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Psychology and Ageing

A Position Paper prepared for The Australian Psychological Society

by a Working Group of the Directorate of Social Issues

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PSYCHOLOGY AND AGEING: CONTRIBUTIONS TO THE INTERNATIONAL YEAR OF OLDER PERSONS.

Executive Summary

When 1999 was declared by the United Nations as the International Year of Older Persons (IYOP), carrying the theme "Towards a Society for all Ages", the Australian Psychological Society (APS) considered it timely to focus on the ways in which psychologists pursue knowledge in this field, and how that knowledge might enrich a "society for all ages". The APS welcomed IYOP as an opportunity to review its own responsibilities, and to consider the contribution of psychological research and practice to the well-being of older people in the Australian community.

As part of the Society's contribution to IYOP, several projects came to fruition during 1999. A Special Issue of the Australian Psychologist entitled "Psychology and the Older Person" was published (Browning & Stacey, 1999). In addition to its existing Interest Group on Psychology and Ageing, the Society established a Working Group to produce a Position Paper that would showcase what Psychology might bring to our understanding of the experiences of older persons, and set down some challenges psychologists might take up in the interests of community well-being.

Like the rest of the developed world, Australia is experiencing a rapid increase in the proportion and absolute number of older persons. Taking the traditional retirement age of 65 as the reference point marking the beginning of "old age", about 12.1% of Australia's population or 1.85 million people fall into this category, with the group aged 80 and over growing most rapidly (McLennan, 1998). Recent population projections estimate that by 2031 nearly a quarter of Australia's population will be aged over 65. Many more such statistics can be cited to demonstrate major changes in Australia's ageing patterns. Furthermore, there are debates as to the meaning of "old" in a nation whose indigenous people have an average life expectancy of less than 60 years. How we interpret such statistics, and how we respond to their challenges, will determine the long-term impact of IYOP on Australian society.

The National Strategy for an Ageing Australia, an initiative of the Federal Government, is charged with "developing a whole of government approach to ageing" (Bishop, 1999, p. vi). The Background Paper launching the strategy stresses that an ageing population reflects a major achievement, being "the result of improved living conditions and medical advances" (p. 1), and presents challenges and opportunities on a scale not faced by previous generations or societies. The Paper lists four themes under which to consider the impacts of, and policy responses to, population ageing: independence and self provision; world class care; healthy ageing; and attitudes, lifestyle and community support. While these reflect particular government responsibilities to manage economic and policy challenges, we believe Psychology can contribute much to public awareness and policy development in all four areas.

This APS Position Paper addresses a spectrum of issues ranging from particular clinical concerns to broader perspectives on life transitions and successful ageing. The Paper begins by examining dimensions of ageism affecting community expectations of older people and the quality of aged care services. Psychologists are invited to turn a critical gaze on themselves in questioning their low visibility in the planning and delivery of such services, and the emphasis in much psychological research and practice on deficits and decline in later years.

Next, the Paper moves on to consider conditions which promote successful ageing. Psychology has much to contribute to public awareness of healthy ageing and the diversity of human experience in ageing patterns, family support structures and meaningful community involvements in later life. Recognition of older people as resources within the community, rather than burdens, is central to the elimination of ageism. The role of health psychology in promoting health and well-being in old age is examined, and its range is illustrated by the examples of chronic pain as a problem dimension and exercise in old age as a health promotion dimension.

While the psychological study of ageing can be traced back at least 200 years, perhaps the most significant recent influence arose from the emergence of the lifespan view of human development, the crux of which is the view that development and ageing are part and parcel of life-long change processes. Through an emphasis on the role of individual differences and the multidimensionality of human development, a contextual metatheory of human development arose which is particularly well-suited to studies of adulthood and ageing (Baltes, Lindenberger & Staudinger, 1998).

More people are living to an advanced age, making study of the later portions of the life span particularly relevant to a complete characterisation of lifespan human development. An examination of key transitions likely to be experienced later in life, such as retirement, grandparenthood and relocation, leads to the conclusion that late life is not well characterised as a series of disasters and withdrawals. With adequate resources, people can effectively live through the adjustment process. Recognising that ageing is a social as well as a physical process, we also examine some issues concerning ageing processes within different ethnic groups in a multicultural society.

We have included a section on the scope and implications of cognitive ageing, to highlight the impressive body of Australian research investigating age-related change in cognitive processes and individual differences affecting them. Changes in cognitive function with increasing age are a matter of both common observation and wellestablished research. While dramatic changes such as those associated with dementia can have adverse consequences for day to day life, changes affecting most older adults are slight, and less likely to interfere with everyday activities, in part because older persons adopt strategies designed to adapt to or compensate for these changes. The nature of such changes and the factors influencing change are unclear, but their complexity confounds stereotypes of inexorable, irreversible decline. Instead patterns of different abilities within individuals become more diverse with age. Older adults generally remember less than do younger adults, but longitudinal studies (that is, of the same people over time) show much later age of onset and slower rates of decline than do cross-sectional studies (comparing older adults with other age groups).

While maintaining a focus on successful ageing, we must also consider the needs of those affected by circumstances such as cognitive change, behavioural disturbances, or bereavement, as well as the needs of informal, unpaid caregivers and paid workers. Psychology is often equated by the public with clinical practice, yet the profession is barely visible in the delivery of mental health services to older persons. Ageism in service provision may result in underutilisation of psychological approaches - for example, older persons with depression may be treated with medication rather than counselling, or "written off" as exhibiting dementia, and thus not treated at all. An overview of older Australians' mental health, together with a summary of psychological interventions for specific mental health concerns, is included to facilitate access to psychological knowledge and services by older Australians.

Throughout the Paper, we have given priority to the inclusion of Australian research. In examining the particular contributions of Australian researchers on aspects of ageing, we hope to raise awareness within and beyond the discipline of the wide range of topics and the long-term implications of some of the research initiatives currently underway in this country. As well as recognising such achievements, we identify a number of challenges facing educators and practitioners in psychology if the discipline and profession are to be ready meet the needs of the current generation of older Australians, not to mention the ageing "baby-boomer" generation.

In developing a framework for this paper, contributors have attempted to be attentive to the consequences of ageism, stereotyping and pathologising of older persons' experiences, and to adopt wherever possible principles of empowerment, respect, and recognition of the diversity and complexity of those experiences. The elements which constitute such diversity and complexity include cohort effects, ethnicity, gender, disability and resource distribution. A common thread underpinning our discussion is that of vitality of body, mind and spirit, which is central to the distinctive IYOP logo.

We hope that one outcome of this Position Paper, together with other initiatives undertaken during 1999, will be a more in-depth understanding among the wider community and its policy-makers of psychological aspects of successful ageing. We also hope that the Paper will be a catalyst for our own profession becoming better prepared to respond to the needs of an ageing population in ways which empower older adults rather than compound any challenges they might face.

Ageism

Ageism refers to generalisations about age groups in our society, with these stereotypes being particularly marked and negative in regard to older people. It affects expectations of older people and beliefs about their preferences, capabilities, weaknesses, reactions, and personalities. Ageism results in the tendency to see old people as all alike, and to overlook differences between individuals. Hoyer (1998) argued that ageism is reflected in the common view that older people are a burden, contribute little and are largely dependent on the finances of others. Smith (1996) also noted the commonly-held beliefs that growing older is associated with increased dependence, loss of self control, social isolation, and disengagement from life.

Several writers have argued that such ageist stereotypes are reinforced, rather than challenged, by gerontological research and literature. For example, Russell (1989) argued that Australian gerontological research and practice was dominated by a focus on problems, while Russell and Oxley (1990) argued that ageing is generally associated in the literature with ill health, incapacity, and dependency.

Yet contrary to popular stereotypes, most older people report that they are fit and well, and there is ample evidence that they contribute a great deal to the community. For example, Greene (1997) reported that, rather than being a drain on society, the current retired generation has provided a large economic subsidy to the generation behind them. They also work as caregivers to family and friends (Wells, 1997) and as unpaid volunteers in community and educational organisations (Greene, 1997; Swindell & Vassella, 1999). In fact, older people themselves provide the bulk of care to other older Australians, and are more likely to give financial support to other family members than to receive it (Wells, 1999; Kendig & Browning, 1997). Society can no longer afford to overlook these contributions, and must acknowledge and develop strategies to make optimum use of the wealth of experience and knowledge possessed by its older members. Currently, this resource is underutilised and devalued.

The impact of ageism on health and community services

Ageism affects the perceived attractiveness and status of aged care as a career, the value placed on older clients, and decision making about services and treatments (Gething, 1998; 1999a). Research indicates that working in aged care is the least preferred option for trainee professionals such as medical and nursing students (Le Couteur, Bansal, & Price, 1997; Pursey & Luker, 1995). Stevens and Herbert (1997) argue that negative views towards older people are particularly systemic in health care where the priorities are based on the value of obtaining a "cure" and on the high status of working with "high tech" equipment. Older people are seen as "bed blockers" because they require longer hospital stays, and so reduce a hospital's apparent efficiency. They may also be seen as failures of the system because they deny health professionals the achievement of the much sought-after goal of a cure.

Misconceptions about older people and ageing have been reported to affect professional decision making and lead to a failure to attend to treatable symptoms. For example, Gatz and Pearson (1988) argued that ageism among psychologists results in underservicing, overuse of diagnoses such as Alzheimer's disease compared with those for reversible conditions, and reluctance to treat depression and other psychological problems wrongly assumed to be an inevitable part of ageing. Many older people thus live unnecessarily with restrictions and impairments.

Ageism in older people

Some of the most ardent proponents of ageism can be older people themselves. A lifetime of negative messages can mean that by the time a person reaches old age, firmly entrenched beliefs have created a "self fulfilling" prophesy, such that the individual comes to act in accordance with them. The result may be limited horizons, opportunities, and freedom of choice. An unwillingness to question the expertise and authority of doctors and other health professionals may also impede the access of older persons to the fullest information and the most appropriate treatment options. Internalised ageism may also affect a person's readiness to seek treatment for conditions that can be alleviated, on the assumption that they are just a part of old age. Yet as Coombridge (1998) observes, being old is not in itself a diagnosis.

Successful ageing

The current approach to ageing advocated by government, supported by this paper, and conveyed as a major theme of IYOP is that of "successful ageing". Successful ageing involves the maintenance of mental, physical and social health. It is closely linked with quality of life. Butler (1991) defines it in terms of four forms of fitness: physical, intellectual, social, and purpose fitness. Physical fitness refers to bodily strength, resilience, and ability. Intellectual fitness refers to keeping the mind engaged and active. Social fitness involves forming and maintaining significant personal relationships.

Purpose fitness refers to having positive feelings of self-esteem and control over one's own life. Battersby (1998) commends Butler's definition for conveying the importance of taking a positive view about ageing and growing old. While terms such as "successful" and "healthy" in relation to ageing may imply the possibility of failure, particularly in circumstances of ill-health, the importance of ongoing attempts to use language in non-stigmatising, inclusive and positive ways should not be dismissed by health professionals accustomed to "deficit" models.

Central themes of IYOP in Australia included emphasis on community integration, respect for the contribution of older people, family and intergenerational issues, the need to promote positive images, well being, health, preventive health, housing, employment, and retirement planning (Conference for Older Australians, 1998). These all reflect an emphasis on successful ageing, independence, dignity, and well being, as endorsed by organisations of older people themselves. For example, the Older Women's Network is working to promote "successful ageing" and to empower older women to take an active and positive approach to old age. Organisations such as The Body Shop have sponsored campaigns to "Celebrate Your Age" and challenge constraining notions of health and beauty. Such initiatives are particularly important in combatting the combined effects of ageism and sexism on a sector of the population where women are in the majority.

Empowerment, freedom of choice and consultation

Empowerment is a term that forms part of the rhetoric of "politically correct" professional language and thinking. However its meaning is somewhat nebulous, and the indicators that can be used to demonstrate its achievement are uncertain. Gibson (1991) notes that it is easier to consider factors which hinder its attainment and features of behaviour which demonstrate its absence (powerlessness, helplessness, hopelessness, paternalism, dependency, and an external locus of control). Gibson views empowerment as a process of recognising, promoting, and enhancing people's ability to meet their own needs, solve their own problems, and mobilise necessary resources in order to feel in control of their own lives. This definition represents a paradigm shift for service providers, to encompass empowerment as a process involving self-awareness, self-determination, and resources - it is not the result of any particular program or service that might be provided. Moore (1998) argues that a range of health, social, well being, and material resource factors combine to influence the power to choose and decide. Ageism in the community provides a major barrier to empowerment, as does the nature of service systems in Australia. Many service providers still operate on the assumption that they know best and that the older client is unable to make an informed decision.

Previous generations of older people were largely willing to accept unequal relationships between "expert" professionals and "passive" clients or patients. But many older people now are less willing to be passive recipients of care, and strongly believe that service providers have a responsibility to listen to them. They believe they are entitled to opportunities for choice and control over their lives, and in theory this belief is supported by government policy emphasising consumer rights. However, many such consumers find that their wishes are in conflict with service providers who seem reluctant to change. What can be even more frustrating to consumers who attempt to exercise their rights is the illusion of choice created by government policy which emphasises freedom of choice while simultaneously reducing funding and narrowly targetting services.

The failure to listen to consumers has been shown to negatively impact on their well being. For example, research conducted by Gething, Fethney, and Blazely (1998) at a major Sydney rehabilitation hospital for older people revealed that older people and health professionals often stated different desired outcomes for treatment, and that professionals were unaware of the client's goals. Older people reported that they felt unconsulted about their needs, and that the treatment they received did not meet these needs or prepare them for a successful return to community life.

It is important to recognise the impact on well being and freedom of choice of government policies and professional practice whose rhetoric appears to be in the interests of the older person, but which, if implemented without consideration for each individual's particular life situation, can inhibit empowerment and well being. For example, the decision to discharge someone from hospital should be based on the individual's readiness to leave and not on the hospital's goal of freeing up a bed or saving resources. The planning process should take into account, for example, whether early discharge would place undue demands on the spouse or family of the older person and thus interfere with their quality of life and freedom of choice. Health economists have yet to consider the costs of inappropriate early discharges, or the costs for informal unpaid caregivers of an increasing emphasis on community care. This increased burden on others who may be frail themselves could thwart the intention of governments to reduce costs. In this context there is a need for monitoring and evaluation in social as well as economic terms of the various discharge planning projects which operate as brokers for community care provision.

Diversity and individuality

There is more diversity within any age cohort than there is between cohorts. Australian legislation and policy acknowledges diversity by recognising minority groups whose well being is to be promoted through provision of services tailored to meet their needs. Examples of such groups are Aboriginal and Torres Strait Islanders, people with disabilities and people from non English-speaking backgrounds. Strategies that take into account such diversity are important, but should avoid the danger of assuming that all people within a given group are the same. With this caution in mind, the following discussion focuses on the cumulative effects of lifelong minority group status, using the experience of disability as a working example.

Stoller and Gibson (1994) argue that older people from minority groups often experience obstacles constructed earlier in life that can become handicaps to well being in later life. For example, the "baby boomer" cohort is the first to contain substantial numbers of people with long standing disabilities. These people have had many life experiences that affect their attitudes towards service provision, their ability to negotiate service systems and their ability to exercise freedom of choice. This generation has experienced deinstitutionalisation, and has been active in the human rights movement. Previous experiences with service systems and service providers have made many wary, but have provided them with practice in questioning the authority of "experts" and a willingness to challenge the system.

However, many more people with disabilities have experienced reduced access to education, employment, community acceptance, friendships, and close personal relationships. These disadvantages throughout life have cumulative effects on well being in old age (Ashman & Suttie, 1995). Inequities in

access to opportunities throughout life deny people who are ageing with long standing disabilities the security, sense of empowerment, and choices that others expect. The result is vulnerability, feelings of powerlessness, and low self esteem (Gething, 1999b). People ageing with long-standing disability are less able to build up financial security and financially less able to retire. They also have reduced access to recreation, leisure, and community activities available to many other older people (Bigby, 1992).

Limited freedom of choice is particularly evident in decisions made about where to live and in regard to the receipt of services and supports necessary to maintain independent living. "Ageing in place" refers to people being able, if they choose, to remain in the particular residence they now occupy and with peers who have similar interests and experiences (Australian Council for the Rehabilitation of the Disabled, 1997). Many people ageing with disabilities believe they will be denied this fundamental component of empowerment. Depending on their level of disability, they may regard entering a nursing home as inevitable, whether or not it is their preferred living option. They anticipate that independent living in the community will be impossible once their caregiver is no longer able to provide support, and without increased levels of care provided at affordable prices (Gething & Fethney, 1998). The impact of government policies on service availability and cost, together with the cumulative effects of life long disadvantage, operate to reduce freedom of choice. In 1998 the Federal Government took steps to redress this situation, by specifying ageing with a disability as a priority area. Several initiatives are now underway to assess needs and develop services accordingly.

Changing service delivery paradigms to meet the needs of the "baby boomer" generation

The next generation of older people (the "baby boomers") differs from previous generations in a number of ways: it is better educated, more ethnically diverse, has not lived through a world war, has different expectations for retirement, is familiar with a 'consumer oriented culture' and accepts that it is appropriate for both men and women to work both inside and outside the home. Kendig (1996) argues that these characteristics suggest older people are becoming increasingly likely to fight for their rights, and will be more assertive consumers with higher expectations than previous cohorts. Their anticipated resistance to existing policies, practices and behaviours will demand major changes in approaches to service provision if society is to preserve the rights and dignity of older people while meeting needs within limited resources.

In her description of the "older people of tomorrow", Silverstone (1996) noted that the areas in which baby boomers appear to be particularly at risk in regard to ageing are: income, security, productivity, health and disability, and social supports. She concluded that they are likely to be more confident about being old and more aware of their health needs, but more uncertain economically. Silverstone expects that such trends will necessitate changes to practice, in terms of consumer rights, professional skills, long-term care, clinical assessments, and skills in community organisation. Optimising service provision for older persons is a multisectorial issue, not just the concern of aged care specialists. In many countries, older people are principal users of health and other services, and this trend will become more pronounced. The Economic Planning Advisory Council (Clare & Tulpule, 1994) estimated that the proportion of total health expenditure used on older people in Australia will be 52% by 2050. Such information, together with deficit-focused reports of older persons' health status, presents a somewhat depressing view of ageing, and confirms negative stereotypes already widespread in the community. However, it contradicts older people's views of their own health, which tend to be much more optimistic (Nutbeam, 1998).

A paradigm shift in philosophies of service provision is needed to incorporate consumer viewpoints in planning and evaluation. However, service agencies and personnel may resist changes demanded by consumers because of attitudes and values promulgated during their professional training (e.g., the service provider knows best and is the "expert"), and because of models which better serve the agendas of service agencies than those of clients (i.e., are "program-based" rather than "needs-based").

Older people from non-English-speaking backgrounds

For the first time, the aged population in Australia includes significant numbers of people from a non English-speaking background (NESB), and their welfare must be factored into any discussion of aged care service provision (Thomas, 1993). The number of older NESB immigrants grew four times faster than that of their Australianborn counterparts in the 1970s, and even faster in the 1980s (Hugo, 1990). It is estimated that people from diverse cultural and linguistic backgrounds will represent 25% of all Australians over 70 years by 2001 (Barnett & Brous, 1997). Yet people from non-English-speaking backgrounds are often excluded from studies of the Australian community because of language barriers (Minas, 1990).

Health and illness are social constructions whose definitions vary across time and cultures. When the health and well-being of older people are considered, it is especially important to take account of psychosocial as well as biological factors (see literature review by Teshuva, Stanislavsky, & Kendig, 1994). In Australia, the dominant model of health care is biomedical. It locates the cause of illness within the body, using biological or physiological explanations for disease causation. Migrants are often viewed as 'problems', not fitting neatly into the culture and structure of the Anglo-Australian health care system (Julian, 1998). Many older migrants, especially from Asian countries, see illness as a result of supernatural forces, the act of another human being, a failure to be in harmony with nature, a disturbance of equilibrium, or punishment for immoral behaviour. Such beliefs impact on treatment choice (Galanti, 1991). For example, older migrants are more likely than Anglo-Australians to use herbal remedies, less likely to consult a pharmacist, and less informed about consumer rights (Quine, 1999).

Health departments in some Australian States have made efforts to ensure that health services are more sensitive and responsive to the needs and wishes of migrants (Rice, 1999), by implementing cross-cultural training for staff, recruiting staff from different cultural backgrounds, and increased liaison with ethnic community representatives (Family and Community Development Committee, 1997). But attempts to address inequities in health and community care are not always satisfactory. Using an interpreter or a family member can result in distorted information and loss of privacy (Maltby, 1999; Shah, 1997). Translating leaflets into other languages without considering cultural contexts is self-defeating (Saini & Rowling, 1997).

Improving quality of and access to aged care services for NESB persons has been a policy objective at State and Commonwealth levels for the past 10 years (Family and Community Development Committee, 1997), with governments typically supporting mainstreaming of services ahead of ethno-specific or migrant-focussed services for costeffectiveness (Julian, 1998). Although the term "mainstreaming" entails an intention to change essentially monocultural institutions to more culturally sensitive ones (MOST, 1995), Castles (1992) noted that catering for migrants only within general services might neglect their special needs and perpetuate structural discrimination. Conversely, basing service delivery on ethnicity can marginalise and segregate migrants. The Office of Multicultural Affairs (1995) criticised mainstream services for lacking cultural sensitivity, but warned against over-relying on ethno-specific services, that favour large, well-organised NESB groups with fund-raising capacity. Rather than a simple dichotomy between mainstream and ethno-specific services, it concluded that strong partnerships were required between ethnic communities and governments, although this would require additional resources.

Despite some improvements over the past decade, health services for older migrants are still inadequate (Rice, 1999). For example, relying on extended family to care for older non-English speaking Australians is not a solution. Contrary to popular belief, carers of older migrants in Australia do not receive sufficient support from extended families (Plunkett & Quine, 1996). Support is needed from community services, as carers from NESB groups are highly reluctant to use the option of residential care. While older people and their carers are known to be more satisfied with ethno-specific nursing homes than mainstream facilities (Westbrook & Legge, 1992), there are few evaluations of health or community services for older migrants living in the community. In Victoria, the Aged Care Branch of the

Department of Human Services has developed a Cultural Planning Tool to assist in the provision and evaluation of culturally appropriate Home and Community Care (HACC) services for people of diverse cultural and linguistic backgrounds (Action on Disability within Ethnic Comunities, 1996).

The mental health of older migrants may be subject to particular stressors associated with migration (Rice, 1999). A study of suicides over 12-years to 1990 found that suicide rates of migrants aged 65 years and over in Australia were mostly higher than in their country of birth (Burvill, 1995). Yet people from non-English speaking backgrounds have limited access to a full range of psychiatric treatments: they are more likely to receive physical treatments such as drugs and ECT, less likely to receive social or psychological treatments, and less likely to be engaged in decision-making about their treatment (Family and Community Development Committee, 1997). Asian people in Australia underutilise mental health services, in part because they may not know what is available (Fan, 1999), and also because existing services may not be culturally appropriate. Asian patients express greater satisfaction with a specialised mental health treatment unit for refugees than with mainstream services (Silove et al., 1997).

Lack of proficiency in English is an often-mentioned obstacle to the participation of older people from diverse ethnic backgrounds in the Australian community, and in their access to public and community support services (Multicultural Affairs Unit, 1997). "Language regression" in old age, involving loss of a second language, is commonly cited, and is complicated by the fact that some migrants, especially women, never achieve an adequate command of English. According to the 1991 Census, 23% of all women born in non-English-speaking countries could not speak English well or at all, compared with 16% of men. Older people born in Vietnam, China, Greece, Cyprus, and Italy have the lowest levels of English proficiency (Multicultural Affairs Unit, 1997). Low literacy levels among older migrants may also affect health negatively.

Differences in sociocultural and illness behaviour patterns may exacerbate barriers (Task Force for the Italian Aged in Victoria, 1987). For example, nurses in Hobart indicated that they had trouble "motivating" Italian older people to do things to help themselves, to take up suggestions and to ask for assistance (Moris, 1992). Blackford (1997) and co-researchers were shocked to find the extent of their own ethnocentricity as nurses. Such difficulties highlight different expectations and value systems.

Psychologists in Australia have tended to overlook both older people and people from non-English-speaking backgrounds, amongst whom women and those living in rural and remote areas may be further disadvantaged, for example, by unfamiliarity with or lack of access to appropriate services (Kliewer & Jones, 1999; De Los Santos, 1996; Pane, 1994). There have been calls for psychologists to become bilingual, but this is unlikely to be a viable solution. Older people from NESB backgrounds are therefore among those most likely to be receiving no psychological services at all. In 1999, the APS established a Working Group to examine options for the collation and dissemination of multilingual tests and other transcultural mental health resources.

Equity issues can only be redressed by conducting research in appropriate languages, by considering specific cultural norms and values, by rejecting problem-focused descriptions of non-mainstream cultures, and by affirming such strengths as respect for elders and ancestors which are commonly cited by ethnic minorities in Australia. Julian (1998), recognising that ethnicity is a factor in the lives of all Australians, contends that the way forward lies in the participation of all persons in the management of their health.

Promoting health and well-being in old age

The health of older Australians

Gains in life expectancy for Australians aged 65 and over have accelerated since the 1970s. Today, men aged 65 have a life expectancy of about 16 years and women about 20 years (Australian Institute of Health and Welfare, 1998). Coronary heart disease and cancer account for most deaths in older people. However, death rates among older adults from coronary disease and stroke have declined over the last thirty years due to a decline in smoking rates and control of risk factors for heart disease.

The health and well-being of older people is a major focus for individuals as they age and for policy makers who are concerned about the "burden" of an ageing population. However, as pointed out by McCallum and Geisselhart (1996), taking a "social problem" approach to ageing ignores the diversity of the ageing experience. Most older people live healthy and productive lives well after retirement. The majority of older Australians rate their health as good, very good, or excellent (Australian Bureau of Statistics, 1997; Kendig et al., 1996), and the majority make continuing contributions to society (Kendig & Browning, 1997; Family and Community Development Committee, Victorian Parliament, 1997). High self-reported health status itself does not require the absence of specific health concerns. Older people generally adapt well to the changes that come with ageing, but well-being may be reduced if the changes affect day-to-day functioning.`

Despite the generally positive picture of old age implied in the notion of successful ageing and reflected in the views of older Australians themselves, people may face a number of health issues as they age, including cardiovascular disease, cancer, injuries from falls, pain and disability from musculo-skeletal conditions,and sensory loss. The most common physiological issues facing older people in Australia, according to the 1995 National Health Survey (Australian Bureau of Statistics, 1997) are arthritis, deteriorating sight and hearing, and hypertension. Since arthritis and eyesight and hearing losses account for about 35% of disability in older people (Gibson, Mathur, & Racic, 1997), prevention and treatment of these conditions would have a significant impact on health and well-being in old age. Incontinence is another issue likely to have a major impact on social participation. Finally, dementia (including Alzheimer's disease), a condition affecting 20% of people aged over 80, has pervasive impacts on all aspects of functioning.

The prevalence of disability and consequent handicap increases with age among adults. Functional disability has considerable impact on well-being since it can adversely affect many aspects of life, including social life, relationships, and the capacity to engage in productive activity. However only about 20% of older people who have multiple health problems are hindered in their lifestyle. The rates of profound or severe handicap in older women are almost double those for older men.

Many of the risk factors for ill health and disability in old age are behavioural, and their consequences can often be managed through combinations of medical and psychological interventions. Psychologists therefore have an important role to play in promoting health and well being in older persons, especially through the field of health psychology, for the most prevalent health problems in old age. The reduction of chronic pain in older people is another example of where psychologists can contribute.

Falls prevention is one area where psychological interventions such as behaviour modification can address many of the risk factors. Falls among older persons are a major public health issue (Browning, Hill, Kendig & Osborne, 1998). Mobility influences well being, and restricted mobility can result from conditions brought on by arthritis, osteoporosis, falls, and feet problems. About 30 percent of people aged 65 and over will experience a major fall each year (Tinetti, Speechley & Ginter, 1988), and the cost of falls related injury in Australia is in the order of $2369 million annually (Fildes, 1994). Many of the risk factors for falls, including balance, muscle strength, use of sedatives, environmental hazards around the home, stress, and fear of falling and consequent reduction in physical activity (Browning et al., 1998) are preventable or modifiable. The risk of osteoporosis, a condition predominantly affecting women, can be reduced by exercise at a younger age.

Promoting exercise in old age

The benefits of physical activity for older people are now well recognised in the research literature, with low levels of physical activity implicated in many problems commonly faced in old age including arthritis, injuries due to falls, depressed mood, and heart disease. The American College of Sports Medicine's Position Stand on exercise and physical activity for older adults (1998, p.992) stated that "…the benefits associated with regular exercise and physical activity contribute to a more healthy, independent lifestyle, greatly improving the functional capability and quality of life of this population." Benefits include increased cardiovascular fitness, improved balance and functional capacity with a consequent reduction in the risk of falling, a slowing in the rate of progression of osteoporosis, and improvement in mild anxiety and depression (e.g., Caplan, Ward & Lord, 1993; Ruuskanen & Ruoppila, 1995). However, the optimal level of physical activity necessary to maintain or enhance function in older people is not yet known (Buchner et al., 1992). Young, Masaki, and Curb (1995), while arguing that interventions should incorporate aerobic, strength, flexibility, and balance training for older adults, recognised that interventions designed to improve physical functioning in older adults still need to be examined for the relative value of different types and levels of physical activity.

Notwithstanding the need for further research, public health policy in Australia and internationally has focused on physical activity as a positive health behaviour for older adults. Public health campaigns such as Active at any Age (Victorian Health Promotion Foundation, 1998) provide positive images of older people exercising.

Despite the fact that at least 50% of older people have no medical reason for not engaging in physical activity (McPherson 1986), the National Health Survey (Australian Bureau of Statistics,1997) found low levels of vigorous exercise in older people. However 54% of those aged 65 to 74 years and 42% of those aged 75 and over engaged in walking. Although participation in regular physical activity declines across the life span, older people are more likely to engage in positive health behaviours (such as healthy eating, not smoking, or moderate alcohol intake) than are younger groups.

The research literature on the initiation and maintenance of physical activity in the general population is vast (see King et al., 1992 and Marcus, Bock, & Pinto, 1997 for reviews). However far less is known about determinants of physical activity in older adults (Lee, 1993; Paxton, Browning, & O'Connell, 1997). One barrier to physical activity in older people is a perception that, for their age, older people believe that they "get enough" (Browning, Kendig, & Teshuva, 1999). This view is linked to ageist assumptions often held by older people themselves that exercise is for younger people. Health psychologists have a role to play in improving our understanding of promoting physical activity in older people through research and in assisting in the design and evaluation of community intervention programs.

Chronic pain

The prevalence of chronic pain increases with advancing age (40-50%), although it is not a typical feature of old age. The main reason for pain in older people is arthritis (Helme, Corran & Gibson, 1992). Pain is a subjective experience involving sensory, emotional, and cognitive components. The longer pain persists the greater the chance of depression, which subsequently intensifies the perception of pain, thus maintaining the "chronic pain cycle". Fifteen percent of older people with chronic pain have no discernible organic cause for pain. Laboratory studies suggest that older people have a reduced sensitivity to pain, and may experience less discomfort than younger people. However, if older people lack coping skills, economic resources, and social support structures, their capacity to deal with consequences of chronic pain may be compromised (Gibson, Katz, Corran, Farrell, & Helme, 1994).

Chronic pain in older people is a significant risk factor for suicide. A review of all patients over 65 years presenting in a 16 month period to Royal North Shore Hospital with an intentional drug overdose, revealed that 7 out of 16 had chronic pain (Montague, 1999). The appropriate treatment of somatic complaints in older people, including psychological treatment, can prevent some suicides. However sometimes people wait many years to be referred for psychological pain management strategies,

and may undergo numerous medical and surgical referrals, assessments, and interventions without any recognition or treatment of depression as a likely consequence of unresolved pain and its accompanying processes.

Psychological strategies are usually incorporated in multi-disciplinary pain management clinics. Strategies focus on modifying pain behaviour and perception through behavioural techniques such as visualisation, and cognitive techniques such as changing unhelpful self talk about the pain. Such programs within multi-disciplinary settings have been shown to be helpful to older people with chronic pain (Puder, 1988). Other psychological approaches include hypnosis, psychotherapy, supportive counselling, and group therapy.

Life transitions and ageing

Central to the concept of lifespan development are the twin themes of consistency and change, continuity and discontinuity. Transitions are major life changes which are lasting in their effects, take place over a relatively short period of time, and affect the assumptions that individuals hold about the world and their place in it. (McCallum, 1986; Parkes, 1971).

Transitions may place heavy demands on the individual's capacity to adapt, but can also provide opportunities to overcome earlier difficulties and to make new beginnings in life. Mid-life and later life are times when many transitions may occur, including retirement, widowhood, becoming a grandparent or a caregiver, acquiring a disability, and moving home or to a residential facility. Each of these transitions may involve substantial changes, demand considerable personal adjustment, and impact both positively and negatively on individual health and well-being. Hence each is a potentially fruitful area of concern for psychological research and practice.

Work, retirement, and redundancy

Workers aged 55 years and over are the fastest growing sector of the labour force, with over 34% of the Australian work-force anticipated to be comprised of people over 50 by 2015 (Family and Community Development Committee, 1997). Nevertheless, unemployment remains a salient issue for older workers, illustrated by a disproportionate concentration of older workers among the long-term unemployed. Ageist attitudes pervade many work environments in Australia, and include stereotypical views of older workers as slow, unable to deal with change, and progressively unable to perform demanding intellectual tasks (Thomas, Browning & Greenwood, 1995). However, productivity does not decline with age, workplace injuries are less frequent for older workers, and older workers have attendance records as good as or better than those of younger people (Seedsman, 1996).

The meaning of retirement has changed over the last generation. Rather than signalling the end of a productive life, it now heralds the opening of a new chapter of experiences for many people. Although retirement has traditionally been viewed as complete withdrawal from the labour force at the age of 65, the age at which people have been retiring has been going down over the past 25 years. Between the ages of 60 and 64 only 47% of men remain in the work force, down from almost 80% 25 years ago (Rosenman, 1996). While women tend to retire earlier than men, the trend for women appears to be for increasing workforce participation in their fifties and sixties (de Vaus, 1997; Family and Community Development Committee, 1997).

Older people who retire are more likely than those who continue working to report decreases in social and physical activity but increases in happiness (Wells & Kendig, 1999). The best predictors of successful retirement are retiring at the time preferred, managing financially, and being satisfied with life as a whole. Sharpley and Layton (1998) found that having prepared for retirement emotionally and socially predicts successful adjustment, while involuntary retirement is a strong risk factor for lower levels of adjustment. However, in Australia only 37% of retired men and 22% of retired women say they have actively prepared for retirement (Wolcott, 1998), and 20% of retired men and 11% of retired women describe themselves as 'forced into retirement' (Sharpley, Gordon, & Jacobs, 1996).

Grandparenthood

Increased life expectancy combined with recent decreases in the fertility rate have led to an unprecedented proportion of grandparents in modern society, and have extended the length of the grandparenting role. An estimated three-quarters of adults will live to be grandparents. While becoming a grandparent is something one cannot control, the form of grandparenting a person adopts involves negotiations between three (or more) generations. Although grandparenting is potentially a highly useful and valued social role, it has received comparatively little attention from researchers in Australia.

Grandparents may act as conduits of traditional family values (Smith, 1991). North American studies show that maternal grandmothers exert more influence on grandchildren than do maternal grandfathers, paternal grandmothers, and paternal grandfathers, in that order. Influence is higher for younger grandparents, and also depends on the amount of contact parents allow grandparents and grandchildren to have (Roberto & Stroes, 1995). Parental divorce can severely disrupt the contact between grandparents and grandchildren, especially on the non-residential side. Geographic proximity, socio-economic status, and cultural traditions also influence the kind and extent of relationships between grandparents and grandchildren.

Most grandparents receive enjoyment and gratification through interactions with grandchildren. In the USA, attention has been paid to the increasing numbers of grandparents rearing their grandchildren because of teenage pregnancy, divorce, drug addiction, AIDS, incarceration, and unemployment within the parental generation. There is no corresponding evidence on changing roles of grandparents in Australia.

Caregiving

The view that older people are a burden on younger generations, and the fear that the weight of this burden will increase as the population ages, are largely unjustified. While older people are the most likely to require care as a result of illness or disability, they are also the group most likely to be providing care to one another, and may also continue to be caregivers as parents or grandparents. There can often be an interdependence between older persons, each with varying levels of disability or chronic illness. The greatest source of help for a majority of older adults with a disability is their spouse (Wells, 1996).

A great deal of literature on caregiving is focused on undesirable aspects ahead of positive outcomes and rewards. However, since most studies have employed nonrepresentative samples of caregivers recruited through services or support groups, the literature probably depicts an unnecessarily pessimistic view of caregiving in later life (Wells & Kendig, 1997).

Undesirable impacts of caregiving may include feelings of burden and restrictions on a caregiver's employment, family life, and social participation. Long-term consequences may include poorer health and increased rates of depression, anxiety, guilt, and distress (Biegel, Sales, & Schulz, 1991). Positive consequences may include increased selfefficacy and satisfaction in fulfilling a valued role. The majority of caregivers carry out their caregiving tasks without experiencing detrimental outcomes (Schofield, 1998). A high caregiving workload and caring for someone with dementia (rather than a physical condition) is likely to be stressful. Risk factors for experiencing caregiving as a burden and for caregiver depression include; female gender, being the care-recipient's spouse, poor health, and a poor pre-existing relationship with the care-recipient. The longer the caregiving lasts the more likely caregivers are to experience stress or depression, or to feel burdened. Having alternative roles (such as employment or family roles) may act as a resource or as a source of extra stress, depending on any conflict between the roles. Access to coping strategies and satisfactory social support may ameliorate the effects of stressors, or act as a buffer between stressors and outcomes (Biegel, Sales, & Schulz, 1991).

Little is known about the process of becoming a caregiver. For adult children of older people, often middle-aged themselves, the transition to caregiver is an extension of filial responsibility. Care by adult children is strongly gendered: adult daughters are three times as likely to become caregivers as adult sons and only half as likely to relinquish care (Dwyer, Henretta, Coward, & Barton, 1992). In contrast, the gender imbalance in spousal caregiving is minor (Wells & Kendig, 1997), with slightly more men than women likely to be the "principal resident carers" after age 60 (McCallum & Geiselhart, 1996). While the transition to caregiving within a marriage usually arises from feelings of mutual affection and obligation, mutuality and balance in the relationship may be disturbed in the process.

Governmental policies encouraging community care and reducing institutionalisation have shifted the responsibility to family caregivers. There has been an increasing awareness of the importance of supporting family caregivers through community services. However, few caregivers use any services or formal supports (Schofield, 1998). Family care is not always the best option, since caregiving can sometimes exhaust the caregiver's resources. The relationship may not always be loving or responsible, and in extreme cases may entail elder abuse or neglect.

While there is evidence to suggest the usefulness of caregiver education, counselling, and support groups, the efficacy of respite (including day centre provision) in reducing feelings of burden is under-researched (Biegel, Sales, & Schulz, 1991). Community service provision may actually increase the likelihood of institutionalisation for a carerecipient (Cohen et al., 1993). It is unclear whether this indicates a benefit of closer monitoring of persons in need of higher levels of support, or an enforced reduction in such persons' levels of independence. In any event, many caregivers see their responsibilities as continuing when their relative is placed in residential care.

Relocation

Current philosophies of ageing emphasise "ageing in place", where older people as far as possible are able to maximise their independence and quality of life by adjusting their chosen social and physical environment instead of moving to a new environment. Older people generally express a strong wish to continue to live in the family home rather than move. However, choice is a critical factor. Evidence suggests that older people who move by choice experience significantly increased levels of adjustment and satisfaction (Joiner & Freudiger, 1993). An important step is for the person to feel able to actively exert control over their new environment and see "home" as the place where control can most easily be exerted (Sigman, 1986).

Both social and medical factors influence a decision to move. Many older people in the community require a high level of care but fail to make use of services, while others with a low need for medical attention live in nursing homes. The older person may take little or no part in the decision to move, with this decision being made on their behalf by family members or professionals, especially general practitioners (Minichiello, 1986).

When an older person moves home (to a retirement village, hostel, nursing home), the permanent reductions in freedom of movement and the severance from former life style patterns are difficult to accept. Adaptation generally requires extensive social activity on the part of the new resident, involving complex negotiations with existing residents and staff. The person should be able to make the new environment as familiar as possible. The opportunity to bring personal possessions with them may provide new residents with historical continuity, comfort, and a sense of belonging (Sigman, 1986).

Widowhood and bereavement

By the age of 65 it is likely that an individual has experienced a number of significant losses of persons close to them. These are most commonly the loss of their parents, but may also include the loss of a spouse, siblings, and friends, or less commonly, the loss of a child. Grief reactions are healthy in such circumstances, and most older people have the adaptive capacity to meet the challenge. Characteristic feelings associated with healthy grief include shock, sadness, numbness, sorrow, yearning, fear, anger, anxiety, helplessness, and abandonment. Thoughts may include disbelief, confusion, questioning, memories of the deceased, and trying to make sense of what is happening. Physical symptoms may include tightness in the chest, palpitations, over-sensitivity to noise, poor sleep, lack of energy, and poor appetite.

Widowhood is an abrupt and severe transition. Many more women than men are widowed - among older people widows outnumber widowers four to one (Martin-Matthews, 1996). Earlier studies found that people whose spouse died themselves had an increased risk of mortality in the following years (Parkes, 1986). This result has not been replicated in more recent studies. The most common negative outcome following widowhood is loneliness (Lund, Caserta, & Dimond, 1986). Other consequences can include lower social participation, lower life satisfaction, and higher consumption of psychotropic medication including anti-depressants and sedatives (Wells & Kendig, 1997). Widows and widowers are at risk for poor nutrition since their daily routines, especially those associated with food preparation and consumption, may be disrupted (Rosenbloom & Whittington, 1993). On the positive side, most widows and widowers eventually make a satisfactory adjustment (McCallum, 1986). For some, widowhood provides an opportunity to begin a new life, and feelings of self-efficacy may increase (Arbuckle & de Vries, 1995).

Grief associated with bereavement is not given a psychiatric diagnosis unless it remains persistent or chronic for 12 months or more. Research with recently widowed older Australian men found that only 8.8% exhibited bereavement phenomena at 13 months post-bereavement (Byrne & Raphael, 1994). The most severe bereavement reactions were found in men who were unable to anticipate their wife's death. Adjustment following widowhood is affected by factors such as: the suddenness of the bereavement (especially if by accident or suicide); financial pressures; low support from family members immediately afterwards and low support from friends further down the track; high commitment to the role of spouse; long-lasting pre-bereavement caregiving strain (Martin-Matthews, 1996); the presence of unresolved issues from a previous bereavement; and a history of past psychiatric problems (Kavanagh, 1990).

The relationship quality before bereavement may affect the course of adjustment: a relationship marked by conflict, or where the surviving spouse was highly dependent on the partner who died, is likely to have negative impacts on the bereavement process. On the other hand, having cared for one's partner may protect the bereaved partner, since it provides an opportunity to come to terms with the death in advance. While some theoretical viewpoints have insisted on the importance of "grief work", recent research indicates that intense preoccupation with the death in the first few months afterwards is a predictor of less satisfactory adjustment two to three years later (Wortman & Silver, 1990). While there are many services designed to assist and support caregivers, very few are available to assist widows and widowers.

Sometimes the death of a partner (especially a caregiver) means that the surviving partner must relocate to residential care, thus compounding the loss. Expectations of a rapid adjustment in such circumstances can have detrimental consequences for both residential care staff and the individual. Psychologists have an important role in assisting the individual with bereavement counselling, in facilitating adjustment to new environments, and helping staff with methods of managing the situation.

The scope and implications of cognitive ageing

Forgetful, rigid, slow, and repetitive are adjectives linked to one of the most enduring stereotypes in contemporary Western culture - that of an inexorable, irreversible decline wrought by age on intellectual ability. The so called "general decrement principle" (Kausler, 1989) has also pervaded most laboratory research on cognitive ageing. This principle assumes that irreversible decrements are inevitably associated with ageing as a consequence of biological degeneration. Although there are well-documented changes in cognitive functioning with healthy ageing, decrements are smaller in magnitude and occur somewhat later than has been commonly assumed (Schaie, 1994). Furthermore, although such decrements are real, they are not likely to have a great impact on the everyday functioning of older individuals who adopt a range of strategies designed to adapt to cognitive changes. Studying the scope and processes of healthy cognitive ageing is essential for developing models of lifespan development and for our understanding of what occurs in pathological processes such as dementia.

Whereas most laboratory work on cognitive ageing has focused on memory and psychometric intelligence, recent work has focused on the study of tasks that are more obviously related to everyday activities such as everyday problem solving (Denney, Tozier, & Schlotthauer, 1992). Cognitive ageing is characterised by two important features, first, different abilities show different patterns of change with age and second, diversity between individuals in ability levels increases. A summary index such as an IQ score is thus not sufficient for describing developmental change in intellectual ability, and researchers have begun a search for individual, biological, and environmental factors that might mediate the increasing diversity between individuals in cognitive performance.

Although it is possible to find instances where memory performance of younger and older adults does not differ (e.g., Luszcz, 1993), more often than not, older adults remember less than do younger adults (Smith, 1996). This is particularly likely to occur under conditions where using specific strategies to encode information would be helpful, where environmental support is minimised, or where the memory task is presented out of context (Smith, 1996). In the past, researchers sought to identify the location of age differences in relation to deficits in the major memory systems (e.g., short versus long term memory) or basic memory processes (e.g., encoding, storage or retrieval; recall versus recognition) (Poon, 1985; Salthouse, 1980). However, current research is more inclined to seek to understand factors that account for age-related variability in memory (e.g., Bryan & Luszcz, 1996; Luszcz, Bryan, & Kent, 1997), processes that contribute to maintenance of memory (Camp, 1988) or longitudinal changes in memory in later life (Small, Dixon, Hultsch, & Hertzog, 1999). The latter reports are interesting in that they show that, even in very old adults, change over a two- to three-year period is quite small, with the majority of respondents showing stability and some showing gains in memory (Luszcz, 1998). This flies in the face of the general decrement principle and, as will be discussed below, is consistent with longitudinal findings on measured intelligence.

Different cognitive abilities show different patterns of change with age. Typically, perceptual-motor ability, spatial abilities, abstract reasoning, and tasks that involve the integration of new information decline with age, whereas verbal abilities and general knowledge are relatively stable, a pattern that Botwinick (1977) referred to as the classic ageing pattern. Horn and Cattell (1967) made a distinction between fluid (Gf) and crystallised (Gc) general intelligence which still provides a useful descriptive framework for summarising age changes in intellectual ability. Fluid intelligence, assumed to reflect the neurophysiological status of the individual, has been found to increase until early adulthood and thereafter decline, whereas crystallised intelligence, concerned with the accumulation of knowledge over time, remains stable or increases throughout adulthood, at least until the seventh decade. Some evidence for gender differences has been found, with women declining earlier on fluid and men on crystallised abilities (Schaie, 1994).

Although similar patterns of change have been documented in both longitudinal and cross sectional studies, the former report much later age of onset and less severe rates of decline than the latter (Schaie, 1990, 1994). Longitudinal analysis of data from the Seattle Longitudinal study, for example, indicated that, with the exception of perceptual speed, performances on primary abilities increased in young adulthood and were maintained into the 60s before gradual decline occurred. Relative stability was a feature of functioning, with approximately 60 % of people tested at age 81 showing no change in ability levels over a seven-year period (Schaie, 1990, 1994).

Different types of abilities are more strongly correlated in young than older adults, suggesting that individuals undergo cognitive ageing at different rates (Rabbitt, 1993b). Clearly age group trends on cognitive tests can mask large individual differences in performance. Much research has focused on differences in cognitive ability between individuals (Christensen et al., 1994) and in particular, on individual, lifestyle, and, environmental factors that might contribute to differences in cognitive functioning and rates of decline (Jones et al., 1991). Identifying modifiable factors that predict good functioning has important practical implications (Luszcz, Bryan, & Kent, 1997).

A range of variables has been linked to effective cognitive performance, including high socioeconomic status (Lantz et al., 1998; Wister, 1996), maintenance of perceptual speed (Schaie, 1994) and high levels of education (Schaie, 1994; Shimamura, Berry, Mangels, Rusting, & Jurica, 1995). Chronic conditions including sensory impairment, hypertension, cardiovascular disease, osteoporosis, and arthritis impact negatively on cognitive performance (Baltes & Lindenberger, 1997, Chodzko-Zajko & Moore, 1994), with a stronger association between health and ability levels for fluid compared to crystallised intelligence (Perlmutter & Nyquist, 1990). Furthermore, the inclusion of individuals who are in ill health or who are undergoing cognitive decline as a result of approaching death (the terminal drop phenomenon) may exaggerate findings of agerelated declines in cognitive performance (Rabbitt, 1993b). Poor health habits such as tobacco smoking, alcohol abuse, and leading a sedentary life are predictive of poor cognitive performance (Berkman, et al., 1993; Hultsch, Hammer, & Small, 1993). Positive benefits of physical exercise are typically found for fluid abilities and basic information processing components like speed, working memory, attentional capacity, abstract reasoning, and nonverbal fluency (Chodzko-Zajko, 1991; Hultsch, Hammer, & Small 1993).

Understanding the role of basic information processing components in normal cognitive ageing has been at the forefront of recent theoretical work. Maintenance of perceptual speed has been identified as a predictor of effective cognitive performance (Schaie, 1994). Furthermore slowing in the rate of information processing is thought to be a major contributor to memory ageing (Luszcz & Bryan, 1999; Salthouse, 1996). Slowing suggests a reduction in cognitive processing resources, our reservoirs of mental energy that have been thought to be responsible for old-age-related declines in memory and intelligence. Such resources have also been conceptualised in terms of working memory and attention. Support for processing resource models comes from studies that find the association between age and cognitive performance is greatly reduced when differences in speed, attention or working memory are taken into account (eg Bryan, 1998; Salthouse, 1996; Stankov, 1988). Researchers in cognitive ageing today are concerned to know how the mechanisms interact, if they make independent or unique contributions to performance, and perhaps, most challenging, whether one mechanism or resource may be basic to the operation of all others, thus constituting a "cognitive primitove". Other fruitful areas of cross-fertilisation come from neuropsychology and neuroimaging, where an emphasis on brain structures and mechanisms coupled with measures of memory performance (Moscovitch & Winocur, 1992) could provide a comprehensive understanding of memory changes in late life.

The mental health of older Australians

Studies of psychological well being in old age generally paint a positive picture. For example, the Health Status of Older People project (Kendig et al., 1996) surveyed a representative sample of 1000 older people living in Melbourne. Over three-quarters of the sample reported very frequent or frequent positive feelings on measures of wellbeing and satisfaction. Three-quarters were extremely satisfied or satisfied with various aspects of their lives, including neighbourhood, friendships, and family life.

Examining mental health in older people requires consideration of psychological well being together with specific mental health problems. Many large-scale surveys have found that mental health concerns are less prevalent in older than younger persons. Data from the 1997 National Survey of Mental Health and Wellbeing of Adults (McLennan, 1998b) suggest that mental health problems decrease with age, with a prevalence of 6.1% in those aged 65 years and over. Mental health disorders included in the survey were anxiety, depression, and substance use disorders (psychotic illnesses were excluded).

Statistics on the prevalence of type of mental condition by gender for those 65 years and over reveal that women experience more anxiety and affective disorders than men, while men experience more substance use problems. The higher prevalence of substance use in older males is not surprising considering this cohort of men. Many were survivors of a World War and may have experienced various symptoms of (diagnosed or undiagnosed) Post-Traumatic Stress Disorder during their life. Women are more likely to use psychological services than men, and a general practitioner (GP) is more likely to be consulted for mental health concerns than a psychiatrist, psychologist or other mental health professional.

However, a number of issues need to be considered when interpreting data from epidemiological studies. For example, research conducted by the Psychiatric Epidemiology Research Centre at the Australian National University (Jorm, 1994) indicated that depression and anxiety were experienced in qualitatively different ways by younger and older people. Their meanings may change over the life span, or between different cohorts: thus the current generation of older people may be more likely to describe their experiences in physical rather than emotional terms. Under-reporting of symptoms on the part of older persons raised with a stoic attitude to emotional problems may partly explain such differences. Selection effects may also be important: those with mental health problems may die earlier and therefore may be underrepresented in the older cohort.

Despite the overall positive picture of mental health in old age, older people, in common with other age groups, can experience a range of mental health concerns. These can affect thoughts, feelings, and behaviour; and influence family and social relations. The major mental health problems amongst older people include dementia, anxiety disorders (e.g., generalised anxiety disorder, panic attacks, post-traumatic stress disorder, and agoraphobia), mood or affective disorders (e.g., major depression and bipolar disorder), and substance use disorders (abuse of alcohol or prescription drugs such a minor tranquillisers (benzodiazepines)).

Psychotic illnesses such as schizophrenia, delusional disorders, and paranoia are less common. Other mental health problems that may affect older adults include adjustment and sleep disorders.

The relationship between disability and mental health was examined in the 1997 National Survey of Mental Health and Wellbeing of Adults Though the prevalence of disorders decreased, the impact of disability increased with age and with the number of mental and physical conditions experienced. With co-occurring physical conditions, both men and women were most disabled by affective disorders (commonly depression), with women more so than men.

Psychological approaches to treatment of mental health problems in old age

The most common mental health problems that can be aided by psychological interventions are depression, suicide, anxiety, and disruptive behaviour.

• *Depression*
Although the prevalence of depression is lower in older adults, it can occur for the first time in later life. It is likely to occur following some stressful life event such as a loss of a close person or a change in role; but can occur without apparent reason. Some people have a tendency to become depressed throughout their life and this can continue in old age. Risk factors for the development of depression include: female gender, social isolation, widowhood, physical ill health, disability, chronic pain, recent bereavement, a family history of depression, and a past history of depression. Prevalence rates of depression in cases of stroke, Parkinson's disease, disability, and dementia range upward from 20% (Snowdon, 1997). If untreated, depression is likely to persist and is a predictor of premature death.(see review by Zisook & Downs, 1998).

One consequence of depression can be suicide. The three main risk factors for suicide in older people are: depression, social isolation, and chronic pain. Suicide rates in Australia are highest for men over 80 years (40 per 100,000). This is higher than the overall male suicide rate during the Great Depression of 1930 (Hassan & Tan, 1989). Suicide prevention is achieved through adequate and timely assessment and targeting interventions at people presenting with high risk signs. For example, Klinger (1999) describes an innovative telelink counselling service established in Western Australia.

Depression is mostly a treatable condition with a reasonable prognosis. Therefore early recognition and appropriate intervention in late-life depression are vital. Older people are more likely to be offered biological therapies such as medication and electroconvulsive therapy (ECT) than psychological therapies (Brodaty et al., 1993), and the probability of receiving ECT increases with age (Glen & Scott, 1999). Drug therapy can produce adverse side effects and compliance problems, while ECT is not recommended for people with heart problems (Coon, Rider, Gallagher-Thompson, & Thompson, 1999). Some late-life depression is responsive to a range of psycho-social interventions including cognitive-behavioural and other psychotherapies, social skills groups, exercise programs, group discussions and caregiver and client health education (Koder, Brodaty, & Anstey, 1996). Research supports the use of a combination of treatment approaches as early as possible (Coon, Rider, Gallagher-Thompson, & Thompson, 1999).

Cognitive-behavioural therapy (CBT) for depression is effective for older adults when it is modified and adapted to take account of physical and sensory loss and ageassociated cognitive changes (Koder, Brodaty, & Anstey, 1996). Because of these modifications therapy can take longer than with younger clients. CBT should not be simply a technical exercise, but should incorporate a warm, empathic, therapeutic relationship, which significantly improves therapy and speeds recovery (Burns & Auerbach, 1996). Medication and CBT have been used effectively in combination (Wilson, Civic, & Glass, 1995).

The heterogeneity among older people requires flexibility in the therapist, and the ability to tailor an approach to the individual. Older people are able to mobilise a variety of strengths and capacities through therapy. Some psychologists use a variety of approaches apart from CBT, such as interpersonal, personal construct, and psychodynamic therapies. The psychologist should inform the client of his/her preferred approach, and negotiate the process to be followed. Individuals can be referred to a psychologist by a GP or can attend without a GP referral.

Given the central role of general practitioners in primary health care, more collaboration between GPs and psychologists is needed in treating depression. A British study suggested that only 44% of GPs referred depressed older clients to psychologists (Collins, Katona, & Orrell, 1997). GP training and education should emphasise the range and potential efficacy of available psychological therapies.

• *Anxiety*

Anxiety is a healthy human emotion that is adaptive in certain situations, where it helps one to anticipate, prepare for and react to threatening events. The symptoms of anxiety are multi-dimensional and include cognitive, behavioural, and physiological changes. It becomes unhelpful when it occurs in the course of everyday life, and becomes excessive and disabling. When anxiety symptoms reach the point where the person feels as though they are losing control of their mind or body, this is described as a panic attack. Despite anxiety being one of the most common mental health concerns experienced by older people, it is usually unrecognised by clinicians, which could be due to the fact that anxious older people mostly present with physical complaints, and often anxiety is concomitant with depression (Rosenbaum, Pollack, & Pollock, 1996).

As with treatment of depression, a combination of psychological and pharmacological strategies may be needed to treat anxiety disorders. Cognitive behavioural interventions such as cognitive therapy, relaxation training, and behavioural therapy have been shown to be efficacious for the treatment of generalised anxiety disorder, panic disorder, phobias, and obsessive compulsive disorder (Rosenbaum, Pollack, & Pollock, 1996). CBT has been successfully used for the treatment of anxiety in people with a cognitive impairment, where anxiety often manifests as agitation (Koder, 1998).

• *Dementia*

Dementia is the collective name given to a group of disorders characterised by symptoms of memory loss, deteriorating ability to think and learn, and personality changes. These symptoms represent a disease process which interferes with social and emotional functioning. They may also result from trauma or infection, and are usually first noticed by the spouse or children. The most common form of dementia is Alzheimer's Disease. The prevalence of dementia increases with age but it is not a typical part of ageing. Its prevalence in Australia is estimated to be 0.7% at age 60-64, increasing to 23.6% at age 85 and over (Jorm & Henderson, 1998). Approximately 120,000 people in Australia have moderate-severe dementia; while another 120,000 are estimated to have early symptoms.

Dementia can be associated with depression, psychosis, and behavioural problems. Early diagnosis is important, because a number of causes of memory loss are reversible, while dementia-like symptoms may be the result of treatable medical or mental conditions, such as depression and/or delirium. Psychological assessment can identify when depression and anxiety are contributing to dementia-like symptoms. Psychologists have an important role in the assessment of cognitive deficits. Clinical psychologists and neuropsychologists use specialised tests and expertise in defining the areas of the brain that are malfunctioning, and thus assist in diagnosis. The differential diagnosis of the dementias is important for the future planning of appropriate care and services for the individual and the family. Psychologists can also assist family members and caregivers in coping with what has been described as the "living death" of a loved one. There is a need for training of support group facilitators for caregivers and in relation to specific issues such as Alzheimers.

The National Action Plan for Dementia Care was a five year initiative of the Department of Human Services and Health, with the aim of achieving overall structural change in aged care services. The main aims were to promote, deliver, and evaluate training; and provide financial assistance to residential care service providers. The aim of training is to improve dementia care practices within residential care services. Psychologists have an important role to play in the development, implementation and evaluation of such training strategies, which have been found to be well-received by residential care staff (Killmier & Gridley, 1997).

Commonwealth funding to the states has been responsible for the establishment of CADMS (cognitive and dementia memory clinics). These are specialised memory clinics where comprehensive assessments are performed by a team of specialist clinicians, typically including a psychogeriatrician, geriatrician, occupational therapist, clinical neuropsychologist and/or clinical psychologist. Their core roles are to provide early diagnosis; to be a publicly visible and accessible specialist consultancy for people with

cognitive impairments and their caregivers; and to provide advice and general information to any person or service in contact with a person with cognitive impairment. An example is the Cognitive Disorders Clinic at Concord Hospital in Sydney, supported by the Commonwealth Department of Veterans' Affairs, as part of the Neurodegenerative Disorders Education and Management Service.

The American Psychological Association (APA) has produced a set of guidelines for the evaluation of dementia and age-related cognitive decline under ten headings designed to promote sensitive, consistently competent, therapeutically useful assessment practices with older persons. These are available on the APA Webpage.

• *Challenging behaviours*
Challenging or disruptive behaviour is defined by its effect on others in the immediate environment rather than by the behaviour itself. Behaviours that present a challenge include inappropriate vocalising, wandering, verbal or physical aggression, and repetitive questions. Nursing homes often house the most severely cognitively impaired persons, but challenging behaviours also occur at home or in hostel settings.

Managing challenging behaviours in residential settings

The majority of nursing home residents are cognitively impaired (80% in a Sydney survey), with at least a third experiencing depression, and another third experiencing generalised anxiety symptoms (Snowdon, Burgess, Vaughan, & Miller, 1996). In that study, the main reason for referral from a nursing home setting for psychogeriatric services was a variety of challenging behaviours in the context of cognitive impairment, depression, and/or anxiety. Behaviours included wandering, screaming, repetitive questions, and aggression in the context of personal care. Residences vary in their tolerance and ability to manage various challenging behaviours. Within a single setting there can be wide disagreement over which patients are challenging (Bird, in press).

The role of the psychologist in residential settings is primarily to assist and empower the staff or caregivers to manage challenging behaviours. Psychologists working in such settings adopt a broad biopsychosocial model to assess and maximise the client's satisfaction in psychological, social, physical and spiritual domains. Psychologists acknowledge the residence as a system; a complex environment made up of physical, human and organisational factors. A thorough assessment of a client in this setting includes a clinical interview, behavioural observations, assessment of the environment including staff perceptions, attitudes, and stress levels, the residence's culture, other residents' reactions and interactions, and interviews with relatives.

Although psychology is defined as the study of human behaviour, psychologists have only recently applied their skills in the management of challenging behaviours. Bird (1999b) outlines the contribution of psychology to this area, noting that is not confined to assessment and classification, but includes the design of methods to ameliorate distress associated with challenging behaviours, and/or changing patient behaviour. A recent study found that challenging behaviours in dementia are equally responsive to an individualised, predominantly psychosocial approach as to a pharmacological approach, and that a psychosocial approach is just as cost effective, and more effective in terms of some measures of caregiver stress (Bird, 1999a). Bird and his colleagues from ANU and Hornsby/Ku-Ring Gai Hospital have developed an intensive case-oriented approach to managing disruptive behaviour which can be used effectively to alleviate the severity of disruptive behaviours in the home or residential care facility (Bird et al., 1998).

Legal and ethical issues

Guardianship
Sometimes it is necessary to seek a substitute decision maker for an older person through a Guardianship Tribunal or Board when the person is deemed to be incapable of making their own lifestyle decisions. A guardian is a legally appointed substitute decision maker. Psychologists can play a role in performing assessments to provide evidence about the older person's decision-making capacities. A report is presented to the tribunal and often the psychologist will attend a hearing to speak to the report. Psychologists' knowledge of cognitive and neuropsychological functioning in older age can inform and assist in other legal questions besides guardianship determinations. One example is the determination of the capacity of an older adult to make a legal decision, such as making a will or assigning a power of attorney.

Elder Abuse
Elder abuse is defined as "physical abuse and sexual abuse, psychological abuse, economic and financial abuse, and neglect occurring in private residential settings. It does not include such occurrences in institutional care, crime and assault in the streets or perpetrated in the home by strangers, nor the discrimination that may occur in access to goods and services" (McCallum, 1994, p.7).

Factors found to contribute to elder abuse are caregiver stress, psychopathology of the abuser, other family violence and the presence of dementia (Sadler, Kurrle, & Cameron, 1995). Many incidents of elder abuse go unreported and/or undetected for fear of punishment, abandonment, shame, and guilt. The NSW Advisory Committee on Abuse of Older Persons has developed recommendations which are appropriate for psychologists to endorse. The committee did not recommend mandatory reporting for elder abuse. Psychologists should be aware of risk factors for elder abuse, and become involved in preventative strategies where necessary by working with caregivers, providing support, working on coping strategies, and suggesting respite options.

Older women may also be at risk of violence by partners or adult children, and may fall between interventions designed to combat either elder abuse or domestic violence separately. For example, traditional women's refuges may not suit the needs of women over 50. Seaver (1996, p. 3) concludes that older women have age-specific strengths and limitations in beliefs, resources, and system responses that "once recognised, can be addressed and made to work for the women instead of against them".

Psychology and psychologists: contributions and challenges

Australian research

Australian psychologists have originated a notable body of research on aspects of ageing, and have participated in several large multidisciplinary studies on an even wider range of topics, contributing their unique perspective to the conduct and reporting of such research. Much of this research has been directed toward mental health issues in older people, but some large projects have addressed more general issues important for all older Australians. Some examples of these areas of research appeared in a recent special issue of the Australian Psychologist (July, 1999).

One example from the mental health field is the survey noted earlier by McLennan (1998a), which found that older Australians appear to have fewer problems in the areas of anxiety, depression, and substance misuse than do younger adults. In the light of other surveys which document high rates of symptoms of mental distress (e.g., Blazer, Hughes, & George, 1987) and high suicide rates among older adults, notably men (Klinger, 1999), studies at the Lincoln Gerontology Centre are examining the nature of depressive symptoms among older people in the community (Wells & Stacey, 1998).

Several other examples of such work come from the Psychiatric Epidemiology Research Centre, which is associated with the Australian National University (ANU). The ANU research group is carrying out further analyses of the detailed data from the National Survey of Mental Health and Wellbeing (McLennan, 1998b), to uncover additional information on the disability associated with these disorders and the use of associated mental health services.

Australian psychology has contributed a great deal to the field of cognitive ageing. While changes in cognitive functions with increasing age are a matter of both common observations and well-established research, the nature of the changes and the factors influencing them are less well known. Influential early work can be traced to George Naylor and Elsie Harwood (1975) at the University of Queensland. They conducted what came to be know as Operation Retirement (Harwood, 1988), a longitudinal study of ageing mainly focusing on learning and memory.

Today there are a number of Australian researchers in several research programs addressing the factors that affect individual differences in the cognitive processes that alter with age. One of these studies is taking place through the ANU's Psychiatric Epidemiology Research Centre in their longitudinal study of a sample of the general population that began in 1990. The Australian Longitudinal Study of Ageing in Adelaide also examines changes in cognitive functioning over time. The aspects of cognitive ageing being examined include intelligence (e.g, Anstey, 1997; Christensen, et al., 1994); attention (Stankov, 1988), memory (Luszcz & Bryan, 1999; Rendell & Thomson, 1999) and, speed of processing (Nettelbeck & Rabbitt 1992; Ward, 1995). The study also has the broader aim of understanding the social, biomedical, and environmental factors that influence age-related changes in the health of older adults. The Health Status of Older People project (Lincoln Gerontology Centre, La Trobe University and the National Ageing Research Institute, University of Melbourne) and its continuation, the Health Behaviours and Outcomes of Older People project conducted through the Lincoln Gerontology Centre and the Faculty of Health Sciences at the University of Sydney, comprise a longitudinal study of health and health behaviours and their determinants in community dwelling older adults (Browning, Hill, Kendig & Osborne, 1998; Kendig, Browning & Young, 2000; Kendig et al., 1996; Wells & Kendig, 1997). The latter studies also examine the role of social factors such as family structure and social support on physical health and well-being.

An additional focus of a different group of psychologists and other disciplines at ANU has been on clinical approaches for older people with dementia and their caregivers (Bird, 1999a). One result arising from the Health Status of Older People Project is that caring for an individual with dementia is in some ways less stressful than the loss associated with widowhood (Wells & Kendig, 1998). Another major finding has been that people with mild to moderate dementia can be trained using the methods of spaced retrieval and fading cues to learn the association between a behaviour and a cue (Bird & Kinsella, 1996; Bird, 1998). Such a demonstration of learning by people with dementia counters the common belief that learning does not occur in these people, and supports the use of applied behavioural interventions for teaching people with dementia alternative means of communication.

An example of multidisciplinary work involving psychologists is that of the Community Disability and Ageing Program (CDAP) at the University of Sydney. Here, psychologists work alongside social workers, nurses, and other social scientists in conducting research and community education on issues associated with living with a disability and with ageing. The CDAP has conducted research into ageism within the community and with professional groups, and has developed the Reactions to Ageing Questionnaire which measure attitudes to ageing (Gething, 1994). The CDAP also conducts research into quality of life issues for people ageing with a disability (Gething, 1999b; Gething & Fethney, 1998).

Training

The field of developmental psychology has traditionally been dominated by a wealth of material on child and adolescent psychology, reflecting perhaps the growth of the field in parallel with the post-war baby boom phenomenon. However, the expanded coverage of adult development in human development textbooks since the 1970s is evidence of increasing interest and research initiatives in what has come to be known as lifespan development. Whether by practical necessity or narcissism, the ageing patterns of the general population as well as within the psychology profession have demanded increased attention to developmental issues of old age, in terms of research effort and textbook content at undergraduate and postgraduate levels of training. This has implications for other professions such as social work and nursing, which commonly utilise psychology texts (e.g., Gething, Papalia, & Olds, 1995) in the human development components of their training programs.

In the past, psychological training has not always prepared practitioners for interactions with older people. Anecdotal evidence suggests that the topic of ageing is often dealt with in undergraduate courses as a small part of human development or abnormal psychology subjects. Until the recent introduction of six-year training for APS membership, part of the problem may have been the acceptance of a four-year basic level of training for psychologists in Australia. Such training must cover the broad domain of psychology, introduce research methods to provide the scientist part of the scientist-practitioner model, and then begin to provide professional training. Four years is insufficient time to do all of this well.

Six-year programs in clinical neuropsychology, clinical, counselling, and community psychology at the Masters level provide an opportunity for better training that includes knowledge of interventions for older people. Whether psychologists work with older people depends in part on their individual preferences as well as on the training they have received. Koder and Ferguson (1998) found that psychologists are not attracted to working with older people, and that the majority of Masters level courses offer little, if any, training in geropsychology. If the training program neither provides accurate information on the needs of older adults in relation to psychological treatment, nor indicates how interventions can be tailored for work with older adults, then any initial reluctance on the part of trainees will be accentuated. This likelihood is increased by the current accreditation standards of most APS Colleges, where training in work with older adults is optional and not part of the standard guidelines. Programs that do not expose students to accurate current information on work with older adults run the risk of perpetuating the negative stereotypes about older adults that lead their graduates to believe such work to be unrewarding.

Specialist training such as the Geropsychology Masters program at Edith Cowan University can play a leadership role in establishing a scientist-practitioner basis for psychologists engaging in research and practice with older populations. At the other end of the training spectrum, it is also essential that undergraduate psychology course content (as well as secondary school psychology curricula and courses taught to nonpsychologist health and welfare workers) be examined to eliminate ageist assumptions and encourage more empowering, respectful and informed approaches to older people. The American Psychological Association (APA) now lists geropsychology as "a recognised proficiency in professional psychology" (Abeles, 1998, p. 857).

In terms of professional development the APS Interest Group on Psychology and Ageing provides a forum for psychologists to attend meetings and seminars in the field and convenes a symposium each year at the annual APS conference. However it is difficult for psychologists working with older people to gain specialist or generalist Professional Development (PD) points in the field of ageing. The APA has taken steps to guide psychologists and other health professionals in their work with older adults (Abeles, 1998). A brochure has been developed addressing topics such as common myths, realities of ageing, psychological problems experienced by some older persons, assessment and intervention, and broad professional issues.

Psychological practice

Psychologists adhere to a scientist-practitioner model in which the results of empirical scientific research inform clinical practice. Thus it is likely that the approaches used by most psychologists are supported by a rationale based on sound evidence. Demonstrations of effectiveness in everyday practice are increasingly considered desirable, but such studies are still not common (Seligman, 1995). Assessment instruments used by psychologists have been shown to be reliable and valid. Psychology is differentiated from other health care professions by its grounding in the study of the full range of human behaviour and mental processes, thereby moving beyond a focus on clinical populations or problems alone.

Substantial numbers of psychologists work with children and adults, but considerably fewer work with older adults (1:66,200 older people) (Snowdon, Ames, Chiu, & Wattis, 1995). In the 1990 National Health Survey Jorm (1994) reported that only 38 per 100,000 men aged over 60 had consulted a psychologist in the last 2 weeks, compared with 275 per 100,000 in the 20-59 year age group. For women over 65 years, there was a higher rate of 86 per 100,000, compared with 389 per 100,000 in the younger age group. The 1995 Survey did not ask about consultation with psychologists, who were classed as 'others'. Psychologists are rarely full-time members of Aged Care Assessment Teams, rarely work in rehabilitation programs for older people, and are employed in a minority of psychogeriatric and geriatric care programs.

There is no established reason for believing that psychological interventions that are effective for young and middle-aged adults would not be effective for older adults. Indeed, the evidence is overwhelming that such methods are effective (Arean et al., 1993; Gallagher-Thompson & Thompson, 1995; Glanz, 1989; Widner & Zeichner, 1993; Wilkinson, 1997). Not only are older people appropriate clients for many common psychological interventions, but even people with moderate dementia can benefit when suitable methods are used (Bird, 1998). One example is the management of disruptive behaviour in older people with dementia, something for which psychology is uniquely qualified, yet an area in which very few psychologists work (Bird, 1999b).

One of the most common functions of those psychologists who do work with older people has been the assessment of cognitive functions. This type of assessment has commonly been the domain of clinical neuropsychologists or others with an interest in degenerative neurological diseases. This specialisation may be one reason for the perpetuation of the incorrect stereotype of older people in general being inappropriate clients for psychological interventions because of an inability to learn and change behaviour patterns, or conversely, that psychologists only work with severely impaired persons. Yet there is a broader unmet need for counselling for depression, loss and grief, and the management of life transitions, especially those involving loss of independence.

Psychologists themselves need to become more interested and active in promoting their services with older people (Ferguson and Koder, 1998). Despite the fact that consultation of psychologists by older people is relatively uncommon (Jorm, 1994), there are other opportunities for psychologists in addition to those mentioned above (Ferguson & Koder, 1998). Physical illnesses, including chronic conditions, are more common among older people than among younger people.

Effective preventive efforts aimed at known risk factors for illness in later life, such as smoking and obesity, largely involve psychological and behavioural change. Similarly, rehabilitation programs that aim to restore or improve levels of functioning following injury to older people can benefit from the incorporation of a psychologist into multidisciplinary treatment teams.

Service delivery models and funding of services

Models of service delivery influence utilisation. Some services are organised along generic lines, where all professionals service all problems. Under specialist models, some psychologists argue that more effective use may be made of their skills, for example in aged care assessment and psychogeriatric teams. Another barrier to access is the fact that in some states mental health teams will not accept new referrals for those over age 65. These referrals are made to aged care or psychogeriatric teams, which are fewer in number, and may not have a psychologist as part of the team. However all community health centres focus to some degree on ageing – thus there is potential for psychologists with expertise to be employed in such frontline locations, as well as in specialist clinics.

While psychological services are usually provided free of charge in the public sector, privately they cost between $75-$160 per hour. The Federal Government itself restricts the provision of psychological services by excluding any Medicare rebate, with only a few private health funds currently offering rebates for psychological services, and less than 30% of the population privately insured at all. There is a community-wide lack of recognition of the role and effectiveness of psychological services. Many older persons and their families may not have considered the sorts of issues psychologists can assist with, such as depression, anxiety, loss and grief. Flowing from this is the lack of appropriate referrals from medical practitioners, lack of appropriate and timely information about the value of services, lack of knowledge about availability of and access to the services, and lack of integrated support services. Older persons may lack transport, and often require home visits.

Psychologists may need to develop greater flexibility in their assumptions about optimal service delivery modes. Many health professionals have a narrow view of what psychologists can do, and often conceptualise psychological services as pertaining to mental health assessment and interventions. And an over-emphasis on assessment can sometimes hinder access to assistance and services. However psychologists also have a role to play in addressing behavioural risk factors for physical illnesses, in designing health promotion programs for older people, and in developing and evaluating local HACC services. From the examples outlined above, it would appear that the reasons for there being few psychologists working with older adults cannot lie in the absence of effective roles for them. The profession must examine its own approach to older people, in terms of research, training, and service delivery models, for further clues to psychology's low profile in aged care service delivery.

Conclusions and Recommendations

This APS Position Paper has highlighted the significant contributions that Australian psychologists make to the field of ageing both locally and internationally. However we believe there is an unmet need in the Australian community in terms of the skills and services that can be provided to our older citizens by psychologists. We have listed a number of recommendations below that we believe if implemented would contribute positively to the quality of life of current and future members of our older community. The recommendations assume that we recognise and value the diversity of our older citizens, and that as a profession our central goal is to combat ageism and empower older people to live satisfying lives whatever their circumstances. Recommendations are organised under six headings, each of which may encompass recommendations directed to the general public, to governments and policy-makers, and to the psychology profession itself. The latter cover two broad areas of our role as psychologists: the 48 provision of psychological services to older people; and research in the field of ageing. Both areas encompass the training and professional development of psychologists.

Ageism

Ageism can result in a tendency to assume incorrectly that some conditions are inevitable with ageing, and therefore, do not need to be treated. This can result in lowered quality of life and well being for older people who have to live with a condition which could have been alleviated. It has been argued that older people, themselves, are perhaps the most ardent proponents of ageism. This can limit horizons and result in a failure to seek treatment for conditions that are incorrectly assumed to be inevitable. Psychologists can act as important role models to their clients and to the wider community. The way in which they behave towards their clients, and their willingness to listen to a client's opinion and provide clear information, convey influential messages which can act as self fulfilling prophesies or, conversely, can support older people in redefining themselves and in retaining a sense of self worth and realistic independence.

Recommendations

- *That health providers, including psychologists, take steps to address the issues of ageism in service delivery for older people*
- *That the APS work with government and non government agencies to promote the positive aspects of working with older people and to reduce the negative myths and stereotypes which make psychologists reluctant to enter this area of practice.*
- *That psychologists undertake research into the implications of ageism for service provision to older persons.*
- *That researchers in ageing and aged care examine their research questions and methods for ageist assumptions and stereotypes.*

Diversity

There is a wider range of individual differences amongst older people than between older and younger people. This diversity must not be overlooked if services are to meet the needs of older people and enable them to age successfully. An important aspect of the education of psychologists is to convey changes and psychological conditions that are a frequent accompaniment of old age. However, it is important that this focus on typical events in old age does not lead to neglect of individuality - each person brings to any situation a unique set of life experiences. A great deal of within-group diversity is based on experience, representing the different trajectories in people's lives following particular transition points such as retirement. Both structural and experiential diversity amongst older people need to be considered in research, social planning and service provision, and interventions need to be individually tailored to maximise positive outcomes from transitional experiences – discharge planning is a case in point.

Recommendations

- *That psychology training programs recognise that diversity is particularly pronounced in Australia's multicultural society, and that diversity is the outcome of many other factors as well as age, including gender, cultural heritage, experience of disability, sexual preference, and so on.*
- *This view should emphasise individuality, noting that it is inappropriate to make assumptions about a person just because he or she falls within an older age group, or belongs to any specific sociodemographic category.*
- *That the APS Interest Group on Psychology and Ageing liaise with other relevant interest groups to foster development of a science of gender, ethnicity and ageing that is responsive to the unique psychological needs of older women and men, older persons from diverse linguistic and cultural backgrounds, Aboriginal elders, older gay and lesbian community members, and people living with disabilities*
- *That developmental models used by psychologists take account of the diversity of human experience through the lifespan, particularly in terms of the health and cognitive functioning of older persons.*
- *That interventions promoting healthy ageing focus on influencing the individual trajectories which follow key transitions in the lives of older persons.*
- *That researchers identify and be funded to address gaps in current knowledge bases, in order to move beyond "one size fits all" models of ageing.*
- *That "cultural planning" be integral to the provision of both mainstream and targeted aged care services, and subjected to monitoring and evaluation processes which are primarily accountable to the groups and individuals most affected.*

Empowerment

"Nothing about us without us" is a catchcry being adopted by increasing numbers of consumer groups in the mental health and disability fields. IYOP initiatives such as the Conference for Older Australians have demonstrated that older people want to be involved in planning and decision-making about matters affecting their own lives and futures. Older people can be expected to demand a greater role in setting their own research agenda and service priorities, to participate widely in community life, and to seek expanded access to learning opportunities promised by new technologies.

Listening to consumers

Psychologists, like many other health professionals have been trained in an approach to service provision that portrays them as the expert. The tendency not to listen to what the consumer or client has to say or to incorporate client viewpoints in decision making can impact on the effectiveness of treatment and on client satisfaction with services.

Recommendations

- *That the APS convey to fellow psychologists the advantages of working with consumers in an equal partnership which acknowledges the complementary value of expert knowledge that has been built up over a life time.*
- *That APS develop policies for continuing participation by older psychologists in the Society, and consult with them about how best to support their well-being and promote the utilisation of their skills. Professional development opportunities designed by and for senior, semi-retired psychologists could be a timely example.*
- *That policies promoting independence and "self-provision" by older persons recognise that economic, geographic and cultural disadvantages may severely limit the choices available to many Australians, and that the provision of resources to support equal access to such choices remains a community-wide responsibility.*

Ageing well

Until recently, much psychological theory was predicated on a model of ageing that focused on deficits and the treatment of problems. Certainly this area of work is important for the training of clinicians, but if psychology as a profession is to make a significant contribution to the well being of the current and next generations of older people, it must broaden its horizons. Psychologists need to involve themselves in "healthy ageing" alternatives to the notion that health professionals only step in when things go wrong. As many of the health problems in old age can be managed through combinations of medical and psychological interventions, psychologists should take a more active role in promoting health and well being in older adults.

Persistent stereotypes of decline in old age promote fears such as "your brain goes", or "I'll end up incontinent". Other common fears restricting the capacity of many older people to make the most of their lives include that of being a "burden" to family and/or caregivers, fears about personal safety in public places, and concerns about reduced physical independence. Psychologists have a responsibility to educate themselves and the general public about the myths and facts of ageing and the lives of older Australians. Psychologists can assist by subjecting misinformation to reality checks (e.g., older persons are statistically less likely to be the victims of assault in a public place than are young men), while taking fears seriously (e.g., older women may be more at risk of abuse in the home, from someone they know, than from strangers).

Older people should not be constrained in participating as fully as possible in public and community life. Research is needed into the mechanisms whereby older people become fearful about matters such as personal safety, and the findings need to be disseminated in publicly accessible formats.

The demonstrated willingness and capacity of many older people to pursue opportunities for new learning, political activism and personal growth, and the value of such activities in economic as well as psychosocial health terms, need to be supported by appropriate funding, for example of non-vocational adult education.

Recommendations
- *That government programs support community development models to prevent isolation and promote recognition and integration of older persons within the wider community.*
- *That psychology move beyond a focus on deficits and problems to acknowledge that the majority of older people lead a healthy and happy old age for most of the time. Models should incorporate current thinking to encourage a view that psychologists contribute positively to successful ageing by supporting people in making the most of their strengths and the opportunities presented by old age.*
- *That community education and lifelong learning initiatives such as U3A or Councils of Adult Education be supported on the basis that healthy, active minds are a measurable community asset in themselves.*

The provision and utilisation of psychological services

The use of psychological services by the current cohort of older people is minimal. While the need for psychological services is clear, especially with increasing numbers of people aged over 65, access and utilisation are restricted by a number of factors.

Education and training

The training of psychologists in the field of ageing has been piecemeal to date. Attention to undergraduate, specialist and continuing education must be a priority if psychology is to respond to the 21st Century challenges of an ageing Australia.

Recommendations

- *That the APS consider the establishment of a standing committee for ageing, along the lines of the APA initiative, whose agenda includes issues in science, practice, policy and legislation, education, public interest, and the APA itself. · That APS training standards emphasise that an important aspect of the education of psychologists is to convey an understanding of the particular issues of old age as well as the diversity of the ageing experience.*
- *That an audit of current undergraduate and postgraduate programs in psychology be conducted to ascertain the type and amount of content related to ageing and older people.*
- *That all APS Colleges examine their training standards for inclusion of appropriate content related to older people.*
- *That the feasibility of developing specialist programs or modules for psychologists in the field of ageing be investigated.*
- *That young psychologists as part of their training be exposed to enthusiastic professionals already working in the field of ageing.*
- *That psychologists educate themselves about older people even if they are not working directly in the field.*
- *That the Psychology of Ageing Interest Group work with all APS colleges to ensure provision of more opportunities to obtain PD points in the field of ageing.*

Service delivery models

There is a paucity of psychologists and other health professionals working with older people in Australia. A number of systemic factors, including funding arrangements, have contributed to this situation. In contrast, aged care funding packages in the USA now require that a proportion of the money be spent on psychological consultations annually. As an early intervention measure, there are also calls for older adults to consider "mood and memory checkups" as part of regular physical health reviews.

Recommendations

- *That the APS develop a policy concerning the role of psychologists in aged care, so that legislators can consider the viability of our involvement in the future, with a view to advancing the well-being of older persons by strengthening psychological practice.*
- *That the APS adapt its marketing campaign to educate General Practitioners and Aged Care Assessment Services about the contributions that psychologists in private practice and public health services can make to the physical and mental health of older people. This might include development of targeted tip sheets.*
- *That the Commonwealth Government fund more affordable psychological services that are rebateable through Medicare and private health funds, and/or incorporated into health and community care programs.*
- *That the APS liaise with the Commonwealth Department of Aged Care, and with the aged care industry, to examine ways in which psychologists can be better engaged in aged care facilities and in community-based service delivery. Links already established with the Department of Veterans Affairs provide an excellent precedent.*
- *That psychologists with relevant expertise be identified for aged-care policy-briefings and submissions.*

Cohort factors

Use of psychological services may be affected by the readiness of older people to seek treatment. The current cohort of older people has a reputation for being more focused on physical than psychological concerns than younger age groups. There is a stigma around mental health for this age group: some fear they will be labelled "crazy" for consulting a psychologist, yet many use their GP as an informal counsellor. There can also be a sense of stoicism as they attempt to maintain control and independence, having lived through many hard times. Older GPs themselves are a part of this cohort which may be less familiar and comfortable with psychological services.

Recommendations

• *That the APS take steps to educate older people and the general public about ageing, with a particular focus on psychological aspects of successful ageing. This education should include information about the role of psychologists in promoting healthy ageing and in assisting older people in addressing concerns related to their psychological and physical health.*

• *That psychologists with relevant expertise be identified and promoted as media spokespersons on issues of ageing and quality of life for older persons.*

Ageist stereotypes

Ferguson & Koder (1998) cite ageist factors as partly responsible for the low referral rate from other health professionals. These factors include low expectations for change and attributing problems to "normal ageing". Psychologists themselves are not exempt from the ageism which characterises the wider population. Psychologists and other health professionals tend to regard working in aged care and with older people as their least preferred option. Steps must be taken to remove the barriers and reluctance in regard to working with older people if psychology as a profession is to meet the needs of the ageing Australian population.

Recommendations

• *That the APS educate fellow psychologists about typical changes which occur with ageing and about how to differentiate these from other conditions which require treatment.*

• *That the APS and the Psychology and Ageing Interest Group educate fellow psychologists and referring agents about ageing and older people using the themes of diversity and empowerment to convey a holistic view that conveys the strengths as well the concerns of older people.*

• *That the APS consider developing a brochure along the lines of the American Psychological Association's older adult brochure "What psychologists should know about working with older adults".*

Research in the field of ageing

This Paper has demonstrated the robustness of Australian research in the field of ageing. Multi-disciplinary initiatives such as the Centre for Positive Ageing in WA illustrate the value of broad-based, locally grounded research, the applications of which can be readily translated into options for improved policy and practice. An example of a collaborative effort to present research in a digestible, user-friendly form for public consumption is the book on memory and ageing by Sargeant and Unkenstein (1998). However we are aware that this Paper also reflects some important gaps in our psychological knowledge base to date, and these gaps reflect imbalances in the constitution of the profession itself. For example, it proved difficult to identify psychological contributions to understandings of ageing amongst Aboriginal and Torres Strait Islanders. We have not included a section on sexuality in later years, although research on the subject disputes prevailing stereotypes of disengagement and inactivity. And while psychologists have contributed much to understandings of the health of older Australians, less has been said about the structural barriers to the kinds of lifestyles known to be most conducive to successful ageing - such barriers may be socioeconomic or class related, or they may be related to the interactive operation of ageism, sexism and ethnocentrism in our institutions and within the community.

Recommendations

• *That research funding bodies support research on ageing directed at the prevention of decline and the promotion of positive ageing.*

• *That the APS Directorate of Scientific Affairs work with the Interest Group on Psychology and Ageing to establish systematic liaison relationships with research funding bodies in the field of ageing.*

• *That psychologists' participation in research planning, review committees and community consultation be encouraged and supported at institutional levels and within APS.*

- *That psychological research prioritise attention to current knowledge gaps, including issues in Indigenous ageing processes, socioeconomic barriers to successful ageing, and service delivery implications of empowerment models.*
- *That older people be supported in setting their own research agendas.*
- *That APS involve older psychologists in the development of the discipline's research priorities in the field of ageing.*
- *That researchers in fields such as cognitive ageing be supported and resourced to translate complex and technical research findings into formats that are accessible to a range of audiences, in ways that draw out implications for everyday living and public policy, for example in dispelling fears about memory decline while encouraging appropriate memory "check-ups".*

Conclusion

The International Year of Older Persons has come and gone, but the true test of its effectiveness will lie in evidence of longer-term changes in attitudes, policies and practices affecting the lives of older Australians. As a national partner to Coalition 99, the umbrella body that co-ordinated IYOP initiatives throughout Australia during 1999, the Australian Psychological Society is proud to have participated in a number of ways. But we recognise that keeping a spotlight on the well-being of older persons may be a greater challenge than highlighting it for just one year. Whichever way we describe the process of ageing well (and the language we choose does matter), principles which promote healthy, successful, positive ageing in a culturally diverse society must stay in the foreground of community consciousness. Within the psychology profession itself, such principles should inform all levels of research, education and practice.

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