Contributors

The *PSIGE Newsletter* welcomes the following submissions for publication: articles, research updates, Letters to the Editor, book reviews. These can be on any aspect of psychological theory or practice with older people.

Articles

Articles form the bulk of contents submitted to the *Newsletter*. 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. These can cover empirical investigations, pilot studies, descriptions of service developments, audits and evaluations. Articles should be submitted three months before publication (i.e. October for the January issue, January for the April issue, April for the July issue, and July for the October issue).

Articles of any length up to a maximum of 3000 words will be considered. Experimental reports should follow convention in terms of subheadings and sections: Abstract, Introduction, Method, Results, Discussion, References.

References should follow conventional format as in journals such as *Psychological Review*:
(1) Book reference:
    Mischel, W. (1986). *Introduction to personality.* New York: CBS.
(2) Journal article:
    Martin, A. & Fedio, P. (1983). Word production and comprehension in Alzheimer's disease: The breakdown of semantic knowledge. *Brain and Language, 19,* 124–141.
(3) Paper in a book:
    Garrett, M. (1980). Levels of processing in sentence production In B. Butterworth (Ed.), *Language Production (Volume 1) Speech and Talk.* London: Academic Press.

Research Updates

The *Newsletter* is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, for example, ideas for discussion or early stage results, which are not ready for formal publication. Try to keep these submissions below 500 words.

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.

Book reviews

Submissions up to 250 words reviewing a text of relevance and interest to the PSIGE membership will be considered. These submissions must include full details of the book (including publisher).

The Editorial Board reserves the right to make minor changes to any submissions. Where major editing is necessary, the authors will be informed.

Images

The *Newsletter* is published in black-and-white. It is not advisable to send complicated, colour diagrams. If you are unsure, try printing the image or photograph out on a mono laser printer to check for clarity.

Please send original image files (.tif, .jpg, .eps or the like), not simply a Word document with the pictures imported into it, as these do not print properly.

Submission Procedure

All submissions must be written in language that is inherently respectful to older people and consistent with the British Psychological Society's guidelines.

All contributions must be word processed. Formatting should be consistent with the British Psychological Society's guidelines.

Please submit articles as a Word file via e-mail to the Editor.

When submitting articles please send the following information:
Full name;
Affiliation (title, place of work);
Contact details (should you be willing to be contacted by the membership);
Acknowledgements (as appropriate).

Finally, all reports of research should indicate whether or not Ethics Committee approval was awarded, and by which Ethics Committee, or whether the work was carried out as an audit/service evaluation project.

All contributions should be sent to: **louisa_shirley@hotmail.com**

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