Clinical Psychology with Older People: a perspective from the UK

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Outline

- PSIGE – a brief history and exploration of the PSIGE mentality
- Training in clinical psychology – the UK position
- Ageism and being ‘specialist’
- Building the evidence base
“You don’t have to be crazy to work here, but it helps...”
PSIGE was formed by people whose colleagues thought they were crazy to work with older people.
Crazy – Oxford Dictionary

- Insane or mad; foolish
- Extremely enthusiastic (about)
- (Slang) exciting, unrestrained
- (Slang) excellent
- Made of irregular pieces fitted together
What led to the formation of PSIGE?

Government commissioned Trethowan Report on the organisation of clinical psychology services: identified work with older people as a distinct speciality within an Area Clinical Psychology Service (1977)

In some places, ‘Head of Specialist Grouping’ posts were set up – typically group of 1
1979: Raising the profile

- Scottish group (PACE) meeting regularly – first newsletter (combined with PSIGE1982)
- BPS Bulletin carried a number of flag waving pieces:
  - Article by Mumford & Carpenter on ‘Psychological services and the elderly’
  - Letter from Jeff Garland asking for interested people to contact him re forming a group as in Scotland
  - Letter from John Hodge outlining aims and functions of PACE
1979 - continued

Age Concern England initiated meeting with BPS Division of Clinical Psychology - November 24th:

- Attended by Sally Greengross and several colleagues
- Jeff Garland & Bob Woods, together with DCP Secretary David Mulhall attended for DCP
- Among planned actions was to call a meeting for all psychologists interested in spring of 1980

Article in DCP Newsletter ‘Sans psychologists, sans everything’ appeared early in 1980 to introduce this development (Woods, 1980)
May 23\textsuperscript{rd} 1980: ‘Inaugural meeting of special interest group for psychologists working with the elderly’

- Held at Corbett Hospital, Stourbridge, West Midlands (courtesy of Anne Broadhurst)
- Agenda included newsletter, regional sub-groups, links with other organisations & appointment of officers
The first conference proper – Leicester University, 1981

- Around 35 people attended
- Cost £20 members (non-residential)
- 106 on membership list
- Agreed constitution and name
The name

SIGPE? Leicester conference flyer 1981
  - Competition for best name announced
  - Prize of a year’s free membership
PSIGE? Newsletter No. 3 – post-AGM 1981
What’s in a name?

When PSIGE formally became part of DCP in 1983 it was: ‘Psychologists’ Special Interest Group in the Elderly of the Division of Clinical Psychology of the British Psychological Society’ - a change of name was considered and rejected!

2003: ‘Psychology Specialists working with Older People: a Faculty of the Division of Clinical Psychology of the British Psychological Society’
A lot of interest from the outset

- But relatively few members worked full-time with older people
- Variable geographic coverage
The perceived mythology
(Woods, 1980 DCP newsletter)

- Few are interested in the speciality and even fewer work in it
- Trainee psychologists will resist having to carry out placements with older people
- There will be a dearth of applicants for new posts
- Training courses provide little training in work with older people
- There is little point anyway – older people are dementing or are too rigid to change or have only a short time to live
The PSIGE mentality 1: passionate about older people

Psychologists working with older people often have a real enthusiasm and passion for the work and for the client group, which colleagues may find difficult to understand.

Sometimes comes from experience working on a ward or care home, or from personal contact in a family context or…

For me it was Denbigh Ward, Fulbourn Hospital, 1973, and the chance to make a difference.
The PSIGE mentality 2: on the outside, excluded

- PSIGE has had to battle for work with older people to be seen as mainstream, core to the NHS and Social Services
- Why do we still have to remind the powers that services for older people are not an optional add-on?
- Why have research studies so often excluded older people?
- Why are less resources available for a care package for an older person with a disability than for a younger person with a disability?
- Why are older people still seen as ‘bed blockers’ and a care home seen as a solution?
Fear of older patients

Cautela, 1966 described ‘gerontophobia’ and suggested that behaviour therapy could be used to desensitise staff, so they feel at ease with ugly or messy patients.

Is ageism still an issue??
The PSIGE mentality 3: the need for like minded souls

- The PSIGE Conference has been the annual ‘fix’ for many a lone worker
- We are not alone…
The PSIGE mentality 4: the pioneer instinct

- So little had gone before
- So much could be done – so many opportunities for innovation, for new projects and approaches
- So many different types of work – such variety of roles and styles of working
The PSIGE mentality 5: welcoming all-comers

- The desire was to be inclusive and for all interested in the application of psychology with older people to find a home in PSIGE.
- Big concern about becoming a BPS sub-system in 1983 was danger of excluding non-psychologists (and non-BPS members) who were denied voting rights.
- Potential for committee co-options to reflect other interests.
- Should perhaps have looked for a place within the BPS outside the confines of the DCP e.g. Section on Ageing?
The PSIGE mentality 6: it’s not a competition

- PSIGE has been characterised by openness and generosity of spirit
- It has welcomed inputs from Assistant, Trainee and newly qualified members
- Point-scoring has been rare
- A wide range of members have shared leadership responsibility over the years
The PSIGE mentality 7: therapeutic optimism

‘Therapeutic nihilism’ was the order of the day

‘It’s organic, there’s nothing a psychologist can do’

‘People with dementia can’t learn’

‘Older people won’t benefit from CBT / psychodynamic therapy / fill in the gap…’

But that didn’t deter us…
The PSIGE mentality 8: committed to training

- The input to training courses increased dramatically in the first ten years of PSIGE (In 1983 survey showed average of 15 hours teaching)
- The Newsletter in the early years was offering reading lists compiled by members
- There were few books available (maybe Birren & Schaie’s Handbook of the Psychology of Ageing, the odd chapter in edited books)
The PSIGE mentality 8: committed to training (continued)

PSIGE members outstanding commitment to offering trainee placements, made the unthinkable possible in the 1990’s:

MANDATORY PLACEMENT EXPERIENCE WITH OLDER ADULTS!!!!

But then came ‘Core competencies’

And a real siege mentality was needed to hold out against the forces massed against us
Clinical psychology training – UK style

- 3 year doctoral programmes – DClinPsy
- Most candidates have 2 years or more experience as assistant psychologists / or research assistants
- Highly competitive to enter programmes (although big expansion in training places)
- 6 x six-month clinical placements (average 3 days per week)
Training UK style - 2

As training places expanded in late 1990’s, it became increasingly difficult to maintain number of older adult placements, whilst retaining quality.

This was seen as a bottle-neck to expansion, and so BPS criteria for accreditation of programmes were revised in 2002.
All trainees must gain clinical experience with people ‘across the life-span’

Trainee log-books of clinical experience monitor this

Special Interest Groups in each region monitor use of placements, to ensure Older Adult placements are used effectively

In Bangor 8/9 trainees have older adult placement – others see older people in Health Psychology or Neuropsychology placement
Teaching input on Older Adults – BPS Accreditation Criteria - 2002

‘While it is appropriate that Programmes should differ in their emphases and orientations, they must all provide academic teaching relevant to the full range of client groups and a wide range of clinical methods and approaches. This will include teaching on children, adults and older adults and cover mild, moderate and severe mental health problems, learning disabilities, sensory and physical handicaps, brain injury, alcohol and other drug problems and range of physical health problems.’
Teaching input on Older Adults

- Bangor has 66 hours teaching specifically on Older Adults
- Adult Mental Health – 105
- Neuropsychology – 57
- Learning Disability – 114
- Child & Adolescence - 120
Is Ageism still an issue?

- National Service Framework (2001) for Older People – age discrimination in health care to be rooted out
- Arbitrary age distinctions not a basis for service provision
- Older people need champions – in psychology (as elsewhere) – under-represented in clinical practice
New cases seen by clinical psychologists in NHS, England, 2002/3

*rate per 1,000 population*

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<td>2.5</td>
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Rooting out ageism in clinical psychology

- Exposure works
- All clinical psychologists need exposure or will continue to follow the negative stereotypes
- Older people already majority of users of NHS in the UK
- As older people reach 20% and then 25% of the population will mainstreaming be required?
Specialist v. ageist

- How can we manage the generalist / specialist divide? Don’t we all work with adults? Can we trust adult services to work with older people?
- If we can no longer define our specialism in terms of age, how do we view it? What are we really about?
- When is our specialist input needed?
- How do we maintain and develop our distinct identity?
The growing evidence base

- There are many systematic reviews and meta-analyses available.
- Woods & Roth (2005) in the second edition of Roth & Fonagy’s ‘What works for whom?’ is a convenient launch-pad!
- BUT, could we do more to add to the evidence-base (whilst recognising the limitations of relying too much on the ‘gold standard’ RCT approach)

- ‘The full range of psychological interventions should be made available to older adults with depression, because they may have the same response to psychological interventions as younger people’
  - Recommendation based on expert committee reports or opinions and/or clinical experiences of respected authorities
Psychological interventions in dementia

- A number of Cochrane reviews are available mainly indicate there is not enough rigorous research (e.g. Reminiscence).
- Can we provide the empirical underpinning for our pioneers’ initiatives? NICE guidelines on management of dementia due out in 2007.
- Can we work with UK Dementia Research Network to achieve good quality research on psychological interventions?
- There is now a large-scale, rigorous evaluation of Cognitive Stimulation groups (taken the mantle of RO), showing significant impact on cognitive function and Quality of Life (Spector et al., British J Psychiatry, 2003).

Treatment and Control Groups - differences between baseline and follow up: Cognition (n=201)

- MMSE: p=0.04
- ADAS: p=0.01
RCT of Cognitive Stimulation Therapy – QOL-AD

Treatment and Control Groups - differences between baseline and follow up: Quality of Life (n=201)

![Bar chart showing QOL change for treatment and control groups with p=0.03]
Self-reported Quality of Life and dementia

- **QOL-AD (Logsdon et al, 1999)**
- **Simple self-report measure of QoL**
  - 13 items, 4 point scale
  - E.g. Energy; Fun; Money; Physical health; Friends; Family etc.
  - Completed in interview with person
  - Domains validated from focus groups (people with dementia & carers) & questionnaires (professionals)
Can you rely on what people with dementia tell you about their QoL?

(Thorgrimsen et al. (2003) Whose quality of life is it anyway? The validity and reliability of the Quality of Life - Alzheimer’s Disease (QoL-AD) Scale. Alzheimer Disease and Associated Disorders, 17(4), 201-208)

- **Internal consistency** (N=201) : alpha = 0.82
- **Re-test reliability – 1 week** (N=38) :
  - Total score 0.87 (intraclass correlation)
  - Sub-scales Kappa’s 4/13 ‘good’ agreement; 8/13 ‘fair’ agreement
- **Inter-rater reliability** (N=38) :
  - Total score 0.96 (intraclass coefficient)
  - Sub-scales Kappa’s 12/13 ‘excellent’ agreement
- **Associated with observed well-being (Dementia Care Mapping) r=0.39 p=0.05**
QoL and cognitive function

Sample of 201 people with dementia in residential homes / day centres (MMSE 14.4 sd 3.8)

QOL-AD not correlated with memory and cognition measures such as ADAS-Cog or MMSE

Higher in those with moderate dementia than in those with mild dementia on clinical dementia rating

Self-rating relates to depression, not cognition

Proxy-ratings relate to challenging behaviour (Hoe et al., in press)
QOL-AD in severe dementia

Hoe et al. (2005) Age & Ageing, 34, 130-135

Evidence for validity and reliability for people with MMSE scores of 3-11

QOL does not decrease as cognition worsens
Recognising the person with dementia – the major change since 1980

- Opens the way for psychological interventions with the person with dementia
- Encouraging work on CBT for depression and anxiety
- Psychologists have a key role in ensuring the perspective of the person with dementia remains centre stage