Time to turn the tables

A COUPLE of recent experiences have made me realise that, in some areas, the teaching of psychology is not being given the prominence it deserves. In particular, I have concerns about psychology teaching in undergraduate medical education and in secondary schools.

The first experience arose from the joint establishment of a new medical school by the Universities of Sussex and Brighton. With Sussex having one of the largest concentrations of academic psychologists on a single campus in the UK, this seemed a good opportunity to promote the teaching of psychology relevant to medicine within a medical school curriculum. The GMC would seem to support this, as their recommendations on undergraduate medical education explicitly mention knowledge of psychology:

> *Graduates must understand the social and cultural environment in which medicine is practised in the UK. They must understand human development and areas of psychology and sociology relevant to medicine, including: reproduction; child, adolescent and adult development; cultural background; gender; disability; growing old; and occupation.*

However, the medical curriculum is often not constructed in a way that provides an explicit slot for psychology or psychological knowledge. Psychology has to muscle in where it can into what are usually explicitly medically defined modules, and module leaders often have a good deal of control over how much psychology (or not) they wish to include.

In this day and age – with psychology having a reasonably high profile amongst lay people – we might expect medical students to crave more psychology. Especially, for example, when it is increasingly apparent that people presenting to A&E and GP surgeries frequently have psychological rather than explicitly medical problems. However, anyone who has taught psychology to medical students will be aware that they often perceive psychology as a burdensome irrelevance.

To get some idea of how the psychology content of medical degrees is perceived within that discipline, I turned to the QAA website and looked at the most recent reports for some well-respected medical schools. In the first report I looked at I found the following:

> *…there was a student perception that, in Phase I, the theoretical content relating to the social and behavioural sciences was too large. Particular concern was expressed about aspects of the Health Psychology Module….a number of students suggested that the emphasis placed upon theoretical aspects of these sciences in Phase I was onerous.*

Ah well – still some way to go. As far as I know, the Society has not been involved in consultation over the psychology content of the medical curriculum. Yet our doctors are a resource for us all, and if we think it would benefit society for them to have a better knowledge of psychology, then we should actively pursue that aim. We do have a committee that can address these issues which seems to have lain dormant for some time (Committee for the Teaching of Psychology to Other Professions). Perhaps it is time to resurrect it.

The second experience came a couple of months ago following the so-called fiasco over A-level grading. I don't know whether you got the same impression as me, but psychology was one of the subjects mentioned quite frequently in relation to students who claimed their overall grades did not seem to match with their coursework grades. This did get me thinking about how psychology is taught at secondary level. I recently visited two local schools as a part of the process of selecting a secondary school for my two daughters. We took some interest in whether they taught psychology: one did not; in the other we were directed to the area where psychology teaching normally took place. If you were interested in science you were directed to the science labs; history or geography, then you went to the history or geography classrooms; for music, to the music room. Eventually we arrived at the psychology… table in the corridor!

Well, I suppose psychology is not a national curriculum subject, but resources in this particular school were very basic for a discipline that would in many cases like to call itself a science – whether it be social or biological. Given the popularity of psychology at undergraduate level, and given the wide range of skills that psychology graduates can offer to a broad spectrum of employers, the progress made in teaching psychology at secondary level over the last 10 years or so must be considered disappointing. OFSTED does not advise on standards of secondary level psychology teaching, but they do provide a document that helps inspectors and staff in schools and colleges to evaluate standards and quality in psychology. This is at *www.ofsted.gov.uk/public/docs01/is16-19/psychology.pdf* for those who are interested.

Graham Davey

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Members may have seen press reports of the recent disciplinary committee hearing concerning the case of Paul Britton. On 29 and 30 October a disciplinary committee met and heard preliminary arguments from Paul Britton's legal team, that due to the length of time since the complaint was first made, he could not have a fair full hearing. The disciplinary committee, an independent and impartial body, agreed that holding a full hearing now would contravene Article 6 of the Convention on Human Rights. I agree that it has been a long time since the complaint was initially made to the Society but I must add that the Society is in no way to blame for all of the delay which occurred. The disciplinary committee did not apportion blame in its judgement for any of the delay, but simply agreed that it would be unfair on Mr Britton to proceed with the allegations at a full hearing, which could still be many months away. Indeed, the process for dealing with complaints against members has been rigorously complied with, and there was no criticism of the Society for doing so. It is simply unfortunate, in this case, that a variety of circumstances resulted in this matter taking many years to come to this stage. As a regulatory body we can continue to pride ourselves on the effectiveness of our regulatory procedures, and this case reinforces the argument that we are ready and prepared to become a statutorily regulated profession as soon as possible.

Professor Graham Davey
President and Chair of the Investigatory Committee

Psychologist wins Nobel Prize

DANIEL Kahneman, a psychologist who has pioneered the integration of research about decision making into economics, has been awarded the 2002 Nobel Prize in economic sciences.

Kahneman has been the Eugene Higgins Professor of Psychology and Professor of Public Affairs in the Woodrow Wilson School of Public and International Affairs at Princeton University since 1993.

In its announcement, the Royal Swedish Academy of Sciences cited Kahneman 'for having integrated insights from psychological research into economic science, especially concerning human judgement and decision making under uncertainty'. Kahneman's work, it said, has laid the foundation for a new field of research by discovering how human judgement may take shortcuts that systematically depart from basic principles of probability.

Professor Kahneman – Nobel Prize winner

Upon hearing of the award – which includes a $500,000 prize – Kahneman said, 'I am much honoured of course to receive the Nobel Prize in economic sciences. I am also keenly aware that such an honour seldom reflects the contributions of a single individual. This is particularly true in my case, since the award is given largely for work that I did many years ago with my close friend and colleague, Amos Tversky, who died in 1996. The thought of his missing this day saddens me.'

He continued: 'The award reflects the remarkable success of an approach known as behavioural economics, which is pushing the frontiers of research by introducing psychologically realistic models of economic agents into economic theory.'

Anne-Marie Slaughter, dean of the Woodrow Wilson School, said: 'We could not be more pleased and proud, not only of Danny but of the superb work he has done. He has married psychology and economics in ways that enrich both academic theory and policy practice.'

Kahneman is the fifth psychologist to win a Nobel Prize, following Herb Simon (decision making), David Hubel and Torsten Wiesel (vision centres in the brain) and Roger Sperry ('split-brain' patients).

Never mind the real Nobels, here's the boll***s

PSYCHOLOGY also had a winner in the recent 'Ig Nobel' awards, organised by the *Annals of Improbable Research* to celebrate research that makes you laugh, then think. At a gala ceremony at Harvard University, Professor Chris McManus (UCL and the Centre for Health Informatics and Multi-Professional Education) accepted his prize for his paper in *Nature*, 'Scrotal asymmetry in man and in ancient sculpture'.

Professor McManus said: 'The paper was written half a life-time ago, in 1976. The simple message is that despite being expert observers of human anatomy, the Greeks got one detail of the scrotum wrong – they made the right testicle higher and smaller, whereas it is actually larger. They did this because they had a theory that said the testicles acted as weights, tensioning the body, and therefore they presumed if the left testicle was lower it also had to be the heavier and hence the larger. In other words a triumph of theory over observation.

'Papers that win the Ig Nobel tend to make people laugh, but a little later people ask, "So what was the reason for doing that?", and then soon after they say "But what happens if...?" Like any good science, therefore, the studies provoke ideas, theories and further observations. The humour shows there is something incongruous, and science can ask interesting questions about things that most people had never even contemplated researching, like belly button fluff, the height of the froth on a pint of beer, or the effects of someone else's highlighting in a textbook – all winners this year.'

❑ *See www.improbable.com/ig/2002/scrotal-asymmetry.pdf*

NICE guidance

THE National Institute for Clinical Excellence (NICE) has published its guidance to the NHS regarding the use of computerised cognitive-behavioural therapies (CCBTs) for the treatment of anxiety and depression.

This is the Institute's 51st health technology appraisal, but the first reviewing a psychological therapy. The guidance states that CCBTs 'may be of value in the management of anxiety and depressive disorders', but concludes that there is not yet sufficient pragmatic research evidence to support its general introduction into the NHS.

NICE recommends that the NHS consider supporting independent research into CCBT to establish how this technology might be used in the future. Recommended research programmes include investigations of user preferences, suitability, needs and educational/cultural characteristics in the delivery and outcomes of CCBTs.

NICE plans to review the evidence for the general implementation of CCBT programmes in the NHS in September 2003.

❑ *The full guidance documents for professionals and patients are available at www.nice.org.uk, or by calling 0870 155 5455 and quoting ref N0156.*

REMEMBERING MARTIN GLACHAN

A celebration of the life of Dr Martin Glachan (see obituary letter, October 2002) is to be held at Whitelands College, University of Surrey, Roehampton at 1pm on 4 December.

Former colleagues and students who knew Martin are warmly welcome and should contact Ginny Farmiloe at *v.farmiloe@roehampton.ac.uk* to confirm details.

Allied against the bill

A THOUSAND service users, carers and professionals were in Westminster on 23 October to put pressure on MPs to oppose the draft Mental Health Bill.

The mass lobby of Parliament was organised by the Mental Health Alliance (MHA), a group of over 50 mental health organisations, to convince the government to make key changes to the draft bill as they decided if it was to be included in the Queen's Speech in November.

Speaking at the rally, the Society's representative Peter Kinderman said: 'Under the proposals the "conditions" that will have to be met before somebody is sectioned are extremely over-inclusive. Our Society has noted that the Human Rights Act gives people an inviolable right to freedom from loss of liberty except where a person is 'of unsound mind'. This cannot simply mean having a mental disorder and needing care. Such a criterion would be met by 1 in 4 of the general population: about 165 MPs.

'The BPS therefore calls for the inclusion of a further specific criterion before someone could be sectioned. This would entail that the "the mental disorder is of a nature or severity so as to impair the individual's judgement to the extent that the individual is incapable of making valid decisions about health care".

'If the government accepts the advice of the Mental Health Alliance, a very good piece of legislation could be produced. If they ignore us, if they ignore you, their plans will be positively damaging.'

Then on 30 October Home Secretary David Blunkett made his first public comment on the draft bill, speaking at a conference marking 10 years since Christopher Clunis, who suffered mental illness, killed Jonathan Zito. Blunkett said that although ministers were prepared to listen to other opinions to gain maximum consensus for the bill, the collective view of the government was that 'we cannot give way to the crucial issue on treatability'. Addressing the bill's critics, he said: 'We cannot simply capitulate to people who present to the world as though they speak for the world when they don't.' He added that those against change in the area of mental health should 'come up with solutions if they think ours is the wrong one'.

Students to have say on lecturers' pay?

OCTOBER saw the prospect of performance-related pay for academic staff, using a new form of student appraisal, raise its head again.

The press were reporting that the plan would be part of the delayed White Paper on higher education, due to be published in November. Undergraduates would be required to fill out forms each year, assessing and grading the standard of their lecturers' work.

JOHN HARRIS (REPORTDIGITAL.COM)

Professor Steve Newstead (University of Plymouth) reacted warily to the proposals. He said: 'One of the most frequently cited studies of student ratings is that carried out in the USA nearly 30 years ago into the "Dr Fox effect". Dr Fox was an invited lecturer introduced to a group of master's students as an expert in his area. He then proceeded to give a charismatic, entertaining, but essentially content-free presentation, which the students rated very highly. Dr Fox was in fact an actor who knew virtually nothing about the topic on which he was lecturing.

'This is usually held out to demonstrate that student ratings tell us nothing about the quality of the teaching and everything about the personality of the lecturer. But, of course, it is not quite as simple as that, and well-designed ratings can give reliable information about a large number of important factors in teaching situations. But to base a person's salary exclusively on them would undoubtedly be a step too far.'

Sally Hunt, general secretary of the Association of University Teachers, said: 'Performance-related pay would be the single most divisive policy this government could introduce into higher education.'

And writing in *The Guardian* on 22 October (see archive at *www.guardian.co.uk* for full article), past president of the AUT Natalie Fenton commented: 'Who in their right mind will teach the least popular, but essential, courses? There would be a national shortage in statistics lecturers before the year was out'.

IN BRIEF

From the Society's Cognitive Psychology Section Conference, 9–11 September, University of Kent at Canterbury.

Alison Wright and Robyn Holliday (University of Kent at Canterbury) examined the effectiveness of the cognitive interview (CI) for eliciting accurate information from elderly individuals. Two versions of the CI both elicited more correct details than a control interview (which excluded memory retrieval techniques derived from laboratory research), with no increase in the number of incorrect details.

A field study by Daniel Wright (University of Sussex) and colleagues found that both white and black participants in South African and English shopping centres were more accurate at identifying faces of people from their own race. Tim Valentine (Goldsmiths College, University of London) and colleagues examined eyewitness testimony data provided by the Metropolitan Police. They found that a suspect is more likely to be identified if the witness is younger than 30 and if the culprit was viewed for over a minute. Effects previously found in laboratory research (weapon focus, own-race bias and the negative impact of a delay prior to the identification attempt) were not seen in the field data.

Anxious participants were faster at detecting a target when it was presented in the same location as the direction of the gaze of a fearful face, as opposed to a neutral face (Jenny Yiend, MRC Cognition and Brain Sciences Unit, University of Cambridge). In other words, they quickly engage attention to the location of potential threat. But anxious participants were not slower in disengaging their attention from such location, which appears to conflict with most of the literature on attentional biases in anxiety.

View the proceedings at http://privatewww.essex.ac.uk/~gdward/bpscog.html

Healing the wounds of the mind

NOREEN TEHRANI *on what psychologists can offer in the wake of recent traumatic events.*

JONATHAN DRAKE/REUTERS/POPPERFOTO

A WORLD still in shock following the terrorist attacks of the 11 September 2001 faced a new atrocity on 12 October. About 200 people were killed and more than 300 injured when a bomb exploded in a Bali nightclub.

For days the media carried stories of the tragic deaths, injuries and lucky escapes. The testimony of the survivors describes massive explosions, followed by panic with people trying to escape the club before it was engulfed in fire. The sound of explosion, the cries of the wounded, the smell of the explosives and burning flesh, and the sight of the dead and injured combined to overwhelm their senses. British tourist Matt Noyce described the scene as one of complete panic, with people diving for the door and trying to scramble over each other to escape. In a disaster the mind, unable to comprehend the magnitude of the event, creates a trauma memory in which these sensory impressions are indelibly recorded.

For the media the story of Bali is already fading away. But this is not the case for the injured, the witnesses and families of the dead. For many the nightmare is only just beginning. The help and support provided in the days and weeks following a disaster such as the Bali bomb is critical to the recovery of the victims, who have suffered wounds to their minds.

Support and safety

Trauma research has shown that people involved in disasters may go on to develop severe and sometimes prolonged psychological distress. However, these problems are not confined to those directly involved in the disaster. In the Bali bomb the friends and relatives who travelled to Bali to identify and claim the bodies of their loved ones are also vulnerable. Exposure to scenes of devastation and chaos in a country unprepared for dealing with a disaster of this magnitude can cause intense distress and secondary traumatisation.

Immediately after a disaster many survivors will experience extreme shock that can numb their physical and psychological reactions, creating a sense of unreality and separation from what is happening around them. As time passes, this numbing reduces and the full reality of their situation becomes clearer. When the initial threat of death has passed, there can be a sense of euphoria at survival, having cheated death. This initial euphoria can suddenly change to a death guilt: 'Why did I survive when my friends died?' This may particularly apply when dealing with the relatives of those who were not so lucky.

The first goal in supporting victims of a disaster is to re-establish feelings of personal safety and security. In Bali this

TRAUMATISED BY IMAGINATION

Just as people around the world were coming to terms with the events in Bali, residents in Washington were faced with a sniper shooting at ordinary people going about their daily lives. The activity of the Washington sniper had a devastating effect on the people living in that area. The terror was intensified by the sniper's chilling note 'Your children are not safe anytime'.

The growing incidence of terror attacks, child abduction, murder and other disasters has led individuals, families and communities to become traumatised not only by the actual events that they experience but also by the *possibility* of the traumatic event happening to them. Seeing the pictures of terror, hearing the accounts of the victims has caused people to identify with the incident and become traumatised by their own imagination. People in Washington were afraid to leave their homes for the fear of being shot, children were not allowed out to play.

The relationship between post-trauma symptoms and the public was established in research undertaken after the September 11th terrorist attack (Schuster, 2002). The study found that over 10 per cent of people who had spent 10 hours or more watching news coverage of the disaster were suffering from post-traumatic stress disorder five to eight weeks after the attack. Perhaps the greatest victim of terrorism is the death of the innocence and the belief in the world as a safe place. The terror of what might happen can be more damaging that the real thing, and this is why terrorism is such an effective tool against whole communities.

was difficult as the whole island felt unsafe and many of the tourists felt unable to go inside their hotels, preferring to sleep on the beach rather than risk being caught by another bomb. The survivors of disasters need to begin to re-establish a sense of control; this may include contacting family and friends at home, looking for the missing and marking the event with the laying of flowers and other rituals (Gibson, 1991). The more that the authorities allow this natural process to occur the easier it will be for the survivors of the disaster to make the transition from shock to recovery.

The focus of the early stages of the crisis recovery period is therefore to ensure the immediate safety and well-being of everyone involved. Where support is provided it should be sensitive and respectful and should not add to the survivor's feelings of being out of control and overwhelmed. Supporters should also try to provide accurate and helpful information. Information on the typical psychological responses to disasters together with practical advice on self-care communicated simply and repeatedly is helpful, as is information on the social and personal support to be made available. Social support has consistently been found to be a powerful indicator of recovery from trauma reactions (Andersson *et al.*, 1997). It is important that at this early stage no attempt is made to begin the debriefing or counselling process. It has been found that early psychological interventions may get in the way of the survivors' own coping processes and delay recovery (Shalev, 2000).

Following a disaster, survivors and families have certain expectations of the help that they will receive, and if the reality fails to live up to these expectations the result will be an increased sense of distress and trauma (Silver, 1986). In Bali the situation for families has been made more difficult by the need to undertake scientific tests to identify the victims, with many of the families having to wait weeks before they are able to fly home with the body of their loved one. However, for many on Bali, the opportunity of talking to friends and family is an important forum for sharing experiences and dealing with strong emotions. Talking is a natural process which helps survivors to gain an understanding and acceptance of what has happened to them (Rose & Tehrani, 2002).

Psychological debriefing

One of the ways that survivors of a disaster can talk about what has happened to them in a safe and structured way is through psychological debriefing, a widespread and popular post-trauma intervention conducted by trained professionals. The debriefing process provides a framework within which the survivor can talk about his or her experiences and receive information on 'normal' types of reactions to such an event (Friedman, 2000).

Although a number of different methods of psychological debriefing have been described, most researchers regard psychological debriefing as a single-session semi-structured intervention designed to reduce or prevent adverse psychological reactions and responses to the traumatic event (Bisson *et al.*, 2000). The BPS recently commissioned a working party to look at the evidence for and against the use of psychological debriefing as a way of supporting victims of traumatic exposure (Tehrani, 2002; available free from *www.bps.org.uk/about/subsystems_boards1a.cfm).* The members of the working party undertook a comprehensive review of the literature and evidence provided by researchers and practitioners working in the field. At the end of this process the working party recognised that most of the current research into debriefing is methodologically flawed and that it is not possible to prove that psychological debriefing is effective as a stand-alone intervention. However, there is a growing body of evidence to show that when debriefing is undertaken by trained and experienced practitioners and used as a part of a total care package it is effective in reducing post-trauma symptoms (Dyregrov, 1998).

If the post-trauma responses do not subside within a few weeks, it may be necessary to consider one of the trauma therapies. There are three main trauma therapies used to support survivors of disasters: cognitive-behavioural, psychodynamic, and eye movement desensitisation and reprogramming (EMDR). Cognitive-behavioural therapy is based on the principles of learning and conditioning. The most frequently used cognitive-behavioural techniques involve exposure therapy, systematic desensitisation, stress inoculation training, cognitive therapy and assertiveness training. Psychodynamic therapy is an approach that seeks to understand traumatic memories in the context of the defensive processes through which the unconscious transforms repressed memories into maladaptive symptoms. EMDR is a controversial therapy in which the survivor is asked to visualise the traumatic memory, rehearse any negative thoughts, concentrate on the physical sensations of the anxiety whilst visually tracking the therapist's index finger. The survivor is then asked to blank out the memory and take a deep breath before recounting their impressions. The eye-movements process continues until the level of distress has been reduced.

As the survivors and the families of those killed in the Bali bombing return home, it is important that they are provided with ongoing care and support that helps them deal with the trauma memories that are trapped inside their minds (Krystal *et al.*, 1995). Whilst many survivors will be able to find a way to make sense of their experiences, others will find the memories of Bali haunting them and preventing them from getting on with their lives.

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