IMPROVING HEALTH:

What can Psychology contribute?
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WHAT CAN PSYCHOLOGY CONTRIBUTE?

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Dublin
Improving Health: What can Psychology contribute?
The promotion of health is a common goal for individuals and communities. Health can be improved by such diverse activities as campaigning for lead-free petrol, shopping for a balanced diet, having a dental check-up and teaching hygiene skills to children and parents.

In the developed world we are increasingly aware that the elimination of the major infectious diseases in the early part of this century has not resulted in a state of optimal health. Instead, although we live longer on average, we suffer from chronic diseases such as arthritis, heart disease and bronchitis. Thus, while medical and environmental advances have added years to life, for many individuals those added years are often years of disability rather than ability. Many of the chronic diseases are diseases of lifestyle, products of years of inappropriate patterns of behaviour. Thus, for example, high cholesterol diets, cigarette smoking and sedentary lifestyles are risk factors for coronary heart disease. The only effective treatment for many chronic diseases is prevention and this requires a focus on attitudes and behaviour.

Psychology is concerned with the understanding of people's mental processes (such as attitudes) and behaviour. Traditionally, it has been perceived more in the role of explaining and treating abnormal behaviour and has been identified mainly with the mental health setting. However, psychological principles and practices in mental health settings have developed from an understanding of the normal processes of thinking (cognition), feeling (affect) and doing (behaviour). This information is now being used increasingly to help understand people's motives and behaviours in the context of general health and medicine. From this understanding follows the development of effective strategies to improve health. For instance,
psychological principles can explain why certain individuals do not follow medical recommendations (a major problem in medicine) and can help in the development of strategies for increasing such cooperation between doctor and patient.

This short publication aims to provide the reader with an understanding of how psychology can assist the development of health care services appropriate to current health problems. It combines information from the international arena with examples of the work undertaken by psychologists in Ireland in order to provide a flavour of the contribution, actual and potential, of psychology to general health care services in Ireland.

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I. General Applications of Psychology to Health

This section comprises four chapters on the general application of psychological principles in the health area: The first chapter is concerned with the maintenance of health; how psychological principles guide health education and health promotion work. The interface of psychology and general medicine is then examined. Here psychology is involved from its contribution to current undergraduate medical education, through research on the psychological and social aspects of medical illness and treatment, to psychological intervention in the context of serious illness and anxiety-provoking medical procedures. Liaison between psychologists and G.P.s is described next as an illustration of the incorporation of psychological care into health care generally. Finally a chapter on sharing psychological skills with other professions serves as a reminder that the dichotomy between psychological and physical health is an outmoded one; all problems with health demand a consideration of psychological components if the problem is to be treated to maximum effect.
Chapter 1

PSYCHOLOGY IN HEALTH EDUCATION AND PROMOTION

Hannah McGee

Education for health has become increasingly important as the major causes of disability and death in the developed world have shifted from the infectious diseases to chronic and degenerative diseases and accidents. These latter are health problems associated with lifestyle and behaviour rather than with agents directly causing disease. For example, one man in eleven dies prematurely (that is, before aged sixty-five) from heart attack, and for each death at least one other individual suffers with symptoms of heart disease such as chest pain or breathlessness by this age. The major causes of heart disease are smoking habits and dietary patterns (via high cholesterol, calorie and salt intake). With regard to degenerative diseases generally, the Surgeon General of the United States of America has estimated that psychological and social factors are responsible for as much as seventy percent of U.S. mortality. He added:

of the ten leading causes of death in the U.S. at least seven could be substantially reduced if the persons at risk improved just five habits; smoking, diet, lack of exercise, alcohol abuse and use of antihypertensive (blood pressure) medication.

With chronic diseases such as heart disease, the impact of medical therapies is limited both by the nature and the scale of the problem. In this event prevention is the only effective approach. Prevention is to be achieved via health education and health promotion.

Essentially health education focuses on the individual with a view to encouraging lifestyle changes in the inter-
ests of health. Health promotion on the other hand focuses on environmental, socio-economic and political factors influential in health; factors often beyond the control of the individual.

The recent Government document (Health - The Wider Dimensions, 1987) incorporated these two aspects in their view of what constitutes effective health programmes to alter lifestyles. They suggested that key policy aspects would be those:

• making the physical, social, cultural and economic environment conducive to healthy lifestyles;
• strengthening the individual's basic capacity to make choices and to cope with stressful situations without recourse to types of behaviour that might damage health;
• improving individual knowledge about lifestyles and health issues;
• strengthening the social support systems (families, self-help groups, etc.) that assist individuals and vulnerable groups to cope;
• drawing up specially designed programmes to deal with certain aspects of behaviour that affect health.

Such policy aspects require planning, implementation and evaluation skills which depart significantly from traditional health service provision. Psychology is the discipline concerned with human behaviour and the influences which affect it. As such it can contribute to current health education and promotion efforts. For example, psychology concerns itself with the relationships among values, attitudes and behaviour and shows how knowledge is a first but insufficient step of health education towards changing behaviour. Thus, widespread knowledge of the impact of cigarette smoking on health has not resulted in
equivalent levels of smoking cessation. Psychology also identifies functions that various unhealthy habits serve for individuals and indicates that efforts at fulfilling the same functions in less harmful ways have greater success by tackling the source of the problem rather than focussing energy on the unhealthy behavioural symptoms. Thus, for example, alcohol is often used as a relaxant and a social lubricant. Education on healthy forms of relaxation and on social and relationship skills empowers individuals with alternative solutions to their problems and in doing so helps to maintain health.

In Ireland psychologists are supporting health education and promotion work. Such work has directly involved them with health agencies such as the former Health Education Bureau in some instances, and in others has arisen from academic and service provision briefs. Reflecting the multidisciplinary nature of the problem and its solutions, this work often involves collaboration with other professions. The contribution of psychology to the improvement of health can be categorised into three main areas. Psychology has contributed by:

- providing information about the influences operating on various healthy/unhealthy behaviours;
- designing and delivering health education and promotion programmes; and
- evaluating health education and health promotion work.

Examples of work in each of these areas are now outlined.

**Providing information on health education and health promotion**

Attempts at improving levels of health in the community must start with a sound knowledge base. Research in
Ireland has identified factors (both general and particular to the Irish context) which inform planners as to the targets and forms of action. Take for example the area of substance abuse. Considerable research information has been compiled by now on substance abuse in Ireland. Concentrating on youth, one large project by psychologists, involving almost three thousand second level students, illustrated that knowledge of the detrimental impact on health of smoking was equally available to smokers and non-smokers. In that sense the initial goal of health education, that is in providing knowledge about lifestyle and health, was achieved. However, students who smoked evaluated the unhealthy long-term consequences of smoking as being of less concern to them. They also perceived numbers of smokers to be higher than did non-smokers. Such findings highlight the need for health education material on smoking to now focus on more sophisticated and selectively targeted messages than the simple "Smoking is bad for you" message. For instance, smokers might be made keenly aware that they are in more of a minority than they had realised (this approach has been adopted with the "Two out of three do knot" campaign). If long-term health consequences appear to have no deterrent effect on teenager cigarette smoking, then campaigns focusing on the immediate negative effects (such as bad breath, social disapproval or cost) need to be devised.

Another large study in Ireland examined the fundamental reasons for illicit drug use of two major drug abusing groups: long-term cannabis users and heroin users. Long-term cannabis users were more often relatively comfortable economically, were well integrated into community life and indulged in cannabis as a form of controlled risk or excitement. On the other hand, heroin users started from a basis of marginalisation in society but also from very low levels of self-esteem. They used heroin in order to feel
good about themselves and to reduce external pressures and the awareness of risk. Given these two distinct psychological needs and reasons for drug use, the view of drug use as a homogeneous activity (i.e. users availing of any and every form of available drug) does not hold up. This Irish work, equally important for the wider health community, highlights the need to tackle not just drug behaviour, but the particular and different motives for different forms of drug-using behaviour.

Providing information on health care also involves providing information on legislative decisions for health promotion purposes: the recent formulation of health promotion objectives in Ireland through the Health Education Bureau's 1987 document 'Promoting Health through Public Policy' included a psychologist member on the nine-person committee.

Two other areas in which Irish psychologists have contributed towards legislative health promotion have been those of industrial noise and new technology. As part of EC concerns with the quality of working life and its impact on health, noise legalisation in the workplace has recently been evaluated. Psychologists in Ireland were involved in this evaluation by examining the impact of noisy industrial environments on the physical, psychological and social well-being of workers. This information then became part of the knowledge base from which the legislated industrial noise level requiring hearing protection was reduced from 90 decibels to 85 decibels across the European Community in January 1988.

Concern about the introduction of new technology in the workplace on the health and well-being of workers has also involved psychologists in the evaluation of these changes in work practices. This type of evaluation serves two health promotion functions. Firstly, in this context, any difficulties identified can be considered with a view to pre-
venting health difficulties. Secondly, and on a more general level, such work (generated from the concerns of workers) serves as an example of how individuals can influence their own environment in relation to health.

While health promotion through legislation is an extremely important avenue in the struggle for health, psychology also highlights some limitations to the further improvement of health through this means. One area currently being researched in Ireland is that of motorcycle accidents. Despite significant decreases in levels of other types of traffic accident via health education and promotion efforts, the level of motorcycle accidents has not decreased. Nor indeed have improvements in braking mechanisms and tyre design decreased accidents. It is now becoming apparent that for a significant number of individuals, risk-taking on motorcycles serves its own function of stimulation and excitement. Thus legislative and engineering improvements simply provoke an adjustment in behaviour (for example, increased speed with the advent of better braking systems) to allow individuals to return to original levels of risk-taking.

A final example of psychological work providing information on appropriate health care has been the work examining the excessive/inappropriate use of hospital resources for the management of a common childhood disorder, gastroenteritis. Examination of medical decision-making and comparisons of families who managed children at home or in hospital for gastroenteritis have highlighted social isolation, and the attendant unalleviated anxiety of mothers, as the key factors in decisions to hospitalise even relatively mild cases of the illness. In this context written health information was seen to be both usable and useful by those concerned as one immediate and practical means of reducing childhood hospitalisation. Besides providing a starting point for the evaluation of such an app-
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Roach, the research project identified the additional costs of hospital care, as opposed to home care, treatment for gastroenteritis cases of equal medical severity to be in excess of £500 per case, thus providing a very obvious financial benefit arising from work towards promoting appropriate health care management.

Providing health education and health promotion

Health education has been provided by psychologists in a number of forms. At its broadest level the presentation of television programmes, such as the series on the 'ABC of Pregnancy' by a psychologist, provide access to health information for a wide audience. Psychologists are also involved in devising and providing drug education programmes for second level students in Ireland. General health education materials for Irish primary school students have also been developed with psychological help; a teacher's manual with a student programme package has been provided for eight- to ten-year olds. This has been tested extensively in the Cork/Kerry region and is now more widely available.

Concentrating on the other end of the lifespan, psychologists have recently addressed the role of the home help in the care of the aged (see Chapter 7). As an exercise in primary prevention the aim of a course for such helpers is to increase awareness of the needs and concerns of older persons with whom they come in contact.

One of the most concrete examples of the promotion of health by psychologists has been the creation of a multifaceted coronary rehabilitation programme in one Dublin hospital for individuals after heart attack. This programme is run on a six-week outpatient basis and includes such components as the provision of clear and accurate information, dietary advice, lifestyle goal-setting, anxiety alleviation, stress management and spouse/significant other
involvement. Besides this secondary prevention work, important work in the primary prevention of coronary heart disease is under way in Ireland. A major heart disease prevention programme is in progress in one Irish county (Kilkenny). The multidisciplinary team involved in researching, planning, executing and evaluating the work focuses on the lifestyle of the entire community. Knowledge, attitudes and then behaviours are then targeted for change towards healthier styles of living. The necessity and urgency of this type of approach to coronary disease prevention is evident from the fact that in 1980 Ireland had the fourth highest coronary death rate of 27 developed countries examined by the World Health Organisation.

As a useful spin-off, psychological involvement in broad health education and promotion efforts helps to break the stereotypes attached to the work of those considered to be mental health professionals. It helps to create an awareness of the wholeness of health and weaken traditional taboos regarding 'mental illness'.

**Evaluating health education and promotion**

The current popularity of health education and promotion is not sufficient justification for their widespread adoption. Evaluation of such programmes is an essential component of their appropriate development and use. Evaluation by psychologists is a built-in component of some of the projects already mentioned here, for instance the heart disease project and the home help project. Psychologists have also been involved in the evaluation of the lifeskills educational programme now adopted for second level schools. Because evaluation is so important in the advancement of any major aim and because psychologists are trained in research design and execution, it is to be expected that they will play an increasing role in the critical analysis of health education and health promotion efforts in the future.
Chapter 2

PSYCHOLOGY AND MEDICINE
Stuart Lewis

Medicine has traditionally been concerned with the diagnosis and treatment of disease. As such it has been firmly rooted in the biological sciences. The great breakthrough for this traditional view was in the early 'Forties with the major developments in antibiotics and immunisation. This meant that at last the acute diseases which were the killers of the early part of the century were preventable and treatable. However, the penalty was that society was increasingly left with the problem of increased morbidity: the residual consequence of preventing premature death.

Modern medicine has thus to deal with a different array of problems; instead of mortality the concern shifts to morbidity, that is, to quality rather than quantity of life. Modern medicine allows society to maintain life, the challenge now is to make life worth living for the individual. This question of quality of life is no less important for the arthritis patient who is house-bound because of pain and stiffness than it is for the patient who is being maintained on a life-support machine. High-technology equipment does not hold the solution to many of today's major health problems; the answers lie rather in prevention, that is, in changing attitudes and, in particular, behaviour.

The influence of behaviour on health and the impact of psychological approaches in preventing and managing health problems is outlined in two areas: that of coronary heart disease (the major killer in western countries) and pain (the common, and often most distressing, component of many diverse medical problems).
Coronary Heart Disease
Coronary heart disease (CHD) is the biggest killer in the western world. As the search for the causes of CHD advanced along biological lines, it became clear that a variety of behavioural influences had an important role to play. Indeed many of the so-called 'physical' risk factors for CHD: smoking, alcohol, and diet have a psychological base. It is, for instance, undoubtedly true that smoking increases the risk of CHD and peripheral vascular disease (a major cause of lower limb amputation in the over-sixties). But why does an individual smoke? And can we help him or her to stop? Similarly, why does an individual opt for a diet high in animal fats, and again, is it possible to help that person to change?

Aside from the problem behaviours of smoking, high alcohol use and poor diet, it has also emerged from preventive studies (for example, in the United States\textsuperscript{11} and in Finland\textsuperscript{12}) that a particular behavioural style, which has been named Type A behaviour, contributes to increased risk. Type A individuals are described as being very competitive, impatient, aggressive and short of time. They are also over twice as likely, over time, to develop CHD. In one study which followed equally healthy men over an eight-year period, those who were Type A at the outset had over twice the episodes of heart disease (for example, angina and heart attacks) as did their counterparts\textsuperscript{11}. Again, can a Type A person be helped to change his/her behavioural style from being time-pressured, anxious and unable to delegate responsibilities, to a style which, while still being efficient, is more relaxed, more in control and in command?

The questions all come down to the single question: can behaviour be changed? The answer, derived from laboratory studies, is yes. This has been amply demonstrated in the area of fears and phobias, and these techniques are now being applied successfully to wider areas of behaviour such
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as smoking, drinking and eating. But what about changing the way we approach the world?

The style of the Type A individual is the outward manifestation of the way he or she thinks about him or herself and the environment. Again, derived from investigations into the nature of cognition techniques have been developed which prove successful in enabling individuals to move from being the stressed Type A person to being a more relaxed (but still efficient) person.

These applications of behavioural and cognitive therapy are being applied successfully in many parts of the world to individuals and, combined with mass health promotion campaigns, are reducing morbidity and mortality from CHD. They are also being applied successfully in improving the recovery rate (and hence the rate of return to work) in those who have suffered a heart attack. Such post-coronary rehabilitation also decreases the likelihood of further coronary episodes. This clearly is of benefit to the health service as well as being of immense benefit to the patient and his or her family.

Pain
Pain is the most common and distressing aspect of being ill. It is frequently the main reason for prompting individuals to seek health care. The cost to the economy and the health service of pain is difficult to estimate but is considerable. It has been estimated in the U.K., for example, that some seven hundred and fifty thousand person days at work are lost annually due to back pain and approximately forty thousand nurses miss work because of back pain. Even if only fifty percent of nurses consult with the problem, that amounts to twenty thousand consultations, and this for only one group of workers in the community. It has long been recognised that psychological factors influence pain perception. We know for instance that more pain is experienced and medicated for at night in hospitals and we know that phantom limb pain
(that is, the sensation of pain in an absent limb following its amputation) exists. Unfortunately, in an era of strict biological thinking, it was all too easy to attribute complaints of pain in excess of that expected for injury to 'malingering'. However, as the biological mechanisms of pain were elucidated, it became clear that there a need to integrate what was known about the biology of pain with the psychology of pain. This was successfully done in what has become known as the Gate Control Theory, first put forward in 1965.\(^\text{14}\)

A first step in the investigation of anyone with pain is to determine its cause. If that cause is amenable to medical, that is, pharmacological or surgical, intervention it is then instituted. Unfortunately, there are many sufferers for whom these approaches are not appropriate or, at best, only partially successful. The patient is then trapped in the cycle of constant and wearing pain, resulting in depression. This, in turn, heightens pain perception which makes the depression worse, and so on. The consequence of this cycle is chronic disability, with the potential for leaving the workforce early and increasing dependence on the welfare system, together with repeated attendance at G.P. surgeries, out-patient clinics and, for some, repeated expensive diagnostic investigations. There is also the cost of pain medications and/or nerve blocks. Indeed, there is also the frustration of the physician!

It would be foolish to suggest that psychological interventions can always 'cure' pain. On the other hand, the Gate Control Theory dearly implies that psychological interventions should alter pain perception such that pain becomes less of an interference in the person's life.

If pain, without appropriate treatment, and from whatever cause, is left unrelieved for a period of time, the patient and those around him/her (family and friends) will behave in such a way as to reinforce pain-related behaviour. Thus, for instance, families may pay most attention to a sick relative when he/she is complaining loudly and remaining in bed.
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In time this behaviour may be more rewarding for the patient than that of trying to return to a normal daily routine.

Techniques have been developed, firmly based on psychological principles, which have been amply demonstrated to be effective in the management of chronic pain. Subsequently, there are an increasing number of clinics dealing with pain, which operate on the basis of a multidisciplinary approach (for example, physician, occupational therapist, physiotherapist and psychologist). One such clinic has recently been established in a Dublin hospital. If we take return to work as the criterion of success then these clinics are successful.

Broadly speaking, these clinics treat inpatients whose pain is chronic (that is, of over six months' duration) and is not accounted for by physical damage. Dependence on high levels of medication is first reduced; this is given at fixed times, rather than on demand, to discourage complaining behaviour. At the same time, family members and hospital staff are encouraged to ignore other pain behaviours such as staying in bed or avoiding exercise. Instead social rewards such as praise and attention are given for activities which ignore or minimise attention to pain. Graded exercise programmes are also devised for individuals so that they and their relatives can see their progress and can be encouraged to reach higher targets. Although such programmes increase tolerance and reduce levels of pain rather than getting rid of it completely, in many cases they have proved the only means whereby a bedridden patient was able to resume a normal active life.

Only two examples have been taken to illustrate how the move from strictly biomedical models of disease to bio-social models has benefitted the patient and the family in terms of the quality of life, the community through return
to being economically active, and the health service through reduction in demands for health care. Equally good examples could have been drawn from gastroenterology (for example, treatment of irritable bowel), obstetrics and gynaecology (infertility), paediatrics (chronic disease such as cystic fibrosis), dentistry (anxiety), general practice (emotional dysfunction, etc.), neurology (head injury rehabilitation), geriatrics (stroke and dementia), and so on. Whatever the illustration two major themes would have emerged:

- strategies for improved care and management in physical illness can be developed from general principles in psychology, and
- psychological approaches are an addition to, not a replacement for, the biological approach to the management of disease.

How is the potential contribution of psychology currently integrated into medicine? Psychological input into medicine currently operates at three levels:

- training in psychology during medical education;
- assessment of psychological aspects of medical problems in research; and
- psychological interventions as part of holistic care in the medical context.

Medical education

Psychology has been a curriculum subject in medical schools in the U.K. and other European countries since the early 'Seventies. In Ireland psychology is currently taught in all but one medical school. In such courses students learn about aspects of basic psychology, such as perception,
memory, sleep, intelligence and child development, and about aspects of applied psychology such as stress, doctor-patient communication, and pain. Psychologists are also involved with other teachers in some medical schools in the teaching of communication skills to students including how to provide information in a way that will be understood and remembered, how to break bad news, how to encourage patients to follow medical recommendations, how to explain illness and procedures to children and how to reduce anxiety.

At this important formative phase in the professional development of doctors, psychology is thus serving to keep the focus on the patient as a person with a range of beliefs, behaviours and worries which must be understood if the best treatment is to be achieved for them. In the Irish context, however, the integration of psychology into medical schools lags behind that of other countries because of a lack of resources.

**Psychological input into medical research.**

Psychological factors may contribute to:

- the aetiology (origin) of disease (for example, Type A behaviour and CHD, worry and peptic ulcers);
- the progress of disease (for example, those who approach cancer with a fighting spirit display slower tumour growth, those who worry more before operations have a slower rate of recovery afterwards).

Research in these areas allows for interventions to prevent illness (for example, stress management to prevent ulceration) and to speed up recovery (e.g. providing information and advice to adults and children before operations).
Psychological functioning may also be influenced by medical procedures, thus it is important to assess the impact of those procedures. Examples here might include the impact of chemotherapy on children's intellectual functioning, of mutilating surgery (for example, breast surgery) on sexual functioning, of medication on mood and memory, and of medication on mother-infant interaction at childbirth.

Research into these areas allows doctors and patients to weigh the overall costs and benefits of certain medical procedures in order to make fully informed choices about treatment options.

**Psychological interventions in medical care.**

As mentioned earlier, psychologists often work with patients experiencing chronic pain (that is, pain of over six months duration) where physical and/or pharmacological methods are ineffective.

Psychological preparation is also useful in decreasing the distress and anxiety accompanying some medical and surgical procedures. For instance, in endoscopy (a procedure where a tube is swallowed in order to view stomach abnormalities), increased anxiety results in muscle tension and increased sensations of choking, thus making the procedure most distressful for all involved. For general surgery, increased levels of anxiety before operations results in a need for increased dosages of anaesthesia to guarantee sedation during surgery. As high levels of anaesthesia are a major cause of deaths during surgery, high levels of anxiety before operations are of major concern to the anaesthetist and surgeon, and surgery can be postponed if this anxiety is not managed.

Psychological principles are also used to promote the development of new skills needed in following certain medical procedures. For instance, for those who become confined to a wheelchair, there is the need to routinely raise their
body in the chair and reposition in order to prevent the onset of pressure sores. This can be a difficult rule to teach patients since they get little encouragement for following advice (by keeping to the advice they never know what they are avoiding) and, because the negative consequences for not following advice (pressure sores) occur some time after starting to ignore it. Setting up a schedule of rewards for the appropriate behaviour while in the early hospital period can promote effective learning of this new skill for patients. Such use of psychological principles is often undertaken by other professionals, for example, nurses and this links with the theme of sharing psychological skills (see Chapter 4).

In conclusion, psychology now contributes in many crucial ways to development and service delivery in modern medicine.
Psychologists work closely with general practitioners (G.P.s) in providing a holistic primary care service to patients. This is a pattern which is more established in other countries than in Ireland but is increasing in frequency here. The most common areas of cooperation are:

- marital and sexual problems (for example, communication breakdown, infertility);
- phobic disorders (for example, fear of animals);
- social-skills training (for example, shyness);
- habit disorders (for example, obesity); and
- addictive problems (for example, smoking).18,19.

The advantages of the developing liaison between psychologists and G.P.s, both to the patient and to the health service, include:

- giving access to psychological help to patients who could not attend a centralised clinic owing to problems associated with travel, work, physical disability or even a presenting problem such as agrophobia;
- greater continuity of care of patients;
- possibility of the psychologist seeing the patient earlier, before the problems have become entrenched;
- less need for referral to other agencies;
- reduced administrative and ambulance service costs.
• greater therapeutic involvement of the patient's family; and
• reduced stigma for the patient\textsuperscript{20}.

The evidence indicates that patients do prefer to see a psychologist at the doctor's surgery rather than in a hospital out-patient setting\textsuperscript{21}. There is also evidence that the involvement of a psychologist induces beneficial changes in G.P. practice generally\textsuperscript{22,23}. In one instance, psychologists ran an anxiety management training group aimed at reducing benzodiazepine drug use among G.P. patients. This aim was achieved but other changes were also observed, including a greater reluctance on the part of the G.P. to prescribe other (for example, hypnotic) medication.

One problem that psychologists encounter, along with their medical colleagues, is failure by patients to keep appointments. Since psychologists tend to spend longer with patients (an hour per session would not be unusual), even one patient dropping out unannounced seriously curtails the usefulness of a psychologist in the general practice setting. To combat this the following system has been tested. When a patient is referred by a G.P., the psychologist sends out an 'open letter' which gives information relating to:

• what a psychologist is and does;
• the various ways help might be given;
• the means of therapy (for example, individual or group);
• what will not happen (for example, no medication prescribed);
• who else will be informed of the treatment plan (that is, confidentiality issues); and
• likely practical arrangements of treatment.

To this is added a brief, open-ended questionnaire asking the
patient to simply describe the feelings/symptoms/problems that have led him/her to seek help and to indicate what has already been attempted in order to overcome the difficulties. Factual details are also requested (for example, home address, date of birth). It is made very clear in the letter, and to the G.P., that no appointment will be sent out until the patient has returned the questionnaires to the psychologist. This intervention has been found to improve appointment-keeping behaviour and it has been suggested that if patients know more about what a psychologist can offer, as well as having the opportunity to opt in or opt out themselves, there will be a better use of the psychologist's time in the general practice setting.

Another method of making optimal use of the psychologist in the general practice setting is the workshop. Here a number of individuals with similar problems can be treated more efficiently and, in many situations, more successfully by the group approach. Typically such workshops are spread over a one- or two-day period and aim to increase the participants' self-awareness, focusing particularly on adaptive coping strategies for handling anxiety and depression, as well as letting them know that they are not alone in their distress\(^{24}\). This approach can be used very effectively with chronic illness populations such as those with breast cancer\(^{25}\).

On a practical note, the services of the psychologist working with the G.P. in the Irish context are paid for by the patients themselves; they are not covered by either the General Medical Service or the Voluntary Health Insurance schemes. Yet the same services delivered in the hospital context (and the out-patient context for medical card holders) are paid for by the GMS and the VHI schemes. Thus there is no incentive (in fact, the opposite) for treating psychological problems at the primary care level.

In the U.K., G.P.s can provide the services of a psychol-
ogist to patients through the Family Practitioner Committee Ancillary Staff Scheme. In one instance it has been illustrated that employing a psychologist resulted in a reduction of the annual practice psychiatric drug bill equivalent to twenty-eight percent of the psychologist's salary.\textsuperscript{26} This is not to mention a whole range of other possible savings, including less use of services and less absenteeism from work.

In the future it would seem appropriate that out-patients have access to the type of service most suitable to them (psychology, physiotherapy, educational counselling, etc.) at the lowest entry point to the health care system, that is, the general practice. From a psychological viewpoint this service, besides providing a better use of resources, would also serve to decrease the stigma attached to those problems of patients which do not have a clear physical cause.
Three of the important aspects of psychological services are:

- the prevention of stress-related physical and psychological disorders;
- early detection of same; and
- treatment of same.

Regrettably, by virtue of the employment locations (often psychiatric hospitals) and briefs of psychologists, the focus of services has been predominantly on treatment with not enough emphasis being given to prevention and early detection. One difficulty is that there are currently not enough psychologists on the ground to provide such a wide range of services. However, there are other frontline professionals who could be trained by psychologists to provide a more efficient, holistic, helping service for those in their care. Targeted professionals and others could include teachers, psychiatric nurses, general and public health nurses, play-group leaders, general practitioners, community workers, leaders of self-help groups and organisations, youth leaders, scout leaders and religious group members.

Many adult coping problems arise from emotional, behavioural and sexual difficulties which may have persisted from childhood. Such problems develop because of dysfunctional systems in which children grow up, such as the family system, the school system, the neighbourhood system and the wider community system.

The family system is usually the major influence in the
development of children. Among the factors that can lead to stressful responses within the developing child are lack of parental skills, continuous parental irritability with a child, marital discord, maternal or paternal psychological difficulties (for example, depression, or excessive alcohol intake, physical illness), authoritarianism, faulty attitudes towards sexual development and emotional relationships, lack of involvement or over-involvement with offspring, lack of communication, continuous criticism and physical abuse. These stressful factors within the family system, which can underlie poor coping in adulthood, can be changed, thereby creating a home environment wherein the child and the adults are each loved, accepted, valued, and recognised.

Psychologists have the skills to provide a training service which could focus on the following topics in the context of the family system:

- parenting skills;
- advice to parents on sensory stimulation within the home in order to optimise the intellectual, creative and sensory development of children;
- language laboratories for parents in order to help them to develop the verbal potential of their children. Such laboratories could be organised in school settings and be aimed at parents of pre-school children;
- problem-solving methods for parents;
- stress management for parents;
- communication skills for parents; and
- life skills development for parents.

The school system is the next most influential system in a child’s life. Here too, prevention programmes can be implemented to aid teachers to foster and nurture the devel-
Training here would emphasise the holistic approach needed within the educational system in order to prepare the child for independent living. Teachers can be sensitised to the developmental stages in childhood and adolescence, leading to a greater awareness of the emotional, social, intellectual and physical needs of a child at particular stages of development. Teachers can also be equipped with the necessary communication, problem-solving and behavioural-management skills so that they can always respond positively to the child. Since occupational stress is the major reason for the loss of staff to the teaching profession, stress management courses can also be delivered to help the teacher better cope with their onerous task.

The neighbourhood system is the next area wherein the child spends much of his/her time. Here poor physical conditions, lack of amenities, unemployment, inadequate services and peer influence can militate against the optimal development of the child. If the child is living in a disturbing, non-stimulating family system, he/she will be more at risk from the negative influences of peers and community problems. Again psychologists are in a position to train community leaders, scout leaders, club managers and others interested in developing resources within a particular community. Training can focus on behavioural management of groups, stress management, counselling skills, communication skills, environmental psychology and how to establish self-help groups.

Persons with a disability are also an at-risk group. Some may benefit from professional help so as to cope more adequately with their disabilities and to achieve greater fulfilment in life. Psychologists, among others, can train the front-line carers of these people: nurses, G.P.s, voluntary workers, home-assistant staff and social workers. Examples of such training inputs are assessment methods, basic
teaching methods, assertiveness and locus of control therapy.

Older people in the community are another at-risk group, and therapies such as reality therapy and counselling methods have been shown to be successful in maintaining, indeed enhancing, the lifeskills and personal fulfilment of older persons. Again, front-line carers of older people: G.P.s, public health nurses, home-help staff, social workers, priests, nuns and other community workers, can be trained in the above-mentioned psychological helping approaches. They, in turn, can pass on these skills to the carers in the home situation (for example daughters, sons, other relatives, foster-carers). (See also Chapter 7).

Other at-risk adults are the ageing single, the separated, those widowed and adults and adolescents living in broken or troubled homes. There has been a mushrooming of self-help groups throughout Ireland to help stressed individuals (for example, GROW; the Schizophrenia Association; singles clubs; the Multiple Sclerosis Society). There is no doubt that these groups do a lot of good for their members. Their effectiveness can be further enhanced by an input by psychologists, again primarily in providing a training for the leaders of such self-help groups. Training may involve provision of a wider understanding of the development of stress, basic counselling skills, group management and helping skills and organisational and leadership skills.

The sharing and development of psychological skills with other professionals is an on-going process in Ireland. For instance, in the Mid-Western Health Board, psychologists have organised training groups for social workers, community workers, play-group leaders, teachers, school principals, G.P.s, and nurses on the following topics:

- Counselling skills
- Leadership and stress
• Childhood development
• Stress management
• Adolescent development
• Adult relationships
• Assertiveness courses
• Anxiety management
• Communication skills
• Self-esteem development

Courses for the public have also been organised through the Vocational Educational Committee, through the Health Educational Officer of the Mid-Western Health Board, through community groups such as the Irish Country Women's Association, Gingerbread, the Irish Childbirth Trust, and through social services and community centre groups. The course topics were:

• Anxiety management
• Adult relationships
• Childhood development
• Understanding depression
• Coping with premenstrual tension
• Know yourself
• Know your child
• Assertiveness
• Coping with stress

Finally, the provision of advice and the availability of instrumental resources are yet further ways in which psychologists can help other front-line professionals and semi-professionals. In Clare, psychologists operate a telephone-advice service to teachers, group leaders, community leaders, youth centre personnel, general practitioners and others. Also provided on request are reading lists, relaxation tapes and hand-out materials.

All of this serves, through the use of psychology and its applications, to improve the standards of health care being provided to the various systems within the community.
II Specific Applications in the Irish Context

This section comprises three chapters describing specific examples of the work of Irish psychologists in the broader health area. The examples are chosen to provide illustrations in the areas of work concerning children, adults and the aged. The first chapter describes an outreach project aimed at developing an environment more appropriate to the needs of children, especially those in deprived settings. Next, work with adult prisoners who are HIV positive is outlined. Finally, a project to correct common prejudices about older people is described. Even those having frequent interactions with older people as part of their work, can display attitudes which are negative and unhelpful. A booklet and video have been devised for use with a range of professional and other groups as a response for developing more accurate and helpful attitudes about this large sector of the population.
Chapter 5

PREVENTIVE SERVICES FOR CHILDREN: THE MOBILE EDUCATION PROJECT

Madeline Clarke

The aim of Barnardo's Mobile Education Project is to facilitate the development of knowledge and skills related to living and working with young children. To this end, the project is essentially concerned with the care and education of young children. Within this framework the project provides a range of services to children and parents and to staff and volunteers working in services for children. The work of the project can be divided into the following areas, which are described more fully below:

- the children's bus service;
- the mobile toy library and advisory service; and
- the mobile training service.

The Mobile Education Project team consists of thirteen staff members encompassing qualifications in pre-school care, early education and psychology. The particular contributions of psychologists to this team approach includes a detailed knowledge of child development issues, familiarity with optimal methods of transferring skills to children and parents, the ability to objectively assess the needs of communities and groups and the ability to design systems for the on-going evaluation and updating of services. There is also a panel of health and education professionals which has been assembled during 1989/1990. Where finances permit, these professionals are called upon to provide parts of courses and seminars.

The Project provides training, information, advice and pre-school services in many different locations and has de-
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dveloped links with those involved with the health and education of children. With its new national focus, these links are now being extended outside Dublin. The present climate of cutbacks has led to resources being withdrawn in some of the areas in which the project operates. This has led, at times, to pressure on staff to provide a wider range of services than is possible.

The impending Children's Bill is poised to set some indicator for minimum guidelines and training regarding services to children. The Project, particularly the Mobile Training Service, is ideally placed (through its inservice training for those working with children and its parent education work) to operate in the climate this will create. The schemes to date are now outlined.

**The children's bus service.**
This service takes the form of:

- providing pre-school services for travelling children in urban areas;
- establishing a community playground in an urban area, involving getting parents to learn how to provide a playground for their children by working alongside staff on the children's bus;
- provision of premises and support for another community group;
- establishing parent and toddler groups in a Health Board Community Care Area;
- providing advisory services on child development and play. (parents and children attend sessions on a children’s bus aimed at demonstrating simple play ideas and emphasising the importance of stimulation in children's development); and
- working in conjunction with summer projects.
During the year 1989/1990 the children's buses worked with seven hundred and eighty-seven children and one hundred and seventy-nine parents.

The mobile toy library and advisory service.
The mobile toy library operates in the same way as the more familiar travelling libraries of books throughout the country except, obviously, that toys and books are made available to children. The mobile toy library work is allied to the work carried out on the children's buses in that it provides a service to families on halting-sites. It also provides a service to pre-schools and schools catering for travellers.

The toy library service is also used by playgroups and parent and toddler groups which are developing with the help of the children's buses and staff. Thus the children's bus and mobile toy library services compliment each other in a way that is most beneficial to children and parents.

During the year 1989/1990 approximately three hundred and seventy-seven children benefited from the mobile toy library service.

The mobile training service: a national training and information service for those involved with young children.
This is the most recent service to be developed by the Project. It provides courses, seminars and intensive sessional work for parents, playleaders and nursery, creche and other staff on aspects of childcare and parent education. An information bank of training courses has been prepared which is now being used with groups where needed. The mobile training service is due to be developed with the arrival of the latest training vehicle: a coach fitted out as a training/consultancy type unit. This unit will be called the 'Mobile Training Centre' and will travel around the country meeting requests from staff and parent groups.
During the year 1989/1990, two hundred and ninety-one people attended courses, seminars and workshops. Nine courses and eight lectures/seminars were provided.

Overall the Project provided services to one thousand, one hundred and sixty-four children and four hundred and ninety-nine staff, parents and volunteers.

The Mobile Education Project is an example of a way in which psychologists can work with other professionals and with children and families to improve the quality of life for children in the community.
Chapter 6

THE PSYCHOLOGIST WORKING WITH HIV-POSITIVE PRISONERS
Desmond O'Mahony

The problem of the human immuno-deficiency virus (HIV) in offenders in prison is of very recent origin. The first testing for HIV in Irish prisons took place in 1985. All those tested were intravenous drug-abusers. The death of a former inmate from acquired immune deficiency syndrome (AIDS) precipitated a rush of requests from a large number of at-risk fellow addicts for the test. There were two consequences of this:

• over a short period of time about twenty-five offenders, male and female, were found to be HIV-positive, and
• a management decision was made to physically segregate those offenders who were HIV-positive from the rest of the prison population.

It is clear that management, staff and offenders alike were quite unprepared for the results of testing for HIV. Management felt compelled to adopt a segregation strategy in the light of the best information available at the time. (Within the prison system, segregation involves keeping prisoners who are HIV-positive in a separate building. There is no contact between these prisoners and the rest, including quite separate food provision, laundry, work and recreation.) Staff were allocated to separation units at a time when inaccurate horror headlines were widespread, and were creating alarm and despondency. The offenders whose tests proved positive were informed of the fact and immediately transferred to the separation unit, quickly re-
A generally accepted belief, at this juncture, among management, staff and professionals, was that the outlook for HIV-positive offenders was very gloomy. It was feared that HIV-positive offenders would rapidly become an increasing proportion of the prison population and that there would be a rapid increase in morbidity followed by regular deaths of offenders. However these beliefs have not come to pass and the prison system has managed to adapt to HIV. Progress of illnesses of HIV-positive offenders is much slower than at first feared. What then had been the psychologist's role in dealing with this problem?

Psychologists, in conjunction with other professionals (especially medical officers and probation and welfare officers) have been involved in accumulating the known facts about HIV and its consequences for the offender, his/her family and his/her significant others. Psychologists have also been involved in establishing the procedures by which offenders have access to the HIV test and what happens from then on. For instance, psychologists see prisoners who ask for the HIV test. (This stage is known as pre-test counselling.)

There are a number of perspectives from which it is possible to view this problem area: the individual offender who is HIV-positive; the institution (that is, the prison); and the needs and concerns of society generally.

**The individual offender**
The psychologist will first come in contact with the person who is potentially HIV-positive in the pre-test counselling setting in prison. The purpose of pre-test counselling is to meet with a prisoner when he/she is most likely to be receptive to information and at a time when he/she is best able to make a realistic and informed choice. It is normal practice to advise the prisoner not to have the test. The rea-
son for this is that the behavioural requirements for those who are HIV-positive and those who are HIV negative are exactly the same. To be specific, if I am HIV-positive then I need to avoid sharing contaminated needles and use safer sexual practices if I am not to infect others. If I am HIV-negative, I also need to avoid sharing contaminated needles and engage in safer sex practices if I am to avoid coming into contact with the virus. This statement is true for everyone but it is particularly important that those who engage in high-risk behaviours (for example, certain sexual activities and intravenous drug abuse) should be alert to these caveats.

If the prisoner decides to take the HIV test and is found to be positive, then certain administrative things follow. Some form of segregation occurs. It is usually the most emotionally charged part of the process. Most offenders who take the test in prison and turn out to be HIV-positive have had a reasonable notion that they might be positive. However, having it confirmed is always a shock. Being pronounced HIV-positive usually has the impact of being told one is going to die. Along with this are a series of major losses in one's life:

- there is a threat to one's existing relationships (family and other);
- there may be a difficulty in forming new relationships;
- there are very difficult choices regarding having children for fear that one may infect one's partner, or that the pregnancy itself may put a HIV-positive woman with an already compromised immune system through a further challenge;
- there is the problem of being isolated in society; and
there is a real stigmatisation within the prison. The psychologist is available to the HIV-positive prisoner and visiting members of his/her family to give information, reassurance and support. This early post-test period has many of the qualities of crisis-intervention.

Each offender found to be HIV-positive will spend the rest of his/her sentence, and all subsequent sentences, in segregation (unless the policy of segregation is altered). In the extreme, a number of offenders will die in prison.

Who are these people? They are mainly young men, from city-centre Dublin, and with a long history of criminal behaviour and involvement in intravenous drug abuse. They are largely enmeshed in a cycle of deprivation, including low social class, large families and poor educational and work records.

Psychologists, among others, have an objective of reducing the spread of AIDS by bringing about a change in the behaviour of these young people. They seek to eliminate needle-sharing and high-risk sexual behaviour. The record shows that many of these prisoners live dangerously in terms of both their sexual and drug-abusing activities. On release, many return to their drug-abuse and report failure to use relatively safe sexual practices.

The Prison
The psychological perspective of the penal institution which includes a segregation unit becomes even more complicated. One important consideration is the implication of segregation for the staff, both those working inside and outside the segregation unit.

Staff are subject to the same misinformation about AIDS as others. Many were initially frightened and quite understandably. Officers with anxieties or questions used psychologists as a source of information and reassurance. Specific and accurate information about the nature and
spread of AIDS and the order of risk to which one is exposed by working in close contact with HIV-positive offenders, has to be provided clearly and effectively to all staff.

Also, within the wider prison (outside the segregation unit) there are large numbers of intravenous drug-abusers who have not taken the test. It is projected that there are at least as many HIV-positive cases among these as there are in the segregation unit. The problem is that they are unidentified. Yet they present an educational target-group every bit as important as those identified as being HIV-positive. Because of the illicit and intravenous use of drugs and the probability of offenders engaging in high-risk sexual activity, the spread of HIV within the prison is likely. An enormous amount of work needs to be undertaken with this group.

In the context of the wider prison population, psychology exercises a research function with the drug-abusing population, among others. Irish prison research has included a survey and follow-up plotting the increase in the number of drug abusers in the prison system and profiling their abuse. The use of prescribed psychotropic drugs within the prison system was the subject of a further survey noting that these drugs are heavily prescribed in institutions where drug addicts form a significant part of the population. Recently completed work with both staff and prisoners measured the extent and accuracy of their knowledge about AIDS. The results give some comfort to those involved in the educational process. Both staff and offenders had a high level of accurate information about the nature and methods of the spread of HIV.

**Society in general**

Finally, from the perspective of society generally, there is an urgent need to protect the population from an exponen-
tial spread of HIV from the relatively small cohort of people involved in high-risk behaviours. The sole preventive measure with any hope of success is education: education about the risks and about the precautions relating to people's behaviour.

Addicts probably represent that group in our society least likely to respond to the educational message. Anything that sets strict limits on the two major positive aspects of their lives, that is, drugs and sex, is likely to have a low success rate. Nonetheless, the educational message does represent the foundations of any appropriate change that may take place and is thus absolutely essential.

The value of the work with prisoners is, in the final analysis, as important and appropriate for society at large as it is for the individual prisoner.
Chapter 7

CONFRONTING MYTHS ABOUT AGEING
Patricia Redlich and Geraldine Kenny

Introduction
There are currently over three hundred and eighty thousand people of sixty-five years and over in the Republic of Ireland. Not only are more people now reaching sixty-five years of age, but more people are living to be seventy-five, eighty and ninety. This population presents a particular challenge to our communities in terms of caring for their needs and ensuring their continuing and maximum participation in, and contribution, to society.

Twenty years ago, research into the various aspects of ageing would hardly have warranted a page in a medical textbook. It certainly was not on the agenda of colleges or training courses for professional, administrative or managerial staff. Today ageing is on the agenda, not just as an academic subject, but as an issue which we have to respond to as town planners, architects, economic planners, social services and health care workers.

Predictably, the issue of ageing and older people has presented itself to the health and social services as a problem. Lack of geriatric beds, attempts to de-institutionalise care, lack of public building programmes with a range from special housing (for example, with appropriate accessibility), sheltered housing (that is, with some form of warden or nursing presence) and, where necessary, actual nursing homes, have put a huge strain on community services such as home-helps and public health nursing. In addition, professional staff in general prefer not to work with older people and this can lead to staffing problems.

Confronted with the necessity to assess the needs of older people as users of services, and with the need to deal with
myths and stereotypes regarding ageing, the Psychology Department of the Eastern Health Board decided to develop some educational input in the area. A project was designed which aimed at producing some worthwhile help for the elderly themselves and for those involved with the elderly, either as frontline staff or as administrators and planners. Central to the task was the goal to do something that psychologists could then give to others, that is, to package skills and knowledge in such a way that others could avail of them. This was seen as essential since on-going staff resources are limited. What quickly emerged from initial research was the fact that a serious stumbling block stood in the way of anyone attempting to understand ageing and care for the elderly. There was no organised, easily-accessible body of sound information on the elderly, no formalised factual data on the various aspects of ageing, and hence no database for assessing need. In the absence of such hard information, there appeared to be a general acceptance of the many myths and stereotypes about the elderly. These myths and stereotypes are developed from a young age and are also held by some older people, not about themselves, but about other older people.

Much awareness, and information-gathering and dissemination had been done, particularly by the voluntary organisations, and in many ways they created the fertile ground for tackling the issue. What was needed was the formalisation of this information into an accessible package. To further the original aim, it was decided to compile an information pack on ageing and the elderly, presenting the facts in an accessible format and debunking myths, stereotypes, and prejudices. This was seen to have three important functions:

* to allow frontline staff in the community to assess their current interventions for effectiveness, for example, allowing home-help organisers to judge
what exactly a particular elderly person needed;  
• to create the information base, or facilitate an understanding of the target population for planners, administrators and professionals designing services and the environment; and  
• to collect information which would be available and useful to older people themselves and to any person from secondary school age upwards.

Production of the educational package
The initial production stage involved combing the research literature on all aspects of ageing: mortality and morbidity rates, health, biological ageing, social structures, psychological factors, incomes, housing standards and so on. In the process a comprehensive reference library on ageing was accumulated, and is available for future use and users. The information was compiled into an information package aimed at the non-expert. The decision on what information to include or exclude from the vast body of research information was based on two criteria: the attempt to be comprehensive and the need to deal with issues which were known to be the subject of myths and stereotypes. For example, incontinence is one of the problems family carers find most difficult to handle, and it often becomes the 'last straw' which results in hospitalisation, or even abuse of older people. Sexuality was given attention as it is still very much a taboo area, and because it epitomises much of what goes into making and maintaining myths and negative attitudes towards older people.

The framing of the information was also influenced by a psychological understanding of the nature of prejudice and the emotional factors involved in taking in information and changing ideas.
Evaluation of the education package.
To test the efficacy of the information package, it was presented as a series of six lectures to two groups of home-helps (see Appendix). These groups were selected because of their close contacts with older people. Before- and after-testing was carried out on the groups (and on similar groups who did not attend the lectures), in an attempt to see if levels of information and attitudes changed as a result of the education programme. The course was found to have achieved its aim.

The task then was to present the information in a readable format for a non-expert audience. The lecture notes were revised in terms of what was learned from feedback during the lectures about how the information was received (for example, what was too complicated and how things could be grouped better in certain themes).

A draft information booklet was read by a selection of people, chosen to represent various age-groups and educational backgrounds. The final booklet crosses many professional boundaries of research: medical, social, and psychological, and covers statistics, facts and an attack on myths and stereotypes in each of the areas covered. Where possible it provides advice on how to tackle some problems (such as incontinence, memory deficits, accidents and senility). By dealing with areas which are still largely taboo (such as sexuality and abuse of the elderly) it also encourages people to tackle their prejudices.

The booklet was followed by the production of a short (ten-minute) video on attitudes to ageing. This video presents the views of young people (often negative and ageist) and the views of older people (views which debunk many myths). It is a useful resource to illustrate many of the myths on ageing and is a good starting point for discussion by community and professional groups. It is also, import-
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antly, a documentation of views about and by older Irish people rather than a teaching aid based on overseas material. Both booklet and video are available for teaching purposes.

In summary, the project was an attempt to respond to a health service need. Psychologists used their skills to distill a body of disparate data into an accessible format which was then tested for effectiveness. Finally, it was incorporated into literary and audio-visual formats, both effective and independent of its devisors.

The lecture programme which formed the basis for the booklet and video is outlined in the Appendix to this chapter.
APPENDIX TO CHAPTER 7:
Programme on Ageing given to Home-Help Group.

Session 1: Introduction.
- Attitude measurement
- Ageism: its consequences and the nature of myths and stereotypes regarding the elderly.
- Facts on the elderly in Ireland: numbers and proportion of elderly people in the population, incomes, living circumstances, marital status, housing and living conditions.

Session 2: Job-related session.
- Job-related component: issues of particular relevance to the target-group (home-helps, in this instance). A trigger video, twenty minutes long, depicting home-helps in an English service, caring for, and reflecting upon their relationship with, their clients. Issues for discussion include the nature of the relationship between the home-help and the client, the need to avoid creating dependency in clients and balancing the wishes of the client with the needs of the home-help.

Session 3: Physical aspects of ageing.
Relevant aspects of the ageing process, and related topics:
- mortality rates and common causes of death;
- disease rates and other illnesses among the elderly (emphasis on the fact that illness in old age is a function of poverty and the consequences of deed and omission throughout life, rather than being specifically related to old age per se);
- mobility, degrees of physical disability, and resulting dependency on services (emphasis on memory, (how it is affected by ageing), and
task-specific dependency rather than total dependency);
• the biological process of ageing, including changes in the senses, (with particular reference to sight and hearing);
• accidents, their most common causes and means for their prevention;
• sexuality, its practice and presenting problems, (with particular reference to the common misconception that sexuality is not, or should not be, a relevant experience in old age);
• incontinence, its causes and management; and
• drugs and the elderly, (those most commonly used by the elderly population, problems of side-effects, dangers of possible negative interaction between the various drugs).

Session 4: Psychological aspects of ageing
• Intelligence (the concept of declining intelligence and related attitudes);
• learning, (the ability of elderly people to learn new information, with particular reference to the literature on adult education and the "university of the third age"); practical methods of overcoming memory difficulties);
• dementia in old age (prevalence, description of the types of dementias, for example, Alzheimer's disease, multi-infarction dementia, functional stages of dementia, and how to communicate with and manage the dementia sufferer);
• personality (the myth that the elderly are all alike; the fact that personality itself is unique and life-long; personality traits such as rigidity and conservatism);
• depression (its nature, causes and therapy); and
• suicide (problems of under-reporting, estimated incidence, methods chosen and causes).

Session 5: Social aspects of ageing
• Informal support groups: the importance of giving and receiving social support, the forms of practical and psychological support provided by family, neighbourhoods and friends, the distinction between living alone, social isolation, and loneliness. Statistics on visits by family and friends to elderly people (British and Irish sources): refuting the myth that the majority of the elderly are socially isolated. The reciprocal nature of social support: evidence that elderly people give psychological and practical support (for example, babysitting, gifts, housekeeping) as well as receive it;
• formal support groups: State entitlements; pensions and benefits (for example, medical, travel, etc.); benefits of special interest to elderly people (for example, chiropody);
• death, dying and bereavement: the process of mourning, attitudes to one's own death and responses to loss of partner, job, purchasing power, friends, social status and health/mobility (elderly no different from any other age-group in their grieving or facing of death);
• abuse of the elderly: the absence of statistics, and the different types of abuse, (physical, emotional, financial and sexual), problems of vulnerability and stumbling blocks to intervention.

Session 6: Conclusion
• Course review
• Reassessment of attitudes
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