

The voice of psychology?

In the August issue, Helen Hughes and Rose Challenger make some powerful arguments for the British Psychological Society to step up to the 'media plate' in 'Psychology and the media – dawn of a new era?'; and the 'exciting times' response from Fiona Jones highlights the potential for the society 'to be the voice of psychology in the UK'.

While these may indeed be exciting times, for many like me who work with one of the most vulnerable groups in our society – children and young people in public care – it would seem that the Society has yet to step up to the 'psychology plate'. Currently, there is considerable media interest in the plight of these children and young people, and although the specific knowledge base to address many of the life-pervading and emotionally-limiting issues faced by these traumatised children lies within psychology, where is the voice of the Society?

In recent years, there has been a dramatic increase in the number of placement breakdowns for children in care, and it is not uncommon for some children to have experienced over 20 placement breakdowns. The psychological damage caused by such

instability will impact on these children for life, yet where is the strong statement of concern from our President, where is the Society's working party set up to consider how the science of psychology could be used to improve life opportunities for children in public care?

While it may be right for the Society to make a statement relating to the reality-TV suicide attempt, the sheer number of children traumatised by rejection, neglect and abuse, warrants the urgent attention of our respected organisation to champion their cause. The

TIM SANDERS

Warfare and aggression

I have for some time been aware that the consequences of warfare between nation states have not been prominent in media reports or in statements made by politicians.

No one of course would deflect from acknowledging the bravery and gallantry of those who have been involved in the many wars and conflicts over a long historical period. One has seen the tribute paid to the survivors of these

disasters and often the appearance in parades of the maimed men and women involved, but very little said about the actual suffering, disablement and loss incurred. It is as if the *inevitability* of warfare, massive armament and maintenance of personnel has been taken for granted as necessary protection of nation states from each other.

One wonders too whether the politicians taking decisions about declaring war or conflict

fully appreciate their responsibility for the terrible injuries that will result.

I am fully aware that necessary conditions have arisen, but also that clearly much needs to be done to prevent situations arising (e.g. the Falklands War) and the critical need for other solutions (i.e. negotiation – from *both* sides).

I am now nearly 83 years of age; I served for a short time in the Canadian Signal

Corps and have seen at first hand the effects of the Italian campaign on soldiers returning to a repatriation camp.

My suggestion is that we, as psychologists, should pay more attention to the phenomenon of aggression as it manifests itself in society and between nations.

Paul R. Stevens

New Milton, Hampshire

contribute

These pages are central to The Psychologist's role as a forum for discussion and debate, and we welcome your contributions.

Send e-mails marked 'Letter for publication' to psychologist@bps.org.uk; or write to the Leicester office.

Letters over 500 words are less likely to be published. The editor reserves the right to edit or publish extracts from letters. Letters to the editor are not normally acknowledged, and space does

not permit the publication of every letter received. However, see www.thepsychologist.org.uk to contribute to our discussion forum (members only).

Diagnosing Alzheimer's

many individual members of the Society who are quietly getting on with their work with individual children and their carers, need the support of the Society to influence politicians, policy makers and most local authority officers, as it would seem they have limited insight into the emotional and psychological needs of traumatised children.

Psychological theory, research and an evidence-based approach, offer the most promising source of 'insight' for working with looked after children. However, the Society as an organisation still has much to learn when it comes to 'influence'. To be the voice of psychology in the UK, we could start nearer home and spread the word within the childcare professions. Stepping up to the 'influence plate' to ensure an informed national approach to children in public care should be a top priority of the British Psychological Society.

Colin Maginn

*Director of The Pillars of Parenting
(a social enterprise supporting the carers of
looked-after children)*

After reading the letter 'Testing delays in Alzheimer's treatment' (July 2009), I entirely sympathised with this wife who just wants her husband to have the best treatment available to potentially help delay the disease progression. There is no cure for Alzheimer's or any of the other dementias, and our job as psychologists is to assist patients, their families and friends adjust to life with the disease.

When it comes to neuropsychological testing, the reality is that geographical areas vary greatly on which tests they perform and over what time period. NICE guidelines (2007) state: '...the three acetylcholinesterase inhibitors donepezil, galantamine and rivastigmine are recommended as options in the management of patients with Alzheimer's disease of moderate severity only (that is, subject to section 1.2 below, those with a Mini Mental State Examination [MMSE] score of between 10 and 20 points), and under the following conditions.' The guidelines then go on to note the conditions.

If only this test is used (and we can all cite literature which demonstrates flaws in the test), it is not possible to categorise the type of dementia the patient may have. This is important as for some

dementias, such as Lewy body dementia, certain medications can actually make the condition worse. It is because of this need to categorise the dementia that more detailed neuropsychological tests are carried out. Some areas will perform a 'one off' battery of tests, whereas others prefer to repeat test batteries over a period of time to look for changes. The tests in these batteries will vary but will invariably tap into a range of cognitive tasks.

What was not clear from the lady's letter was whether her husband had been given a blood test to rule out physical causes for his memory problems. In some areas a CT scan is also performed so that medics have a wealth of information (blood, CT and neuropsychological test data) to support them in making an accurate diagnosis.

The country is becoming more aware of dementia, and as healthcare professionals we need to ensure that we inform those who come to us for help of the processes, and why these processes are in place. When we are anxious about our health, then a week waiting for results may seem a lifetime, let alone the months it may realistically take.

Jude Hancock

Chippenham, Wiltshire

Steve Boddington (Forum, August 2009) provides a very clear and informative summary of how a diagnosis of dementia is arrived at; however, I am uncomfortable with one aspect of his explanation namely the statement that the definitive diagnosis of Alzheimer's can only be achieved at autopsy (histological assessment).

Some years back a team led by the psychologist David Snowden studied a group of 678 nuns (The School Sisters of Notre Dame), who were remarkable for one thing in particular – the uniformity of virtually their entire adult lives. All agreed to be formally cognitively assessed and donated their brains at death for autopsy. Whilst for many there was a correspondence between their clinical presentation and histological findings, it was certainly not a simple one-to-one correspondence. 'Plaques' and 'tangles' abounded for some (Braak staging V+) with what appeared to be only modest cognitive problems; for others pathology remained very low yet presented with a very typical Alzheimer's-type clinical picture.

Could it be that the 'only 80 per cent' diagnostic hit rate that Boddington describes for his team reflects not the lack of skill of his team but rather a problem with the way an accurate diagnosis is being conceptualised?

Thomas Kuhn tells us that scientific paradigms are essentially conservative structures that resist change through ignoring inconsistent findings. The nun studies clearly challenge the purely medical model implied in Boddington's reductionist statement. Nor should we read support for this reductionist interpretation in the fact that there is a drug to 'treat' Alzheimer's. It has been my experience that for the very few who appear to show any discernable signs of actually benefiting from this drug, that this is down to the mildly mood elevating properties of Aricept countering the depression (which in its own right lowers cognitive functioning) so often seen in patients on initial diagnosis.

Stephane Duckett

*Royal Free Hospital
London*

POETRY CORNER

Alien

Its reflecting masses shine blind
Pausing me to stop, think,
Shaken by a frame of time, a frame
of thought,
A frame of nothing.
Curtains always shut,
Like my heart.
What lies beyond, a broken home?
A haven of lies drawn by an artist?
Or a lost soul, surrounded in secrets.
What lies behind
My web of lies
A child crying, crying out for comfort
Tell me you love me, care.
Glasses off, awake to the world,
People don't listen.
I'm insane.
Curtains drawn, lights are on,
Someone tell me where I'm from.

NOTICEBOARD

I am a second-year trainee studying towards the Professional Doctorate in Counselling Psychology at London Metropolitan University. I have a particular interest in **psychotherapy and dementia**. If you are working within a service that offers psychotherapy for individuals with dementia, are currently conducting research into this area or have a general interest in this area I would be eager to hear from you.

Philippa Blythe

pmb0035@londonmet.ac.uk, 07504 926184

In common with many members of the BPS reaching retirement, I have a collection of, say, 20 thousand plus conventionally printed professional books. Broadly, mine are in the fields of: Child Development; Psychology; Education; Literacy; Measurement and Research Methods.

Other than using them as fuel, what **alternative ways of constructively disposing of my professional library** to potentially interested organisations or individuals can colleagues suggest? Amnesty International and Oxfam have already taken many – and could take more. Ideally, I would be delighted to gift *all* my professional books to any organisation or individual in this country or elsewhere where the books could be shelved and available for use by students and staff.

Peter D. Pumfrey, FBPsS

peter.pumfrey@man.ac.uk

Do you work in an interprofessional team? We are developing a **two-part questionnaire to assess conflict and resolution strategies in interprofessional teams** and need people to complete the current version. Each part takes around 10 minutes to complete. Please e-mail me for more details. Thank you!

Jo Rose

j.r.rose@exeter.ac.uk

Are you a therapist working with clients with substance misuse problems? I am carrying out **research into processes of change in therapy for clients with substance misuse problems**. I am conducting this research for an MSc in counselling psychology at Roehampton University. If you have been a therapist in the substance misuse field for more than one year and would be willing to take part in an hour-long interview into your experience of delivering therapy, then I would be very pleased to hear from you.

David Smith

drsbbox@googlemail.com

Minding our clinical language

I see that in the August issue you ask members to contact you with views on David Pilgrim's letter objecting to the use within *The Psychologist* of medical language such as 'people with schizophrenia'. I am writing in support of David's point. A major contribution of psychologists within psychiatric settings (and arguably more broadly in society) is to point out that phenomena traditionally seen as biological defects (and as rendering those affected somehow less than human) can be understood in the same way as other 'normal' psychological processes. Language is an important part of this and it is disappointing to see *The Psychologist* itself using non-psychological language.

Guidelines for contributors to *Clinical Psychology Forum* require language to be 'psychologically descriptive rather than medical'. I would suggest that a similar guideline would be appropriate for *The Psychologist*. I would also refer you to the 'note on terminology' in the Division of Clinical Psychology's report *Recent Advances in Understanding Mental Illness*

I wholeheartedly agree with David Pilgrim. Interestingly, I decided to bow out of becoming a coordinator of the proposed new personality disorder network within the PCMH faculty, precisely on these grounds, that I just couldn't reconcile being involved with something defined by that term. And yet, there are still many psychologists who are happy to use diagnostic terms, often on the basis of pragmatic reasons, whereby, for example, funding is acquired to improve services, with proposals being directly linked with diagnostic terms and NICE guidelines. And of course, if diagnostic terms are problematic, then how much more so are NICE guidelines that are organised around diagnostic terms? I could go on...

Penny Priest

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Clinical psychologists need and deserve the Society's support in declining to use the term 'schizophrenia' in their practice within the NHS. This does not need to amount to an anti-psychiatry position, or to deny the benefit of medical intervention. Psychologists will typically favour a more phenomenological understanding of distress, and have found terms such as 'psychosis' more fitting as a descriptor of someone with unusual beliefs and experiences, or someone whose experience is not consistent with consensual reality. Psychiatrists are generally aware of our ambivalent-to-negative perception of the diagnostic term (this one in particular) and, in my experience, many share similar concerns

and *Psychotic Experiences*, downloadable from the Society's website (www.bps.org.uk/3ndn).

The note warns that because different terms used by different people reflect a more general debate about the nature and causes of people's experiences, and because some common words may carry pejorative connotations, we should take care to ensure that the terms we use do not imply anything we don't intend. In general, the DCP's advice is to avoid words that imply a particular framework for thinking about psychotic experiences (e.g. medical terms such as 'patient'). If such words must be used because they refer to others' work in which this was the terminology adopted, the DCP suggests adding quotation marks to acknowledge that there is debate about underlying assumptions.

Thank you for putting this on the agenda for the next Psychologist Policy Committee meeting. I look forward to hearing the outcome.

Anne Cooke

Salomons Canterbury Christ Church University

– 'negative symptoms' can be seen as a post-psychosis retreat from the interpersonal world, or as a form of depression; the prognosis associated with schizophrenia is hugely pessimistic as demonstrated by long-term outcome studies; the term itself has major public relations problems (though we must admit that 'psycho', even if meant to be shorthand for psychopath, doesn't do those presenting with psychosis many favours).

Psychologists have faced problems along the way by (typically) taking this position. Clinical psychologists working to develop NICE guidance in relation to CBT for psychosis were barred from challenging the title of this guidance; thus we have NICE guidance on the treatment

of schizophrenia. In order to serve people within mental health services where psychiatrists, and nurses, hold dominant positions, we can find ourselves in compromised positions. We are challenged, I believe correctly, to come up with a better classification system in order to facilitate service users coming together around shared experiences (the Hearing Voices Network is a great counter to this challenge), to differentiate between service users for the purpose of benefits assessments and research. We can use

psychosis and additional descriptors (paranoia, grandiosity) to the extent that we are comfortable, as well as terms relating to frequency, intensity and duration (persistent vs. intermittent) to resolve this. Most importantly, we can formulate, offering service users and colleagues psychological and psychosocial explanations as to why experience veers toward distress and/or unusual experience. And we are not alone – the National Schizophrenia Foundation is now, very tellingly, called Rethink...

I do hope this straw poll might trigger a debate within the BPS as to whether we do, indeed, need a classification system for at least heuristic purposes; and, if so, what would serve as a more phenomenologically relevant and more compassionate, inclusive and recovery-focused terminology. We might even find that some, or many, psychiatrists join us in this endeavour.

John Hanna

DCP Policy Director and Chair, Psychosis and Complex Mental Health Faculty

Regarding the 'Offensive language?' comment in the August issue, it is necessary to take into account the purpose of ellipsis. Given the strict word limits imposed upon writers in professional journals and the like, it may be necessary to make use of ellipsis in order to save words. In the specific case of 'with schizophrenia' and 'with a diagnosis of schizophrenia', it is reasonable to consider the abbreviated form to be practical when one is restricted by word limits.

A reason for this is that without having to explicitly state 'I will strictly adhere to political correctness and will not reproduce medical discourse' at the start of your written work, it is somewhat established that authors in the scientific community, specifically psychology, will not write intentionally to offend or dismay a specific reader or even violate political correctness. If a specific

distinction between two phrases is warranted, then authors may explicitly outline the difference as necessary.

Moreover, given that the study of or writing about schizophrenia per se is not limited to psychology but extends to the medical arena, it will often be the case that one's reading of such literature should be adaptable and flexible. This flexibility is further necessary particularly if the supposedly offended or dismayed reader is not the most relevant audience for that piece of writing.

Lastly, if one reads between the lines rather than ticking boxes for the writing style and correctness of a particular author for a literacy test for example, this will certainly broaden one's appreciation and understanding of quality academic writing and embrace its rectitude.

Bhupinder Kuwar
Birmingham

For the common weal

This year marks the 60th anniversary of the Commonwealth. Although various organisations are associated with it in order to improve the lives of its citizens, I struggle to find any psychological body that works with the Commonwealth to promote better psychological well-being. Does anyone know of one? If not, would the BPS work with the psychological societies of other Commonwealth nations?

While efforts are made to improve the physical well-being of African people, surely there must be a need for psychological issues to be addressed, especially in Commonwealth nations that have recently experienced turmoil? If there is not a psychological organisation working within the Commonwealth, I hope that soon there may be.

John Wayland
Harwich

FORUM THE REAL WORLD

The summer is over. The nights are drawing in. Your last holiday is a fading memory, the next a distant dream. So here is a tip to make it more rewarding when it finally arrives. If you are going away and want to understand the culture that surrounds you, join a crowd.

Of course, traditional psychology would tell you that people lose their identity and forget their usual ways when they become part of crowds. Crowd members are mindless, primitive and violent. The clear message is therefore to keep away from crowds – they are mad, bad and dangerous to know. But this is bunkum. It is intellectually bankrupt. And worse still, it threatens to deprive you of an enjoyable and enlightening time. For in crowds, people act as social subjects and act on the basis of shared cultural understandings.

For instance, each time we go to the United States, we are struck anew by just how different – how exotic – it is to us. To understand this difference just go, say, to a baseball game. The facilities are good, the food may not exactly be healthy but it is tasty. People are relaxed and playful. In lulls of the game, they perform in order to be picked out and shown on the vast screens in the stadium. The screens also encourage people to respond to the game – when to cheer or applaud. And people respond. They are consumers. They want to be entertained. They expect a good product.

Can you imagine that at a football game in the UK? If a screen tried to tell people how to behave they would jeer more than cheer. For they, the fans, really 'own' the club. They decide what is appropriate, not some disembodied voice. For these fans, attendance is about loyalty – and that loyalty is best proven by attending despite appalling facilities, pies made of condemned meat, and dull pointless games. Listen to fans talk and the games they will talk about are the trips to pre-qualifying games in distant parts of Europe where they got lost, got sick and, after being held up by officials at ground, caught only the last 10 minutes of a 0-0 draw. That, not the glory games, establishes their authenticity.

And so, in the apparent ephemera of people whacking balls and the reaction of crowds, you discover something important about how, despite our common language, we really are members of distinct cultures who see and value and respond to things differently. In short, if you want to get a grip on the local culture, miss out on the museums, gravitate away from the galleries and try the terraces instead.

Steve Reicher is at the University of St Andrews. **Alex Haslam** is at the University of Exeter. Share your views on this and other 'real world' psychological issues – e-mail psychologist@bps.org.uk.

obituary

Glynwen Lloyd Jones (1971–2009)

Our friend Glynwen Lloyd Jones sadly died in February 2009 and is much missed by her family, friends and the clinical psychology community in South Wales. She qualified as a clinical psychologist in 2007 and had followed her lifelong passion for working with children and families.

Glynwen originally took a degree in sociology and social policy at the University of Bangor in North Wales. Following this she worked as a media education officer, travelling Wales in a transit van, and then in a marketing role for S4C. She described how her switch to psychology was a result of inspirational conversations with a psychologist while they were both stranded in a hut during a rainstorm in Australia. She subsequently threw herself into the hard work required to gain a postgraduate diploma in psychology at Cardiff University. Two assistant psychologist posts in North Wales followed before she secured a place on the South Wales clinical psychology

training course.

As a trainee psychologist, Glynwen was dedicated, hardworking, humorous and hugely popular with her colleagues. Her sense of effortless style made her the envy of her fellow trainees. Whenever she had the opportunity, she followed her interest in child and family work and drew on systemic and attachment theory with an ethos of creativity and thoughtfulness.

After qualifying, Glynwen took up a post in child and family psychology services in Gwent. She consolidated many skills in this post and faced the challenges of community work, including fending off dog attacks with her handbag! Her thoughtful and warm approach benefited all who knew and worked with her. We

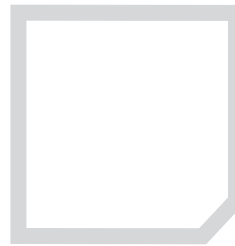
are sure that she would have continued to make an enormous contribution to the profession and the children and families she worked with.

All who knew Glynwen realised the importance of her family to her, and she regularly travelled to North Wales to spend time with family and work on renovating her farmhouse on the Llyn peninsula. Although she lived in Cardiff in recent years, her heart belonged to North Wales. She was thrilled at the prospect of motherhood and gave birth to a beautiful baby girl in December 2008. We are sure she would consider Fflur her greatest achievement.

Our thoughts are with her partner Wil, daughter Fflur and her family. She is greatly missed.

Elanor Maybury

on behalf of the South Wales DClinPsy 2004 cohort (Bethan, Elanor, Emily, Helen, James, Jess, Libby, Lynn, Reem and Sarah)

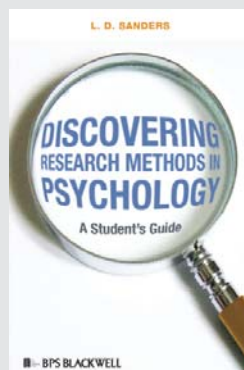


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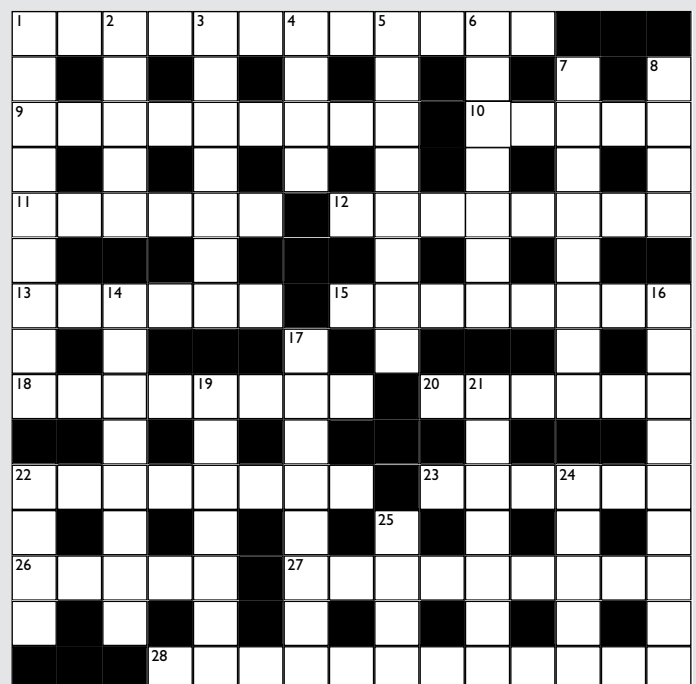
no 47

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Send your entry (photocopies accepted) marked 'prize crossword', to the Leicester office (see inside front cover) **deadline 12 october 2009. Winner of prize crossword no 46** Jill Domoney, Oxford

no 46 solution Across 1 Shiffrin, 5 Phobia, 10 Asphalt, 11 Lazarus, 12 Catch trial, 13 Fits, 14 Ritual, 17 Traits, 19 Number, 20 Extort, 23 Tidy, 24 Determined, 28 Patents, 29 Settler, 30 Addled, 31 Bel canto. Down 1 Search, 2 Input, 3 Flashbulb, 4 Inter, 6 Haze, 7 Barrister, 8 Assess, 9 Olfactive, 15 Inundated, 16 Largesse, 18 Automatic, 21 Utopia, 22 Adorno, 25 Ensure, 26 Nylon, 27 Anne.

obituary

Irene D. Martin (1926–2009)

Irene died on 18 April after three years living with a terminal diagnosis. She had lost the use of one arm and endured much unpleasant treatment over the years, but no one outside her immediate circle would ever have guessed since she never complained or bemoaned her lot. Irene was tremendously courageous and determined to make the best of every minute. To this end she and I made half a dozen visits to the Continent during those years, finally making a trip to Amsterdam in January this year.

I had met Irene 58 years ago in 1951 when we were both enrolled on the University of London's Postgraduate Diploma in Abnormal Psychology at the

Maudsley Hospital. This year-long course was the only academic qualification at that time in clinical psychology, the profession still being in its infancy. Irene and I became close friends over that year, although we parted company professionally. In 1952 at the end of the course Irene decided to seek academic research, rather than clinical work, and was appointed Research Assistant to Professor H.J. Eysenck, who was in charge of the Maudsley Psychology Department and to Professor Linford Rees at Bethlem Hospital.

In 1955 she gained her PhD on the basis of her work on muscular tension in psychiatric patients. Many PhD students in the Psychology Department will

no doubt remember her warmly for her personal support and for her sharp, incisive intellect in the supervision of their work. In 1966 Irene was promoted to the post of Senior Lecturer/Reader to Professor H.J. Eysenck. The main focus of her research interests was that of evaluative conditioning and cognitive processes, upon which topics she wrote many articles and chapters. In 1987 she co-edited with Hans Eysenck *Theoretical Foundations of Behaviour Therapy*, which found a wide readership.

In 1991 Irene retired, although she continued some collaborative research. In 2001 Irene's husband Alec, an occupational psychologist, died. She has two sons,

Nicolas and Johnathan, and a daughter, Cathy. She also involved herself with the young lives of her six grandchildren and derived a deep pleasure from their company. Speaking as her closest friend, I knew her to be a person of the greatest integrity and loyalty, thoughtful, caring and sympathetic, with a personal warmth that made her for me, and no doubt for many others who knew her, a highly respected person and a greatly valued friend.

Deone Bartlet (née Vernham)
Impington, Cambridge

| across

- 1 Pre-surgery meds given time by politician in Piagetian stage (12)
- 9 In charge after three-wheeler almost delivers antidepressant (9)
- 10 Stage of development one has during exercises (5)
- 11 Catch partner almost coming back (6)
- 12 Restored, I chose no holding together (8)
- 13 Starts ECT (6)
- 15 Doctor reopens archetypes, initially, in Jung's aspects of character (8)
- 18 No transference might be (8)
- 20 Prisoner following stream showing tiredness after flight (3,3)
- 22 Soundness of mind when crossing a river to get clean (8)
- 23 Memory researcher wound dressing in operation (6)
- 26 Third Greek character to identify distance of stimulus from threshold in psychophysics (5)
- 27 Cricket side mean as a rule (2,7)
- 28 The girl's clear about number with inclination to follow the majority (4,8)

| down

- 1 Social psychologist who studied nonverbal communication makes speech to male offspring (9)
- 2 Order given in benediction (5)
- 3 Among wolves, bay wildly for act of retaliation (7)
- 4 May be played in list, we hear (4)
- 5 Idle finished behind second (4,4)
- 6 Keep at an unconscious level concerning the media (7)
- 7 Anal, or, it might turn out to be of sound mind (8)
- 8 Christmas in France upset researcher suicide risk factors (4)
- 14 Some forgo no myths evident in Reich's personality theory (8)
- 16 A German's self-world for this concept of existential therapy (9)
- 17 Topless lover's put on weight? Too much information! (8)
- 19 Make laboratory measurement getting it right in gallery (7)
- 21 Happening to get part of Freud's psychic apparatus, it's clear (7)
- 22 Wise person includes note in stamped addressed envelope (4)
- 24 School exercise (5)
- 25 Chap's additional number for German writer (4)