In the news article ‘We should bring death back to life, into the open’ (September 2014), your journalist claimed they were unable to find psychologists who support assisted dying, hypothesising that ‘[p]erhaps there is a desire in the community to address and resolve issues rather than using this quicker means to an end’.

We write as psychologists who do support the right for terminally ill, mentally competent adults to have the choice of an assisted death. We do so precisely because we want to address and resolve the issues that are currently faced by dying people, rather than turn our backs on their suffering.

In the article Professor Owen Hughes asserts that he ‘certainly wouldn’t support assisted dying for people who have pain’. This is an uncompassionate response to the significant minority of dying people whose symptoms cannot be relieved by palliative care. The wishes of such people should be heard and respected within a legal framework. Secondly, suffering at the end of life is a much broader concept than simply pain, and only the dying patient has the right to determine how much suffering they can endure.

Dr Brett Smith is wrong to equate assisted dying and disability. Lord Falconer’s bill makes no reference to disabled people or to the quality of a person’s life. The bill addresses a fundamental issue with the quality of a person’s death. To that end it is strictly limited to terminally ill, mentally competent adults. Furthermore, and in contrast to Dr Smith’s claims, the voices of “ordinary” disabled people are present in this debate – according to a 2013 YouGov survey, 79 per cent of people with disabilities support assisted dying.

Professor Scott Murray wants people to be able to discuss their end-of-life concerns. An assisted dying law would encourage this much more than the current law does by providing terminally

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One reason for supporting the Assisted Dying Bill is that the alternative to a relatively quick and painless ‘assisted death’ is not eternal life – certainly not for those terminally ill people who fall under the remit of the proposed legislation.

Instead it is what the person themselves (and those who love them) may experience as a protracted, distressing, and undignified dying process.

Advances in medical technologies have increased our lifespan but sometimes with what people consider a severely reduced quality of life (Sears & Stanton, 2001). A life with little or no consciousness (maintained by ventilators or feeding tubes) is commonly viewed as a life not worth living (Demertzis et al., 2011).

In response, many countries, including England and Wales, have given statutory force to ‘Advance Decisions’ which allow people to specify, while they still have the capacity to do so, which treatments they want to refuse in the event that they lose the mental capacity to make the relevant decisions at the time. It is perfectly legal to refuse any and all life-prolonging treatments as long as you have mental capacity to do so – and this is legally defined as the ability to understand the decision you are making, to remember and weigh up the relevant information, and to communicate your decision (Mental Capacity Act 2005). According to the UK charity Compassion in Dying (www.compassionindying.org.uk), only around 4 per cent of people in England and Wales have completed Advance Decisions – in part because of a persistent myth that ‘next of kin’ are able to make medical decisions on behalf of loved ones (Kitzinger, 2014). Advance Decisions (along with other well-established principles requiring the withholding of ‘futile’ or ‘burdensome’ treatment) mean that it is lawful – and indeed, can be required by law – for doctors to withhold or withdraw life-prolonging treatments even if this results in your death (so-called ‘passive euthanasia’). However, it is not lawful for doctors to give you medication with the intention of causing your death (so-called ‘active euthanasia’ or ‘assisted dying’). This is what the proposed legislation in England and Wales seeks to change – but only for a very limited category of patients who meet three strict criteria: they must have mental capacity, no more than six months left to live...
ill patients with transparent choices. Patients would no longer fear criminally implicating their care professionals by raising their concerns, and this would lead to clarity on what treatments are available to them. In Oregon (where assisted dying is legal, under strict safeguards) only 1 in 10 who discuss assisted dying with their doctor go on to have an assisted death.

Currently, around 300 terminally ill people take their own lives every year in England and every two weeks somebody from the UK travels to the Dignitas clinic in Switzerland to die. These problems will not go away until the law on assisted dying changes. Parliament must act on this issue, as the Supreme Court has recently acknowledged. Healthcare professionals should contribute constructively to the debate. Outright opposition, as expressed by the professionals your journalist consulted, is comparable to turning our backs on the suffering of dying people. Under The Assisted Dying Bill, those consulted, is comparable to turning our backs on the suffering of dying people.

"The four stages that Professor Murray finds that psychological distress occurs can be ameliorated by treatment. Likewise, the bill does not help profoundly disabled people like Tony Nicklinson, paralysed from the neck down after a stroke (see tinyurl.com/cttg9zo). He wanted the ‘right to die’, yet was physically unable to take his own life. He would have needed to be killed by someone else, which under current law would constitute murder. Since Nicklinson did not have a terminal illness and also was unable ‘to self-administer the medicine’ he, and people like him, are excluded from the provisions of the bill. In sum, the bill opens up the possibility of an assisted death to only a very restricted group of people. It leaves those who do not qualify for assistance and fear an ‘undignified’ or protracted death with the alternatives of death resulting from withholding or withdrawing treatment or alternatively – as ‘Dignity in Dying’ (www.dignityindying.org.uk) campaigners point out – an early pre-emptive suicide while still having the mental capacity and physical ability to do it."

I write as a retired GP and a supporter of assisted dying. I have read the Hansard account of the House of Lords debate and while the majority of contributions were helpful, a number of speeches from the noble and learned Lords did not address the provisions of the Bill. Professor Hughes and Dr Smith do the same.

There is no proposal to offer assisted dying to anyone who has chronic pain or disability unless he or she has a terminal illness. In addition, the patient must be of sound mind and settled intention. The four stages that Professor Murray finds that psychological distress occurs can presumably be identified and ameliorated by treatment.

In Oregon, where assisted dying has been available for 16 or 17 years, people described as vulnerable, those with disability, chronic illness, psychological illness and low socio-economic status, are underrepresented in the people who have assistance to die.

Iain C. Kerr
Glasgow
It was with great interest that I read the article on the Assisted Dying Bill in the September issue of The Psychologist. I took an active part in contributing to the role of psychologists in assisted dying (AD) during my career in the NHS, having acted as an expert witness to the original proposal by Lord Joffe in 2004, and offered a response to legislators in the subsequent years. I also chaired the BPS working party on the role of psychologists in end-of-life care, which produced a report (BPS, 2008) that is currently being updated, and acted as an expert witness to the Demos Commission on Assisted Dying when the current iteration of the Assisted Dying Bill was being reconsidered.

I find the article in The Psychologist deeply disappointing from a number of perspectives. Firstly, and most importantly, while it informs the reader that the current bill refers to making AD available only to those people with a terminal illness and in the last six months of their lives, it fails to mention that there would be a rigorous assessment process, which involves considerable investment of time, knowledge and skill on the part of the healthcare (and potentially other) professionals involved. It is an entirely voluntary process, and the safeguards to ensure the person requesting assisted dying has full mental capacity are robust. I would urge anyone who has a serious interest in the bill to read it. The bill most closely follows the Oregon Death With Dignity Act (DWDA), and thus readers might also look at the research from the US, predominantly Oregon, which legislated for the DWDA in 1997, and who have been collecting robust data since that time (see tinyurl.com/nfq8uqa).

There is also a body of independent research looking at factors such as doctors’ attitudes to AD, the nature of the people who request a lethal prescription, and the effects on the palliative care services (Battin et al., 2007). It is also helpful to look at the websites of Dignity in Dying (www.dignityindying.org.uk) and Care not Killing (www.carenokilling.org.uk), which offer two very different perspectives on the potential impact of the bill.

A further disappointment is the inclusion of two clinicians who are not involved in services for people with a life-limiting illness. The bill is very clear that it refers only to people with a life-limiting illness, therefore people with chronic pain, or a specific disability would, by definition, be disbarred from requesting AD. The final contributor, who works in primary palliative care cites his own work, which while offering interesting data, provides neither new information (we have known about the critical stages in the experience of having cancer since the work of Jimmie Holland in the early 1970s: see Holland et al., 2010), nor is it relevant to the issue of AD, because, as stated above, a request for AD can only be made in the last six months of life (so far as it is possible to prognosticate), thus other critical periods for significant psychological distress can, and should be managed by other means, whether through medication and/or psychological therapies (Brennan, 2004; Sage et al., 2010).

There is a strong implication in the article that pressure groups for people with disabilities are anxious that a change in the law would put individuals with disabilities under implicit pressure to volunteer themselves for AD, were the bill to become law –the ‘slippery slope’ argument. While not wanting to dismiss the anxieties of such groups, it is not possible for this to happen within the remit of the bill. It is very specific, and as stated above, most closely matches the DWDA, and not that of the models that many of the Benelux countries have adopted, which often incorporate euthanasia, in which a person is helped to die through a physician administering a lethal drug, and AD, in which a physician prescribes lethal drugs, and the patient themselves taking them if/when they believe right time has come.

Evidence from Oregon suggests that while the numbers of people with life-limiting disease requesting a lethal prescription have risen steadily since 1997: a total of 1173 people have had assisted-dying prescriptions written and 752 patients have died from ingesting medications prescribed under the law, the proportion of people who take the drugs, as opposed to having them in a safe place at home, remains between 50 and 60 per cent year on year. This means that from 40 to 50 per cent do not take the lethal drugs, and die from other causes. However, they have the peace of mind of knowing the option is there for them if they need it (see tinyurl.com/nfq8uqa).

From a clinical perspective, having worked in specialist palliative care for 20 years, and having a consultancy in the field now, I found the patients who talked about wanting to commit suicide, or having help to die were many, and the number of people who took their own lives very low.

In summary, while it is laudable that The Psychologist has chosen to consider this issue, it is disappointing that the opportunity to engender well-informed and open debate seems to have been missed. Perhaps the BPS should consider developing a debate with interested parties, including representatives from faith groups, relevant pressure groups, the Royal Colleges, etc., particularly given that the issue is ‘live’ at the moment, while the bill progresses through the parliamentary process.

Finally, and perhaps of most importance, we need to ensure that the profession is at the forefront of the important conversations that individuals

letters

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Letters

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Robert Sternberg, Oklahoma State University

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References


We should bring death into the open

In the service where I work as a clinical psychologist, many of our clients are drawn from well-off, educated backgrounds, having had successful careers and often placing great value on cognitive ability and academic endeavour. Though not common, I have come across a number of clients who express a desire to end their lives following a diagnosis of dementia. I think particularly of one very intelligent man in his 80s who is extremely cognisant of the decline in his cognitive faculties, monitors these changes constantly, and is well informed about the prognosis for his cognitive future. Since his diagnosis he has expressed an unwavering wish to take his life. His family, realising that he is likely to do so in a less controlled way, have offered to take him to Dignitas in Switzerland. This is difficult and expensive for a family to undertake. However they are endeavouring to respect their father’s desire to hold his fate in his hands as they have always done. This while having to overcome their own conflicting feelings.

In my role I have supported this gentleman for eight months. We have considered the impact of euthanasia on his family, as well as exploring his feelings around the changes that he is experiencing (physical, emotional and cognitive). The gentleman does not appear depressed on either objective or subjective measures and any negative appraisals are directly related to his diagnosis of dementia. He has been assessed to have capacity. Therapy has been successful in challenging his belief that his cognitive decline will be rapid and sudden and that life with a diagnosis of Alzheimer’s disease is not worth living. He has agreed to postpone his suicide, but is adamant that it is the way in which he wishes to end a very independent life. He is anxious that by postponing his suicide he will pass the point where he is able to commit it.

As you can imagine, this has been a challenging road for a new psychologist to tread. While ensuring that I am not perceived to support his desire to end his life, I need to respect my client’s wish to live (and yes, die) as he chooses. I have had to consider how to give him sufficient support so as to engender trust and prevent him from disengaging from therapy, while not actually encouraging his actions. I have explored this complex ethical dilemma within supervision and considered our profession’s responsibility with regard to safeguarding.

I support the Assisted Dying Bill, to give the terminally ill the right to choose to be assisted to die, which was the subject of the article ‘We should bring death back to life, into the open’ in the September issue of The Psychologist.

I fully support the aims put forward by the specialists in relation to their areas of expertise, but none of them makes any mention of an individual’s right to make their own assessment of whether or not their life is worth living.

Professor Hughes wants ‘greater availability of pain management’; Dr Smith wants better support and more suitable accommodation for disabled people and the promotion of a more positive view of the potential for a disabled person to have a good quality of life; Professor Murray wants better palliative care, particularly better psychological support for the terminally ill; all of these are important points which would undoubtedly make life better for many terminally ill people. But that is not the issue here. It is not for any specialist to judge whether the application of the best techniques available will make life worth living for a particular individual.

I believe the Assisted Dying Bill will enhance the wellbeing of all terminally ill people, by giving back to each individual some of the control that they have lost – the ability to choose to terminate their own life should they judge that it has become intolerable. (There are safeguards in the bill to prevent such decisions being implemented on a whim.)

This choice is particularly important for those suffering deteriorating health. Without that reassurance, some feel they must take their own life while they are still able to do so. They fear that if they live (happily) a few more months, even years, they could become unable to die without assistance should their life become intolerable. At that point they would be forced to suffer months of an intolerable life, or to ask a friend or relative to risk imprisonment by helping them to die. Neither is acceptable, so they must choose to end their life while they can do it alone. That is the only way they can retain control – and lack of control over one’s fate is psychologically debilitating.

The knowledge that there would be the choice to be helped to die if life were to become unbearable would give many the confidence to enjoy life despite their declining abilities.

Richard Mobbs
Kingston upon Thames
Creative Britain is certainly a phenomenon, if it exists, which we and our descendants will have to nurture if we want to thrive. But what is this; and as your correspondent David Wood writes in (Letters, September 2014), exactly where is it?

Stephanie Taylor (‘Creative Britain, August 2014’) gives much useful information about what the Department for Culture Media and Sport designate as creative industries, comprising ‘advertising, architecture, the art and antiques market, crafts, design, designer fashion, film and video, interactive leisure software, music, the performing arts, publishing, software and computer services, television and radio’ which evidently contributed (in 2010) £59 billion to the national economy.

Before examining (social) psychological aspects of the above industries it would be useful to set the economic size of all this activity alongside that contributed by other industries. A Wikipedia article (citing the UK Office for National Statistics) reports that in 2011 the construction industry contributed £87 billion to the UK economy; its largest component being the London Crossrail project; aerospace has an ‘annual turnover of £20 billion’ with British Aerospace the largest component, being the world’s second largest defence contractor.

By composing the list above the DCMS might imply that other industries are not so (or not at all?) creative. Some critics will judge by the utility of the output and would argue that the defence (armaments) manufacturers are not creative but destructive; I have read similar arguments about large sections of the drug industries. Leading from this it is also easy to find critics and analysts who argue that much of advertising and screen products (including video games) arbitrarily designated ‘creative’ by the DCMS is destructive.

Taylor turns to those who challenge a focus on individual creativity. An expert is cited who proposes that ‘creative behaviour is the outcome of favourable circumstances’ (and how might they arise?). Ah! Creative behaviour is what we (informed and influential people) say it is. ‘Social psychological studies [all of them?] challenge the conventional association of creativity with individual genius or special talents’ (Taylor, p.592); please count me out of this view. We need to notice how G.F. Handel powered his way, from a very early age, against his parents’ designs for him, to establish himself as performer and creator of music – and, then, agreeing with the ‘social’ gurus, to become a builder in an existing industry (opera) and the creator of a new one (oratorio). There is no doubt much to be said about

‘I’m no expert’, says female psychologist...

I love psychology. I have monopolised many a dinner party talking about it. By chance/serendipity fate I met someone who was researching for a book that interweaves the story of James Sadler, the first Brit to fly, with the author’s own journey to conquer their lifelong fear of heights. Crucially, he wanted to recreate Sadler’s hot-air balloon flight – horribly incompatible with his height phobia. A perfect excuse to chat about psychology for hours.

Long story short, the book has been published [see review on p.792]. I am so proud – like a kid with a show and tell – that some of my comments made it into the story. We’ve also done a couple of local radio appearances to promote the book and contribute to the public dialogue about mental health.

The very odd thing is that my appearance in the book and on the radio is consistently prefaced with the phrase ‘phobia expert’. I am at the start of my career as a psychologist, seemingly surrounded by people more experienced, skilled, and deserving of that status. It feels a very odd title for me. I was trained to consider power relations; the inherent inequality of the title ‘Dr’. In fact, I’d go so far as to say that if I were given feedback that ‘Hannah took the expert position’, I would consider it rather an indictment. So at first, I was taken aback.

Always the dutiful psychologist, I consulted my supervisor, who suggested that I may never think of myself as an ‘expert’, but I know a lot more than the average person and therefore have a valuable contribution. A peer suggested that public engagement is one of the most useful things a psychologist can do – and in common parlance ‘expert’ is probably a reasonable title. A friend looked at me quizzically and said, ‘Hannah, you’ve been training for the best part of the last decade…?’

And then comes a seemingly unrelated intersection. Women, we hear, still occupy only 24 per cent of the most senior posts in the country. We earn less, we take longer to progress up the career ladder. Why? Well, apparently women wait longer to apply for promotions, they are less likely to describe themselves as experts, they promote themselves less aggressively. When looking for contributors for Channel 4 news, Jon Snow noticed that when he asked women to appear as an ‘expert’, they would say, ‘It’s not exactly my expertise, I ought not do it’. Men would say ‘It’s not exactly my area of expertise, when do you want me?’.

In a roundtable discussion at the British Association for Behavioural & Cognitive Psychotherapies conference recently, a quick headcount suggested 13 of 75–80 attendees were men. But... of six panellists and one chair at the front of the room, only one was a woman. Toward the end the panellists began to mention the conferences/books they were currently promoting. When her turn came the one woman said ‘Oh I don’t have anything to promote’, and the panel moved on. Someone else jumped in: ‘You have a book out! [to the audience] It’s excellent – buy it!’ It seemed to encapsulate in 15 seconds the facts and figures and dissections of culture that we read about.

I feel so passionate about redressing this imbalance. The Every Sexism Project, founded by Laura Bates, has examples and statistics that leave us in no doubt that sexism is alive and well: it ranges from quietly being sidelined or subtly patronised (‘Calm down, dear’ from the lips of our very own PM), to outright vitriolic abuse (such as that received, and responded to in such a dignified manner,
The end of prosopagnosia?

My eye was caught by two articles in the August issue. The first of these was Elliott and Grigorenko’s ‘The end of dyslexia?’. They noted that some children self-evidently find it more difficult than others to learn how to read and write; however, the concept of dyslexia had not really contributed much to our understanding of this, nor to our ability to intervene usefully. They also noted the way in which the term ‘dyslexia’ has come to be used for political and campaigning purposes, which has arguably confused an already confused situation further: ‘the label is a cultural meme that remains unscientific and conceptually problematic’.

The second article (‘Getting engaged with the public’, Society) was partly about prosopagnosia – ‘face blindness’ – and it struck me that many of the points made in the dyslexia article might equally apply to the suggestions in the prosopagnosia piece. For example, it was claimed that 1 in 50 suffer from face blindness, without the term being adequately defined (i.e. are we talking about the ‘I don’t recognize my wife’ variety, or the ‘I’m not very good at remembering new faces’ variety?). There were also suggestions that a national charity should be established, that health and education professionals should be made more aware of the condition, and even that ‘a set of guidance notes’ should be developed.

I am reluctant to take all this at face value. Severe prosopagnosia is without doubt a difficult condition to live with, but I worry that – as with dyslexia – people may self-diagnose then seek a formal assessment (I’m freeing up my diary in anticipation) in order to get a formal diagnosis, which is unlikely to result in any useful intervention. Could it be that the ability to ‘learn’ and recognise a face, like many other cognitive abilities, is simply a skill which is more-or-less normally distributed in the general population?

John Higgon
Clinical neuropsychologist
Dumfries

by both Mary Beard and Sarah Millican). Such treatment arguably contributes to the significantly higher prevalence of (almost all) mental health problems in women than in men. Daniel Freeman’s recent book cites that in the last year 25 per cent of adult men had significant psychological difficulties, but for women the figure was a whopping 37 per cent.

As a young woman, I want to play my part. Women should be more assertive about their abilities. We should take ownership of our sphere of knowledge. This feels alarmingly incompatible with my suffocating pressure to be modest; to reject the ‘expert’ title… but when the two stances feel incompatible we mustn’t be discouraged. We’ve got to start navigating our way toward a compromise.

All of a sudden, I hear an imagined fragment of voice… “I’m no expert”, says female psychologist. Well, no wonder then if everyone stops listening. Since the knowledge I already have is useful for other people, particularly in the public arena, why not share it?

Hannah Stratford
Research Clinical Psychologist
Oxford Centre for Anxiety Disorders and Trauma

Memory – from zeal to fantasy

Over many years of acting as memory expert witnesses we have identified four groups of people who are happy to stand up in court and give ‘expert’ memory advice, whether or not they are ‘memory’ expert witnesses: bona-fide memory researchers, the Zealots, the Old Guard, and the Fantasists. When we wrote our article (‘Beliefs about autobiographical memory’, July 2014) we confidently expected to hear from these last three groups, and we were not disappointed (see Letters, September 2014).

The Zealots have a fundamentalist belief that memory is accurate, particularly so when it is of emotionally negative or traumatic events. This group place great emphasis on any findings that selectively give support to their single central belief. This is why the modern view of human memory, outlined in our article and based upon a full review of the scientific findings, is so troubling to them: the vast amount of data on autobiographical memory shows the notion of ‘accuracy’, and indeed of ‘confidence’, to be highly complex. Even worse, no memory is accurate in being a complete or literal copy of an experience (the core of their belief).

Members of this group would benefit from studying the important and influential 2008 report Memory and the Law from the British Psychological Society’s Research Board (download via tinyurl.com/oydxy3x). A team of national and international memory researchers provided advice on memory distilled from a wide and representative range of memory research. The modern view of human memory is based on about 35 years of research into many different aspects of memory, including beliefs about memory, extensively reviewed in this report (as well as in the recent volume by Nadal & Sinnott-Armstrong, 2012, and a forthcoming volume, Conway et al., in press).

The Old Guard is represented here by Professor Michael Kopelman, a colleague of ours and one of the country’s leading psychiatrists, a bona-fide memory expert, and a leading expert witness in our courts for several decades. Kopelman is clearly right to note that psychologists give expert advice in many areas and not just in cases that prominently feature memory. Our interest is, however, in those cases where memory is the only or main evidence. In such cases the Court of
Dyslexia – the issue is outcomes

I read the continued articles and letters on dyslexia with a depressing sense of déjà vu. It has always puzzled me why educational psychologists have a problem with the term – clinical and occupational psychologists have no issues it seems (e.g. Psychological Assessment of Adults with Specific Performance Difficulties at Work, guidance produced by a working group of the BPS Division of Occupational Psychology). Indeed until the late 1970s we had the then Department of Employment recognising dyslexia and the Department of Education refusing to.

I should have picked up a clue as a young Research Fellow at the University of Aston in the mid-1970s. I was addressing a group of educational psychologists who had requested a seminar on our research showing differential neuropsychological processing and individual differences in cognitive skills in dyslexics (aka contemporary research!). I was showing the atypical reading and spelling errors shown by children in our research cohort/assessment centre. The Principal Psychologist interrupted me saying ’We don’t want to see the children’s work, but to talk about the politics of dyslexia.’ Sadly, an attitude that seems to have persisted.

Yet terms like autism, ADD, ADHD, MLD, SLD, dyspraxia, dyscalculia are not the subject of condemnation and ‘doesn’t exist’ polemic. Perhaps they should. Take autism for example – well accepted as a diagnostic descriptor by local authorities some of whose psychologists, despite the SEN Code of Practice from 1981 to now, the BPS report of 1999 and the Rose report of 2009, still baulk at ‘dyslexia’. Autism is much vaguer – is it a ‘spectrum’, where does Asperger’s finish and autism begin, should one include all the ‘triad’, what level of social communication dysfunction are we talking about, how is it measured?

For me, having run a school for dyslexic children for 27 years, the issue is outcomes. If you are identified as ‘dyslexic’ (or indeed another SEN) you are more likely to get the help you need. I don’t accept that this means less support for others, we should support all SENs fully. Importantly, being dyslexic implies a particular kind of teaching programme (different from e.g. MLD, comprehension impairment, etc.), without which they will not make progress.

Of course, children do vary but descriptors are a convenient overarching shorthand. So, one could say (without entering into the discrepancy or ability/achievement model debate!) that the child has: ‘A specific learning difficulty characterised by a severe delay (despite conventional literacy teaching) on a standardised psychometric assessment (i.e. more than 1 SD from the mean) in reading decoding (with better reading comprehension if decoding was supported), spelling, writing and phonological skills, sometimes associated with poor (on a standardised test) working memory, processing speed, non-word reading, rapid automatic naming; the implied etiology being neural pathway processing leading to the underlying cognitive skills resulting in the behavioural observations describe above.’

Hmm… seems a clear diagnostic descriptor, but rather a mouthful, how about a shorthand description? I know – dyslexia.

Dr Michael Thomson AFBPsS
Ramsgate, Kent

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Male Psychology

Alongside the June special issue on men’s psychological health, the first Male Psychology Conference was held at UCL in the same month. It was such a success that we have extended the programme for next year’s conference an extra day in order to include more presentations and include workshops. We had excellent keynote speeches this year (on modern masculinity, government policy and even a Jungian take on sexuality) and presentations (mostly clinical psychology), posters and dynamic renditions of poetry exploring PTSD and being a male victim of domestic violence.

We hope by next year that sufficient numbers of BPS members will have voted for the creation of a Male Psychology Section of the BPS in order to focus research and discussion on the important topics in this field – vote at http://response.questback.com/britishpsychologicalsociety/malepsysection.

In the meantime, we invite presentations and workshop proposals for 2015 (see www.malepsychology.org.uk).

John Barry
UCL Medical School
Luke Sullivan
Barnet, Enfield and Haringey Mental Health Trust
Martin Seager
Central London Samaritans

Letters
EMDR – time will tell

Regarding EMDR, my observation – in the light of 10 years' practice and supervision – is that if anything, Dr Robin Logie underestates the case for the therapy (July 2014). While EMDR may look similar to other treatments from the outside, the inside view (Kahneman, 2012) gives a rather different picture.

Beyond the numerous RCTs in its favour, EMDR has striking and novel features that stand out clinically. For one thing, actual trauma processing can, at best, be extraordinarily fast in EMDR. I personally have had various cases in which the traumatic memory was resolved in 10 minutes or under given actual processing – to the astonishment of all concerned. In such cases, it seems as if a bubble of consciousness, temporarily problematic due to trauma and often with significant somatic links to the memory, has been burst. This type of experience is not so unusual: I estimate that I hear a jaw-dropping EMDR story of rapid and/or deep symptomatic relief at least once a month.

My prediction – and only time will tell if it is correct – is that EMDR will turn out to be the first in a new class of psychotherapies that work differently from conventional talking therapies, perhaps via different neural and somatic pathways, and at deeper levels.

As one instance of this possibility, bear in mind that nightmares (often emerging as the royal road to the underlying issues via association) are frequently targeted for successful processing. At another, it is possible to process traumatic memories swiftly and successfully in virtual silence with EMDR. This not only can protect the service user (and clinician) in cases of extreme trauma since a full and painful verbal account is often redundant, but it is also hard to explain via the paradigm of conventional talking therapies.

In short, given the view from the clinic, there is reason to think that – for those service users stable enough to undertake it – EMDR may be the quickest, and most powerful psychological tool currently at our disposal. This could explain why EMDR is gaining ground among psychological therapists of all stripes who know a good thing when they see (or rather hear about) one. I think something different is going on here. Time will tell, as I say.

Dr Roger Kingerlee
Principal Clinical Psychologist, Norfolk and Suffolk NHS Trust

Reference

Practitioner psychologist – a title without division

I have read with interest the recent letters regarding parity between clinical and counselling psychologists within the NHS and feel there is a wider issue.

I am a forensic psychologist who has completed all of my training and post-qualification employment within the NHS, and as such have often had to work to have my training, qualification and, in some cases, even professional judgement considered on a par with clinical psychologists. My understanding is that, as June Richards (August) points out, there is an agreed level of parity between clinical and counselling psychology within the NHS at all grades, and posts that do not require the 'essential competences' of either will be advertised as 'Clinical/Counselling, while this is not true of clinical and forensic psychology.

The long-standing relationship between the NHS and clinical psychology training, and the associated financial commitment this has involved, lends itself towards clinical psychologists being favoured for many NHS jobs. However, increasingly, the NHS is providing services to other agencies, such as criminal justice, therefore individual specialism has to be recognised.

I understand and accept that many jobs within the NHS require the specific skills and training of a clinical psychologist; however, we should not limit applications to posts where other modes of training have equal relevance. The HCPC title of ‘Practitioner Psychologist’, I believe, helps to promote parity between disciplines and this should be embraced by the NHS. Why not advertise a post for a ‘Practitioner Psychologist’ and let the individual skills and experience of the applicant inform the recruiting panel whether they are suitable for the job?

Bryony Crisp CPsychol Leeds

We can echo Carolyne Keenan’s (Letters, July) experience of being ruled out for NHS posts purely on the basis of adjectival title or (mis)perceptions of what that title represents. In our own cases, we have faced this dispiriting and frustrating experience more often than not when seeking promotion in our local area, despite having already proven ourselves in NHS psychologist posts.

The various applied Divisions within the BPS (Divisions being an unfortunate term), have done a great deal of good collaborative work at the national levels. However, there still appear to be pockets of the NHS where a mutually respectful attitude and recognition of shared competences has yet to filter through. In the context of NHS changes, particularly in relation to the commissioning of services and the delivery of psychological therapies by a wide range of professionals, it seems all the more important that we are psychologists first and foremost, and the specialisms are secondary. Politicians, commissioners and managers are generally uninterested in our internal differences, and indeed will be dismayed if such a small profession cannot present a united front and a common expression of the strengths we can bring to the NHS.

As counselling psychologists, we simply want to do the valuable work we have been well trained to do, and see enormous value in working closely with clinical psychologists and a wide range of other professions. We try to help our clients to recognise and modify outdated or unrealistic perceptions – can we psychologists do the same?

Lewis Blair
Rachel MacLeod
Glasgow

Editor’s note: The Society has previously written to NHS trusts (most recently in September 2011) advising them that ‘advertisements for psychology posts should seek applications from Applied Psychologists who meet the required competencies for the post. Where specific essential competences are needed this must be clearly specified and consideration must be given to whether an applicant, through CPD and post qualification experience may have acquired these competences, despite adjectival title, and so be eligible for the post.’
Sex offenders - time to step outside the anger?

In recent years revered public figures popularised by their achievements and good standing in the community have been revealed as child sex offenders, triggering shock waves across social consciousness. Once a totem of the better side of human nature, they proved to be otherwise. What happens next? The public feel betrayed and deceived and so redefine, demonise and dismiss ‘him’ as ever being like ‘us’. Public resentment and rage follow, fuelled by sensational stories from the media. The response is understandable – no one condones abuse; but it will alienate the offender whist promoting the myth that sex offenders are isolates and psychopaths. Some are of course, but most are not. This myth is created by media reporting that fuels public anger towards offenders and inhibits the potential for safe reintegration. The reality is, most men who sexually offend do so within the family home or are known to the family and have many socially acceptable, even admirable qualities.

Research proposes that the first sexual experience sets the pattern of expectations for the future. If it has been deviant, the possibility of that affecting sexual behaviour as an adult increases. However, without empathic insight into these issues, an aggressive public attitude is not tempered and maintains the fear of reprisals, deviances are secreted and a covert life evolves alongside mainstream cultural beliefs, behaviours and values. Thus, he is enabled to live, work and achieve as an accepted member of the community: a celebrity, bank manager, clergyman, accountant, policeman, judge, psychologist, plumber, window cleaner, sportsman, politician, student, teacher, soldier, sailor, social worker, and more.

The problem exists across the whole of society, within all religions, cultures and professions, and across all levels of educational achievement; this is not an isolated population. Yet as a society we appear startled when it makes front-page news. Feeling betrayed, we separate ‘him’ from ‘us’, demoting him to a stereotyped deviant set apart from ‘normal’ people. But by doing this, we deny ownership of a sexually destructive undercurrent in the culture, reverting to blame and attack, which fail to explore the origins of a problem created within a society whose lack of ownership drives it underground.

For those whose deviant thoughts are in the ‘contemplative stage’ or where a short sentence did not enable prison treatment, probation treatment is also unavailable. Unfortunately, there is little community treatment apart from the costly private sector. Where then do offenders or potential offenders go for help? With the current availability and cultural attitude to sex-offender rehabilitation, the answer is likely to be nowhere! Disclosure has become too much of a risk. In an ideal world, a non-punitive supportive attitude from the public and available community treatment services prior to abuse would be the way forward.

The issue raised here is contentious as it suggests reduced risk requires a change in public attitude and media reporting, which without political back up is a ‘big ask’. But new ways of thinking are required as the old way is failing: offenders are still alienated, psychological damage to victims continues, the financial cost of processing sexual offending increase – arrest, legal processing, prison, probation and finally long-term monitoring in the community. Arguably, the biggest inhibitor of change is media myths that generalise negative characteristics of all sex offenders and inflame societal attitude. Meanwhile, as we reel from revelations about public figures, society’s attitude inhibits offenders requesting help. For this to be different a change in media reporting and public attitude is required.

The question remains: Is it possible to affect a change in public attitude through insight?

Alex Hossack
Consultant Clinical Psychologist
Liverpool

Conrad Graham (1929–2014)

Conrad Graham who died on 7 August after a long illness, was a key figure in the early history of the Association of Educational Psychologists. He had a long career in the profession in London, first in Ealing and then as Senior Educational Psychologist in what was at that time the Borough of Willesden. He steered the educational psychology service there through the combination of Willesden with Wembley to form the London Borough of Brent, where he was Chief Educational Psychologist for 17 years. He helped to shape Brent’s response to rapid changes in the school population and to complex challenges from the vicissitudes of the 11+ examination. His contributions to the latter were informed by a longstanding interest in the psychometric underpinning of the test regime and its ill-understood complexities.

Conrad described himself to friends and colleagues as an ‘inveterate joiner’, and a good number of the many societies and...
David Smail (1938–2014)

Aged 76, David Smail died on Sunday 3 August this year. As coordinating editor of Clinical Psychology Forum, I put together only three special issues specifically dedicated to individuals whilst still alive – one to Dorothy Rowe, one to John Clements, the other to David. Clinical psychologists queued up to write for all three. David, ever modest, was taken aback when his copy came through the letterbox. By then he knew how much his work had influenced my roles as writer, editor and Director of Psychological Therapies. Over a whisky in Nottingham we talked a little of how ironic it was that we both emphasised the individual in context but when it came to putting those we admired on pedestals there was no room for all the other factors involved in that elevation. (To add to the irony I had succeeded him as Chair of the Psychotherapy Section of the BPS.) Fluent in French with a rich understanding of philosophers like Sartre and Merleau-Ponty, David would have been admirable if he had never entered clinical psychology.

He trained at Horton Hospital in Epsom and then at Claybury Hospital in Essex and entered his life when he came to speak at Leicester University in the late 1970s. He had been the first editor of the Psychology and Psychotherapy Association Newsletter after co-founding the PPA with Miller Mair and Don Bannister. The Newsletter became Changes, which I was asked to edit in 1988, and a few years on changed again to the Journal of Critical Psychology, Counselling and Psychotherapy. Ten years earlier Dorothy had recommended David’s Psychotherapy – A Personal Approach and some of us in her department became immediate converts. One reading of PAPA was that therapists might attend more to what patients were actually saying about their lives, a commitment that required months or years of regular meetings rather than quick-fire behavioural or psychodynamic constructions. There was something both alarming and humbling about discovering just how many challenges were faced by those in the mental health system. These weren’t challenges that therapy could possibly fix.

David was head of clinical psychology services in Nottingham until 1993 and retired from the NHS in 1998. He held the honorary post of Special Professor in Clinical Psychology, University of Nottingham, from 1979 to 2000. One role at the university was as part of the student counselling service, a position he likened to being an encouraging dad to young people struggling with being away from home and crushed by the expectation to succeed. He gave up his counselling role when he found himself being kept awake on Sunday nights ahead of counselling sessions on Mondays. It was typical, I think, of David that his caring should lead to sleeplessness. Not content with a life of full retirement he continued to write and was a founder member of the Midlands Psychology Group.

Curiously, in Forum and JCP, I have reviewed all of David’s books with the exception of his last – Power, Interest and Psychology: Elements of a Social Materialist Understanding of Distress (PCCS Books, 2005). Guy Holmes and I were commissioning editors for the latter. David had left us with pretty much nothing to do. As in public talks, the text was precise, the humour sardonic and the sources broad: Tolstoy and Jung get three references, Foucault six and Skinner and Thatcher one each (the same number as Hitler, Christ and Toscanini).

The September issue of JCP is a tribute to David. This time he won’t be around to read it but I shall raise a glass anyway.

Craig Newnes
Shropshire

organisations he joined were eager to elect him to honorary posts where his organisational skills made things happen. At one point in the early 1960s he held five concurrent secretariats, and that may not have been the peak of his activity. The most far-reaching of his professional initiatives was as originator and joint founder of the Association of Educational Psychologists. Conrad was its first National General Secretary and later a successful President. He played an important role in ensuring that its services to members extended beyond those of a trades union to the provision of focused professional support and consultation.

In 1976 he left Brent and joined a number of other educational psychologists in the small team of Inspectors of Special Education in the Inner London Education Authority. He had responsibility for special education matters in all schools in a large division covering two boroughs. He also had specialist responsibility for work across Inner London with pupils who had emotional and behavioural difficulties. Colleagues had always turned to Conrad for advice and for practical support. Now more than ever his calm approach to knotty problems, his clear-sighted analysis of any situation and his firm, confident judgement were in great demand. He was close to the schools and the teachers and supportive of them but also able to look at their needs from outside dispassionately. He retired in 1988 after 40 years’ service in education.

One of his own favourite anecdotes from his days as a politician illustrates some of those qualities of perspicacity and determination that characterised Conrad’s whole career. He was asked to interview an intelligent, 13-year-old boy who had an obsessive interest in poisons. There was no direct evidence, but on the basis of the interview Conrad became convinced that he was administering poisons to others in small quantities. His immediate superior in the local authority hierarchy was loath to take action. So Conrad ensured police involvement through his own local network, leading to the boy’s conviction. Sadly after release from Broadmoor some years later Graham Young killed three workmates with poison and was sent to prison for life. The episode illustrates some of the qualities that professional colleagues valued highly in Conrad. He was able to see past the surface of things, was always willing to face difficult facts and was ready to do whatever was needed to achieve the objectives he thought were required. He is survived by his wife Kay, their two children and four grandchildren.

Tony Cline
University College London