Introduction

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This volume marks the continuing growth and development of clinical psychology with older people. Since the first edition of this handbook was published (Woods, 1996) research activity has continued to increase in relation to all aspects of ageing. Both 'normal' and 'abnormal' aspects have been extensively studied; the area of overlap between the two has become more evident, although still not well understood. Opportunities to develop clinical psychological services for older people have been apparent in the UK and elsewhere and no longer can the contribution of clinical psychology to services for older people be seen as simply one of 'promising potential'. There is now ample evidence of psychological practice with older people in a wide range of contexts working with most of the common problems experienced by older people and their supporters. Within the broader family of clinical psychology, work with older adults has, perhaps belatedly, achieved recognition and is less likely to be seen as a rather esoteric, minority interest.

This volume stands as witness to a remarkable degree of progress in the field. Although there remain large gaps in the evidence base for interventions with older people, there are now sufficient indications of effectiveness to underpin a number of evidence-based reviews (e.g. Gatz *et al.*, 1998; Livingston *et al.*, 2005; Woods & Roth, 2005) and to inform evidence-based guidelines, such as the NICE-SCIE guideline on supporting people with dementia and their carers (NICE-SCIE, 2006). The latter document includes recommendations on psychological therapies for depression and anxiety in dementia, and for psychological distress experienced by family caregivers, a psychological approach to behaviour that challenges, and psychological interventions, such as cognitive stimulation, to enhance cognition in people with mild to moderate dementia. In addition, it is recommended that a neuropsychological assessment be carried out in all cases of suspected dementia.

This volume aims to provide an up-to-date review and synthesis of theory and research evidence relevant to clinical practice. Although there are a number of chapters that specifically address issues relating to dementia, the range of psychological problems experienced by older people is addressed. A brief first section covers the key aspects of the psychology of ageing, as well as providing a health psychology perspective on the physical health problems experienced by older people. This section provides the necessary underpinning for a consideration of psychological problems in later life. Detailed discussion of important aspects of the service context for clinical psychology in later life includes primary care,

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residential care and the situation of people with intellectual disabilities. Two sections address the key aspects of clinical practice – assessment and intervention. A wide range of intervention approaches are discussed, for the range of psychological problems, and interventions with family care-givers are addressed in Chapter 16, based on a well-developed model of understanding and assessing the care-giving situation and also in Chapter 32, based on an analysis of the extensive evidence-base.

However, for all that has been achieved, it is important to acknowledge some of the challenges that this now-mature specialism will be likely to face in its next phase of development. These challenges arise from several interacting factors. Firstly, there is the nature of the ageing population, which will define the target group for psychological services for older people. Second, there are challenges arising from the position of older people in society, and the diverse experiences of later life that results from a society that has embraced the active older person, but where disability and dependency lead to a risk of social exclusion. Third, there are developments and pressures specifically relating to the profession of clinical psychology, including training and issues of recruitment and service development. Finally, there are personal challenges that arise in working with older people, which are by no means new, but must be encountered by each new cohort of clinical psychologists entering this field.

WHO ARE OLDER PEOPLE?

Across the world, there are an unprecedented number of older people. Taking the age of 65 as an arbitrary dividing line, in 1950 there were, according to United Nations statistics (United Nations, 2006), just under 131 million older people in the world, representing 5.2% of the total population; by 2005, there were estimated to be 477 million (7.3% of the total population), and by 2025 older people are projected to form 10.5% of the global population, with 839 million older people – a six-fold increase in 75 years.

There are differences in the overall level and rate of change between regions of the world and individual countries. In general, northern European countries were at the vanguard of population ageing, with many parts of Africa showing the smallest proportions of older people. Population ageing is now very rapid in parts of Asia. Table 1.1 shows the changes in the population of people aged 65 and over in five selected countries from 1985–2025. The UK and Sweden represent the northern European countries, which have shown relatively little change over the last 20 years, already constituting over 15% of the population in 1985. The US has also shown relatively little change in this proportion, but has yet to reach the level seen in the UK and Sweden 20 years ago. Australia has had a slightly more rapid growth, but it is in Japan where the most dramatic changes have occurred, with the proportion of older people having nearly doubled in 20 years, almost reaching 20% by 2005. This trend looks set to continue in Japan, with more modest, but clear and important, growth in the population aged 65 and over in the other selected countries too. Table 1.2 indicates the changes over the similar time period in the population aged 80 and over. In the UK and the USA, the numbers of people in this age group are projected to have doubled over the period 1985–2025. Again, Japan is showing the most dramatic rate of change, with 10% of the population projected to be aged 80 and over by the year 2025.

Typically, at present, life expectancy at birth is greater for females than males. For example, in the UK, in 2005 it was 80.7 years for women and 76.1 years for men; in Japan,

Table 1.1 Population (thousands) and percentage of total population, aged 65 and over in selected countries

	UK	US	Sweden	Japan	Australia
1985	8 578	28 423	1 491	12 450	1 588
	15.2	11.7	17.9	10.3	10.1
1995	9 169	33 399	1 542	18 264	2 151
	15.8	12.4	17.5	14.6	11.9
2005	9 684	36 751	1 557	25 255	2 662
	16.1	12.3	17.2	19.7	13.1
2015	11 358	46 355	1 909	33 120	3 600
	18.1	14.1	20.2	26.2	16.1
2025	12 986	63 203	2 155	35 835	4 788
	19.9	17.8	21.9	29.5	19.6

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2006 Revision* and *World Urbanization Prospects: The 2005 Revision*, http://esa.un.org/unpp.

it was 85.2 for women and 78.3 for men. This is reflected in women out-numbering men, especially in the higher age groups. For example, in the UK, the sex ratio in those aged 65 to 69 is 1 male to 1.08 women, whereas in those aged 80–84 the ratio is 1:1.62, and amongst those aged 85 and over it is 1:2.47. In the US there are seven times as many female as male centenarians (United Nations, 2006).

However, this longer life expectancy may be at the cost of women living more years in poor health. For example, UK figures suggest that expected years lived in poor health from age 65 onwards are 5.8 years for women and 4.3 years for men (Evandrou, 2005). Limiting long-term illnesses are common in the older age groups (see Chapter 4, this volume). Over three-quarters of women (and 70% of men) aged over 85 have such a condition, whereas only around 20% of men and women aged 50–54 are similarly affected (Evandrou,

Table 1.2 Population (thousands) and percentage of total population, aged 80 and over in selected countries

	UK	US	Sweden	Japan	Australia
1985	1 802	5 916	332	2 215	267
	3.2	2.4	4.0	1.8	1.7
1995	2 272	7 565	411	3 881	466
	3.9	2.8	4.7	3.1	2.6
2005	2 685	10 625	482	6 178	712
	4.5	3.5	5.3	4.8	3.5
2015	3 049	11 958	497	9 849	944
	4.9	3.6	5.3	7.8	4.2
2025	3 597	14 642	638	12 929	1 254
	5.5	4.1	6.5	10.6	5.1

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2006 Revision* and *World Urbanization Prospects: The 2005 Revision*, http://esa.un.org/unpp.

2005). Among those aged 65–74 and 75–84, 40% and 60% respectively have a limiting long-term illness. However, from a psychological perspective, it is important to note that subjective health is not necessarily poor: 56% of women and 58% of men aged 65 and over with a limiting long-term illness rate their own health as good or fairly good (Evandrou, 2005).

The Health Survey for England (2005) reports a number of health indicators for people aged 65 and over (excluding those living in institutional care settings). Arthritis was the most common chronic disease reported by women (reported by 47% of women and 32% of men), whilst for men cardiovascular disease is the most common condition (reported by 37% of men and 31% of women). Two-fifths of older people reported functional limitation in at least one area of activity. For more than half of these, the area of difficulty was being unable to walk 200 yards without stopping or experiencing discomfort. The prevalence of functional limitation increased with age, with around a quarter of men and women aged 65–69 having at least one functional limitation, compared with 65% of women and 57% of men aged 85 and over. Similarly, the proportion having multiple areas of functional limitation also increases with age. Nearly a fifth of women (19%) and 17% of men aged 85 and over report three or more areas of functional limitation, whereas the corresponding figures for those aged 65–69 are 2% and 4% respectively. The risk of falls increases with age, with 43% of men and women aged 85 and over having had a fall in the previous 12 months, compared with 18% of men and 23% of women aged 65-69.

Other chronic conditions that were common in the over 65 population included diabetes (13% of men, 10% of women), asthma (10% men, 12% women) and chronic lung disease (9% men, 7% women). Nearly two-thirds of people aged over 65 were hypertensive (62% men, 64% women), in that they either had raised blood pressure at the time of assessment or were taking medication for high blood pressure. It is important to note that of those taking medication, only 50% of men and 45% of women had blood pressure in the acceptable range. Over a fifth of people aged 65 and over had visited their general practitioner in the previous fortnight; this was related to their self-assessment of health, but not to their age.

Broadly comparable figures for chronic conditions are reported from the US (Federal Inter-agency Forum on Aging-related Statistics, 2006), for people aged 65 and over (again excluding those in institutions), with lower rates of self-reported hypertension (48% men, 55% women); higher rates of diabetes (men 20%, women 15%); slightly lower rates of asthma (8% men, 10% women); and higher rates of arthritis (43% men, 55% women). Nearly half of men aged 65 and over (48%) reported having some difficulty with hearing, and 14% had some difficulty with vision. For women, the corresponding figures were 34% and 19% respectively.

The Health Survey for England (2005) indicated that substantial numbers of older people had little contact with friends (reported by 36% of men and 31% of women) or with family members not living in the same household (reported by 31% of men and 24% of women). A severe lack of perceived social support was reported by 18% of men and 11% of women. Living in areas with limited access to local amenities such as supermarkets and post offices was more likely with increasing age, and was related to poor health in men. Participation in organizations was associated with better health, as was contact with friends and perceived social support for women in the sample. People over the age of 80 appear to be at particular risk from social exclusion on multiple indicators (HM Government, 2006). Thus, they were more likely to live in below-standard housing, experience fear of crime, have difficulty accessing important services, be on a low income, be less likely to meet up with friends,

have access to transport, and participate in adult learning, volunteering or other physical and leisure activities.

In summary, the clinical psychologist working with older people in the second decade of the new millennium, in a developed country, will be working with many more people in their 80s and 90s than would have been the case 20 years ago. In these age groups, women will outnumber men, of course. Multiple chronic health conditions will be common and these may lead to reductions in the person's ability to manage day-to-day activities, although they do not necessarily lead to a perception of poor health. Sensory impairments will also be common. A significant minority of older people will not have good social support and may feel isolated from contact with friends and family.

AGEING IN SOCIETY

The demographic changes and population projections documented in the previous section reinforce the assertion that we live in unprecedented times. Although areas of the world where population ageing has proceeded at a slower pace may hopefully learn from the experiences of the northern European countries, for example in planning health and social care services, on a global level society has never before included such proportions of older people.

Often these changes are viewed as a problem for society as a whole. In the UK, there is near-panic as to how it will be possible in the future to pay for the pensions earned over many years by those who will reach retirement age in the next decade or so. There is equal concern over the projected costs of long-term care to meet the anticipated costs of providing care for increasing numbers of older people predicted to require nursing and personal care and unable to live independently.

Equally, these changes provide a great resource to society, of experienced and mature individuals, able to contribute to the workforce directly, or through providing childcare for their grandchildren, allowing others to work, or contributing through volunteer activity, or performing other caregiving tasks for family members and friends.

It is these two faces of older people in society, which may be crudely characterized as 'burden' or 'resource', that reflect the ambivalence experienced at personal, professional and societal levels. We all have a personal investment in ageing and most people wish to avoid an early demise, but there is the concern that increased life expectancy will simply result in a longer period of life lived with disabling health difficulties. Brayne (2007) suggests that there is some limited evidence emerging that 'compression of morbidity' is occurring in population studies, with the average period spent prior to death in a disabled state not increasing with increasing life expectancy.

It is the fear of this aspect of ageing that Butler (1969) argued gave rise to 'ageism', which he described as reflecting 'a deep seated uneasiness on the part of the young and the middle-aged – a personal revulsion to and distaste for growing old, disease, disability, and fear of powerlessness, uselessness and death.' Ageism is now often more broadly defined, to include discrimination on the basis of age at any point in the lifespan (Bytheway, 1995) but the original sense of devaluing and distancing from older people and the negative features that have become associated with ageing, remains relevant and raises personal as well as professional issues. It is now also evident that such ageism is not confined to younger and middle-aged people; older people may well bring these powerful feelings to late life.

This tension is also apparent in the distinction that may be drawn between the 'third age' and the 'fourth age'. The third age of life reflects the period beyond work and employment. It follows on from childhood and working life and allows for many, new opportunities for enjoyment and self-development. The University of the Third Age is well-established and well-known as a virtual learning community, where older people share knowledge, skills and wisdom in the pursuit of learning and development rather than to gain qualifications or degrees. Equally well known are the older people who post-retirement find opportunities for travel and exploration, or who establish themselves in places where previous holidays have been enjoyed. For a proportion of third agers (but by no means all), a good quality of life is attainable, with financial resources and health matching aspirations. There are certainly clear signs of current cohorts of older people making inroads into some of the disempowering forces that surround them, particularly in the roles of consumer and campaigner.

The fourth age, on the other hand, takes us again into the arena of disability and poor health, dependency and disease. It includes all the fears of ageing, embodied in Butler's definition of ageism, which affect older people just as much as they do younger people (although the focus of fear of death in older people tends to be process orientated rather than the fear of nonexistence reported by younger people; see Woods, 1999). It can happen suddenly, such as when a person has a severe stroke, or develop gradually as multiple disorders combine and accumulate to a point where the person is no longer able to maintain a degree of independence satisfying to him/herself. It is not necessarily triggered by a limiting long-term health condition; as mentioned previously, many older people maintain a positive view of their health whilst having such a condition. It happens perhaps when changes can no longer be assimilated into the person's self-concept as an independent, capable person, and the challenge becomes one of accommodation to receiving help with personal care and daily life, whilst maintaining dignity and individuality. Third age/fourth age transitions are not necessarily irreversible; there may be recovery from a stroke or mobility may be regained following an operation for fractured neck of femur, for example, but the fourth age is a period of great vulnerability. Maintaining control over even small aspects of daily life may become difficult; feelings of powerlessness and frustration may arise in situations where help must be asked for and received in carrying out activities that were previously easily accomplished. Decision making may seem to be taken over by others, and major decisions, such as moving into a care home, appear to have to be made quickly, at a time when all the consequences may not be clear. As one older person commented to the author regarding the process of being discharged following an acute admission to hospital: 'I was offered a choice of what care home I went to, but I wasn't offered the choice of going back home.'

Finding meaning and purpose in the fourth age is probably the greatest remaining challenge for gerontology. There is now no question that those older people who have reasonable health, economic and social resources can, and usually do, have a satisfying and fulfilling later life. Those who, for whatever reason, are less fortunate in these respects, will have a more difficult task in maintaining wellbeing in the final chapter of their lives (see also Chapter 2, this volume) as they face social exclusion and disempowerment.

These considerations illustrate something of the diversity of the experience of ageing. Conventional, but arbitrary, age thresholds for pensions, retirement, services or benefits, such as 60, 65 or even 75 mean that people with a range of ages of at least 25 to 40 years are being grouped together. An important gerontological finding is the greater variance shown by older people in many areas of life (e.g. Rabbitt, 2006). Older people have had longer

to follow their own developmental path, to develop different skills, interests, motivations, preferences and abilities and to have different life experiences, and so may be more different from each other than groups of younger people. The influence of cohort effects is a further key aspect of gerontological research (see Chapter 3, this volume) which contributes to diversity. The 70 year old today is in a very different position from the 70-year-old person of 1980, in terms of life experiences, position within society and expectations of their phase of life. Each generation of older people brings to later life its own history and values and will accordingly influence and be influenced by the social culture of the time. Add to this differences arising from cultural and spiritual background, ethnicity, sexuality and gender, and the diversity is evident (see Chapter 26, this volume). Different individuals will have unique narratives of their lives, a life story to tell. They will have witnessed and been influenced by many changes in the socio-cultural-political environment, in technology, in the media, in world view, but the story will be fundamentally rooted in a network of relationships, varying in depth and nature. The movement away from the use of terms such as 'the aged' and 'the elderly' reflects the realization that generalizations about such a diverse population are of dubious validity.

Our preferred term 'older people' is remarkably vague, of course, potentially encompassing almost the whole population. However, discrimination on the basis of age is now becoming the subject of the same scrutiny as racism and sexism, for example, in relation to employment and the provision of healthcare and social care services. There is an interesting paradox, in that, in both England and Wales, a National Service Framework for Older People has been published (Department of Health, 2001; Welsh Assembly Government, 2006), each setting the explicit target of rooting out age discrimination; however, these are the only National Service Frameworks for a population, rather than a disease or group of diseases, as if being older is, in itself, a disorder to be treated.

Age appears in so many ways to be such a useful metric (as was evident in many of the statistics quoted in the previous section). It has so many strong and powerful associations that it is tempting to, irrationally, impute to it explanatory power. For example, suppose there is a medical procedure for some condition, which is ineffective if the person also happens to have arthritis; research might show it to be ineffective in nearly half of older women (see prevalence of arthritis cited previously); its effectiveness would be shown to be less in older people, but to deny it to people on the basis of age would, of course, be illogical. The important criterion would be presence/absence of arthritis, whatever the person's age. Brayne (2007) describes age as being 'the elephant in the room', a large, overwhelming presence, which makes it difficult to see any of the other factors that may also be present. Age is simply a convenient summary of numerous processes occurring over time; it is clearly not a single, unitary process in its expression in older people. Until this is fully recognized, dealing with age discrimination will be extremely difficult, as it will have the aura of rationality and common sense.

A clinical psychology of ageing must be responsive to the dynamic tapestry produced by the interaction of cohort effects, temporal changes and the myriad of processes occurring to the individual over time, which are conveniently subsumed under the umbrella term 'ageing'. The key point here is that no part of the overall picture is static: older people, the social, historical, political and economic context, the pattern of services. All are dynamically interrelated; mismatches between expectations and reality are inevitable when so much change occurs so quickly. A good example of the interaction between social expectations and psychological function was provided by Levy and Langer (1994). In a cross-cultural

study involving groups from the US and China, it was shown that memory performance in later life was related to positive views of ageing. In cultures where older people were respected and valued there was less apparent decline in cognitive function with age. The older person cannot and must not be studied in isolation from their context; they are enmeshed in a presumptive world order, rich in accumulated experiences and expectancies.

CLINICAL PSYCHOLOGY WITH OLDER PEOPLE

In the UK, the development of a specialism in clinical psychology with older people can be traced back to the late 1970s. Prior to this, there were a few individual clinical psychologists in posts working with older people, and some pioneering examples of clinical psychological research on older people and the dementias (e.g. Savage *et al.*, 1973; Shapiro *et al.*, 1956; Whitehead, 1973). Then in 1977, the Trethowan report on the future organization and development of clinical psychological services was published by the government's health ministry, and identified work with older people as a distinct speciality within area psychological services. This initiative encouraged the development of posts in each area, heading up this new specialism. These posts were often encouraged and supported by the pioneering old-age psychiatrists, who were already building from a base of institutional provision for older people with mental health problems to establish new services, outreaching to the community, setting up day hospitals and showing the importance of visits to the person's home. By 1979, a momentum was developing for the isolated practitioners in this field to come together for mutual support and to make common cause. In the *Bulletin of the British Psychological Society* (BPS) of that year there was an article on 'psychological services and the elderly' (Mumford & Carpenter, 1979), and two letters on this topic. The first, from John Hodge, described how a small group of psychologists in Scotland, all working with older people, were meeting regularly; the second, from Jeff Garland, sought interested people to make contact, with a view to establishing a similar group in England. The following year, with the encouragement of Age Concern England and the BPS Division of Clinical Psychology, 'PSIGE' (Psychologists' Special Interest Group in the Elderly), as it came to be known, had its inaugural meeting. It quickly established itself as a valuable source of support and communication between those interested in this work, most of whom worked in isolation, often with colleagues who were rather bemused as to why anyone would choose to work with older people. A regular newsletter, an annual conference and regional groups quickly became the pattern of activity, which has continued to the present time. Psychologists' Special Interest Group in the Elderly became formally part of the British Psychological Society Division of Clinical Psychology (DCP) and was instrumental in ensuring that work with older people became a mandatory component of UK training in clinical psychology. It is now a Faculty of the DCP, and although retaining the acronym PSIGE, it is now known as 'Psychology Specialists Working with Older People'.

By the 1990s, training programmes in the UK were seeking to ensure that all trainee clinical psychologists had clinical experience with older people, as well as academic teaching covering the area. At the same time, the number of training places began to increase, and those clinical psychologists working in the field worked extremely hard to attempt to provide sufficient clinical placements, so that all trainees could have a full placement, rather than gaining more limited experience with a small number of older clients. Although many additional posts were established at this time, there were continued difficulties in recruiting

psychologists to work in this area, thus compounding the shortage of qualified psychologists able to provide training placements.

By 2002, the shortage of clinical placements in work with older people was seen as the major obstacle to increasing further the numbers of training places in clinical psychology as a whole. A substantial increase was perceived to be required to meet the needs of the National Health Service (NHS) for clinical psychologists to work in a range of specialist areas, with many vacant posts, and training courses not keeping up with the demand for additional posts from the service. This led to a dilution of the placement requirement, so that whilst experience across the life-span continues to be compulsory, a specialist older adult placement is no longer required. Older people might be seen, for example, whilst on a neuropsychology or health psychology placement. PSIGE continues to be committed to providing as many training placements as possible, so that the majority of trainees have a good quality specialist placement.

At the time of writing, less than five years after this action was taken, the total number of training places is falling once again, as a particularly severe NHS funding crisis means that, for the first time in many years, expansion of clinical psychology services has been halted, and clinical psychologists finishing their training are finding some difficulty in obtaining an NHS post in the area and specialism of their choice. This is in the context of increased demands for evidence-based psychological therapies in the NHS, and so may be a temporary setback. However, it seems unlikely that mandatory placements (in any area of work) will be reintroduced. There is now a greater emphasis on core competencies, transferable skills, a wide range of experience and individual training pathways, rather than all trainees having specified placement experience. However, all trainees continue to have academic teaching in relation to older people. PSIGE has had an important role in setting out the parameters of training in work with older people, both in relation to clinical experience and academic teaching. The suggested syllabus for the academic component (PSIGE, 2006a) is

1. General issues in ageing
2. Normal ageing and the impact of life events
3. Physical and psychological disorders in older people
   - 3.1 Understanding dementia and related disorders
   - 3.2 Presentation of dementia and related disorders
   - 3.3 Assessment of people with dementia and related disorders
   - 3.4 Psychological problems in later life
   - 3.5 Physical health in old age
4. Service provision
5. Intervention approaches and clinical skills development
   - 5.1 Interventions in the early stages of dementia
   - 5.2 Interventions in the later stages of dementia
   - 5.3 Rehabilitation
   - 5.4 Cognitive-behavioural approaches
   - 5.5 Other psychological therapies and approaches

In the US there have been similar pressures on supervisory resources and the same difficulties in ensuring that a meaningful experience in work with older people is obtained (Knight *et al.*, 1995). The development in 1993 of a specialist group – a Section on Clinical Geropsychology (Section II) of the Clinical Psychology Division of the American Psycho-

Table 1.3 New cases seen by clinical psychologists in NHS, England, 2002/3 (rate per 1000 population)

	All	Male	Female
All ages	3.8	3.5	4.1
0–4	2.2	2.8	1.7
5–15	3.4	4.0	2.7
16–54	4.5	3.7	5.2
55–64	3.3	3.0	3.6
65–74	2.6	2.4	2.7
75–84	2.7	2.7	2.8
85 and over	2.5	2.8	2.3

logical Association – has given a focus to initiatives to develop specialist training in this area.

Qualls *et al.* (2002) report on the results of a survey of 1,227 practitioner members of the American Psychological Association and found that whereas only 3% viewed older people as their main professional focus, as many as 69% reported currently providing some psychological service to older people, although the median provision was less than 3 hours per week. The survey indicated that 40% wanted to increase their involvement, and showed a great need for continuing education provision in relation to older adults. Psychologists had received relatively little training previously, with relatively little growth in the amount of training in work with older adults having occurred. In Australia, a reluctance to work with older adults is noted by Koder and Helmes (2006). Their survey of 500 psychologists suggested that supervised practice is helpful. A special interest group on ageing in the Australian Psychological Society was inaugurated in 2005, with increased psychological provision for older people amongst its aims. Similarly in the US, Qualls *et al.* (2002) conclude that older people are not receiving the access to psychological services that their level of need would indicate, with level of provision growing slowly.

In the UK, Woods and Roth (2005) examined whether older people are experiencing age discrimination in terms of access to clinical psychology services. Taking initial contacts with clinical psychologists in England as a crude index, in 2002/2003, only 11% were with people over 65, despite them forming approximately 16% of the total population; a person aged 16–54 was 1.7 times more likely to have an initial contact with a clinical psychologist than someone aged 65+ (Department of Health, 2003). Table 1.3 indicates that only infants up to the age of four are less likely to be seen by a clinical psychologist.

It is worth considering why older people do not receive equitable access to psychological services. Given the high prevalence of dementia in the over-75s, additional to the common mental health problems that affect adults of all ages, one might predict the need for psychological service would be greater. There may be cohort effects, with current older people perhaps not being so familiar with psychological treatments but other possible factors must include lack of recognition of psychological problems in older people and failure to refer on for specialist input, as well as underprovision of specialist services.

Psychology Specialists Working with Older People has also been instrumental in producing guidance regarding the appropriate levels of psychological service provision for older people, for example in the document *Commissioning Clinical Psychology Services for Older People, Their Families and Other Carers* (PSIGE, 2006b). This document

argues that clinical psychologists specializing in work with older people should be core members of:

- Secondary mental health care services for older people
- Services for younger people with dementia
- Services for people who have had a stroke
- Services for people who are at risk of falling
- Intermediate care services
- General hospital care for older people

The roles envisaged in each area include direct clinical work, indirect clinical work (with paid care-workers and other staff), teaching and training, service development and research and evaluation.

For a catchment area population of 250,000 people (with 45,000 older people), this model envisages a team of nine psychologists, including some at assistant level. It is argued that specialist services such as addictions, eating disorders, traumatic stress and forensic services should accept older people as clients with no age cutoff, with support from older adult psychology services as required. Primary care counselling and psychological therapy services, it is suggested, should either be provided by a properly resourced service for adults of all ages, or a separate primary care psychology service for older people. Whichever option is taken, there should be provision to meet the complex needs of older people, including home visits, longer periods of intervention and extensive liaison with other agencies (see PSIGE, 2002 and Chapter 19 of this volume). Needless to say, such a level of provision would require a dramatic increase in most areas of the UK.

The debate regarding the best model of provision for primary care services reflects perhaps the most challenging issue currently facing clinical psychology with older people in the UK. This relates to the extent to which specialist older adult psychologists are required. The argument can be made that having insisted that all clinical psychologists prior to qualification have experience and training in working with older people, there is no reason why a clinical psychologist working in, say, an adult mental health team should not see adults of all ages. Why should a 63-year-old person with depression be referred to an ‘adult’ clinical psychology service, while someone who is 65 is referred to an ‘older adult’ psychology service? Is this not simply a good example of age discrimination, which must be tackled and removed?

There is no doubt that the success of providing good quality clinical placements in assisting recruitment to older adult posts, may have been at the expense of maintaining a distinct specialism. In some parts of the UK, perhaps as a cost-cutting exercise, the specialist psychology service for older people has been put under threat, being replaced by services ‘for adults of all ages’. There is widespread concern that pioneering and highly valued services that have taken years to establish and develop will be swept away in the apparently worthy pursuit of removing discriminatory practice. The crux of the difficulty is, of course, any inflexible use of an arbitrary age cutoff, which must always lead to discriminatory practice. Avoidance of such cutoffs means that services should be offered on the basis of clinical need. This in turn requires some specification of what profile of clinical need requires a specialist older adult service. This might, for example, include the dementias whatever the age of onset and perhaps depression complicated by physical health and/or complex social needs. Additionally, service choice can be offered to the older person, who

may have strong feelings about not being treated by an 'older person's service', or may prefer to have a service that specializes in problems associated with later life. There will also be a need for an enhanced consultative role with less experienced colleagues, in relation to their work with older people, where developmental and lifespan issues would need to be addressed. However, ageism is such a constant threat that older adult specialists must ensure that older people do not experience indirect discrimination when all-age services do take responsibility for their care. This can be attempted through monitoring of referral and treatment rates and comparing with the age distribution in the population. As the official referral figures quoted above indicate, older people are far from being in a fair position currently.

PERSONAL ISSUES

Lee, Volans and Gregory (2003) surveyed 371 clinical psychology trainees in the UK and identified a number of rewards and challenges in relation specifically to working with older people. The emotional impact was evident and included feelings of hopelessness, feeling overwhelmed by the situations experienced by some older people and being confronted by older people's experiences of multiple loss. More positively, trainees found the work rewarding in that they discovered that they could make a real difference to the older person's life and that their attitudes to their own ageing became less negative as they discovered that older people were not 'an alien species'; skills and abilities learned with other client groups were, they discovered, applicable with older people. Some trainees have had very little previous contact with older people and may bring to the placement a whole host of negative stereotypes and expectations.

Placement experiences where these matters can be freely and openly discussed with an experienced supervisor are an essential part of training to work with older people. A prime reason for placement experience being a vital component of training to work with older people is the opportunity it provides to dispel the mythology that surrounds ageing and older people. However, the opportunity to address issues of therapeutic hopelessness and impotence, to be faced with real adversity and to witness the impact of multiple losses all provide invaluable developmental experience for the aspiring clinical psychologist.

Continued postqualification supervision is just as necessary, of course. The exposure to ill health and death can interact with the psychologist's own fears and concerns, perhaps in relation to parents or grandparents and their mortality. It can be very difficult, for example, to lose a relative at an untimely young age, and then be working with an 85 year old who expresses a wish to die but continues to have life. Issues of transference and countertransference (see Chapter 28, this volume) in a therapeutic relationship where the client is typically older than the therapist may show a pattern of development as the therapist's life situation changes – perhaps from the comfortable and productive position of the favourite grandchild to the more uncomfortable situation of the adult child, where conflicting goals, and assertions of parental authority are more evident. There are many areas for supervision to address; for example, self-disclosure is one of a number of boundary issues that frequently arise in working with older people; should older people's questions about the psychologist simply be seen as a natural (and sensible) curiosity about the abilities of a person 50 years their junior to make an intervention in their life, and receive a factual response; or, should they be seen as an aspect of the therapeutic process, to be analysed and probably not directly

answered? The clinical psychologist needs to be comfortable in discussing taboo topics with the older person: discussion of death and dying, religion and spirituality and sexuality are too often avoided, and yet each may have great salience for many older people. Again, these are areas where supervision can be helpful, especially where the person's views and beliefs are difficult for the psychologist to hear.

For some psychologists, the range of work possible with older people is one of the attractions. To carry out a neuropsychological assessment, work with an older person on adjusting to a health problem, work psychotherapeutically with another client and then advise a care home on a behavioural programme all in the space of one working day or two can be very satisfying but it requires a great many competencies. For some psychologists the feeling of being 'a jack of all trades and a master of none' is frustrating; in a sense, for them, the work is not specialized enough. Working with older people typically has been a place for the all rounder. It may be that as services for older people become more developed there will be greater scope for specialization, with the acquisition of further training and skills after qualification.

Finally, this handbook takes a fundamentally positive view of ageing and working with older people. It espouses a wide range of interventions for the diverse problems experienced by older people and stands in marked contrast to the therapeutic nihilism that surrounded work with older people within living memory. However, it is important to emphasize that blind optimism can be just as damaging. Not all difficulties can be fixed; some negative thoughts are not distortions but a realistic appraisal; some situations have to be endured. The goals of intervention that are important for the client may seem small and insignificant to the therapist but are nonetheless, meaningful in relation to the person's quality of life. This person-centred perspective, taking time and trouble to hear people's own perspective, to understand their meanings and motivations, to hear their story, must be at the heart of a clinical psychology of later life that has value and worth.

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