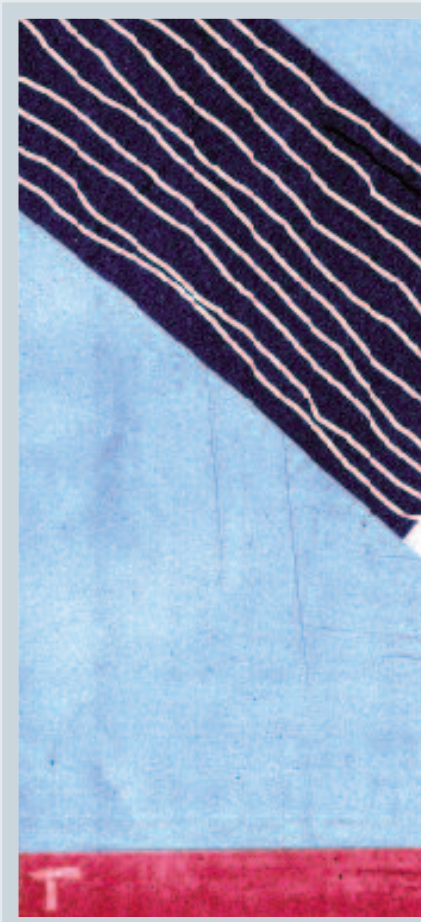
# Decline of the NHS



Not long after the Labour government under Blair came to power a message descended to those of us working in the NHS that we could no longer use the headed letter paper of our own part of the NHS, and that everyone had to use standardised headed paper. At the time I wondered what this bizarre diktat meant. Within a few years I realised that it had heralded increasing control from above, with clinicians' opinions being ignored. The implementation of the National Service Framework for mental health services, pushed through by service managers, imposed new structures on the service in which I worked which were against the wishes of the clinicians involved. In consequence in 2004 I left the NHS, especially as by then
I realised that working within it would likely mean increasingly being told what to do, with the further likelihood of growing pressure to work in ways that contradicted my own clinical judgement. Having also in the 1980s been a founder member of a CMHT, one which had no 'manager', I was also becoming highly critical of the increasing prioritisation of managers over clinicians. Associated with this I had developed a very sceptical attitude to the culture of meeting 'targets', as well as to the centralised control over clinical judgement implicit in the so-called NICE 'guidelines'.

In their book *The Puritan Gift*, published in 2007, Kenneth and William Hopper described how in the latter half of the 20th century, in the USA, bad management practice came to increasingly replace good. They described what they call the 'cult of the (so-called) expert manager' and how this had caused serious harm to previously successful American businesses. They described such bad management practice as having various features – the so-called managers' lack of actual personal knowledge or experience of the business or service they were managing; top-down control rather than a system of good-quality manager–staff relationships with specific responsibilities as far down the management chain as possible; emphasis primarily on financial considerations to the detriment of other issues; and the use of inappropriate 'measures' rather than good qualitative knowledge. The overuse of 'outsourcing' was also mentioned as a feature of such bad practice.

The Hoppers also described how such bad management practice had harmed health care in the USA, as well as other important areas, such as education and the armed forces. The section of their book on health care mentioned how the British NHS also seemed to be affected by such bad management practice, stemming initially from the implementation in the 1970s of recommendations in a report on nursing by Brian Salmon, 'who went on to destroy the company he chaired'. This meant that nurses lost control to managers, including control of their own wards. More generally, the Hoppers' description of bad management practice seemed to be in accord with what I had seen developing within the NHS, forced along by central government.

We have now had the Francis Report, which documents the serious failings within one British hospital's physical health care, failings which are far from being confined to that one hospital. The Hoppers' words about the US healthcare system could apply equally now to the British: 'For the authors, the symbol of the new era has to be the half-eaten, dried-out meal sitting for hours by a hospital bed occupied by a semi-conscious patient.' Moreover, as Narinder Kapur quotes from the Francis Report (in his article on it in January's *Psychologist*), it is clear…the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases, inhumane, treatment'; 'finances and targets were often given priority without considering the impact on the quality of care'; 'it [is] morally wrong to put


Tim Sanders

targets of that sort ahead of the nursing needs of patients'. This all happened despite a variety of organisations supposedly monitoring NHS practice, and despite NICE.

Also, at the time I left the NHS the IAPT scheme was 'in the air'. I was sceptical of this as well. It now seems to have been forced upon adult mental health services around the country. In consequence, clinical psychologists in adult mental health services appear to have become an endangered species, being replaced by a workforce of lesser paid and lesser trained staff, whilst the IAPT scheme seems to help a just small minority of people referred to it (Griffiths et al., 2013). Rigid and simplistic forms of CBT, supposedly 'evidence based' and conforming to NICE guidelines, are being used (Taylor, 2013).

It is also worthwhile to consider issues such as the criminal record/disclosure and barring service check, and the Health and Care Professions Council (HCPC), in this context of seriously declining health care, increasing political and managerial control, and the culture of absurd 'targets'. How much do CRB checks cost the NHS each year? Why so many of them, repeated so often? Clearly they did nothing to stop the decline of physical health care. Are they anything but a waste of time and money? Then there is the HCPC, set up by the Labour government and in effect taking control away from clinicians in yet another way, by removing from us the right to manage our own professional ethics, or to even call ourselves by our correct titles without their approval. It is also evident that employers make complaints to the HCPC, and that its procedures do not seem to take due regard of the high possibility of malicious complaints (Taylor, 2013) or those from certain types of patient – for example the paranoid and those with a history of abuse who project onto the clinician, and whose complaints are really manifestations of their psychological problems rather than reflecting anything objectively in the behaviour of the clinician.

Certain questions need to be asked: Is the existence of clinical psychology in adult mental health services now under very serious threat? Within those services is the practice and development of forms of psychological therapy other than supposedly NICE authenticated simplistic CBT also under threat? Have mental health services been seriously undermined by IAPT? If the answers to these questions are in the affirmative, what action should the BPS take and what are the implications for clinical psychologists generally?

We are now under another government than one under which the NHS deteriorated so badly. Unfortunately this current government began in a way beloved of politicians, by instituting yet another reorganisation of the NHS. It has also recently brought in an Act of Parliament allowing aspects of health care to be put out to tender. Will that mean that clinicians can once more exercise their knowledge and skills in organisations that support good practice, or will they come under increased pressure, whether from private companies whose priority is profit (and who employ staff as cheaply as possible) or from centralised government diktats, targets and control? Will there come about all too often a combination of mismanagement, bad private business and bad government regulation and control?

The chairman of the Care Quality Commission has recently said: 'The whole culture of the NHS became so focused on targets that it obscured what real quality was about…' The Care Quality Commission is going to publish 'Ofsted style' ratings of hospitals. Will these be useful ratings and promote actual good care? As a parent, I witnessed the decline of school education under the regime of Ofsted, SATs and ratings, so I am very sceptical. Will the CQC and its ratings actually get rid of an absurd target culture in the NHS or merely replace it with another version?

Finally, I have no doubt that very serious decline in the NHS occurred as a result of the actions of the Labour government, combined with the growing influence of bad management practice. However, I have no confidence that the present government is any better, nor that such bad management practice has been adequately and widely recognised for what it is.

**Ian Wray**
*Sheffield*

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## FORUM SURVIVAL GUIDE

Recently I escaped a very soggy Oxford to make it down to London for a symposium on 'Increasing value, reducing waste' in research, marking a special issue of *The Lancet* (see tinyurl.com/qelvgsc).

I was excited by the symposium because, although the focus was on medicine, it raised a number of issues that have much broader relevance for science, including pre-registration of research, criteria used by high-impact journals, ethics regulation, academic backlogs, and incentives for researchers. It was impressive to see that major players in the field of medicine are now recognising that there is a massive problem of waste in research. Better still, they are taking seriously the need to devise ways in which this could be fixed.

Iain Chalmers (James Lind Initiative, Oxford) presented one of the most disturbing slides of the day, showing that although many studies had firmly established the effectiveness of a treatment to prevent bleeding during surgery by around 2002, a further 20 studies including several hundred patients were reported after that date. Researchers often don't check the literature to see what has already been done, so there is wasteful repetition of studies. In the field of medicine this is particularly serious: patients may be denied the most effective treatment if they enrol in a research project.

In psychology and neuroscience I think there's more of a problem with *lack* of replication. But there definitely is much neglect of prior research. I lose count of the number of papers I review where the introduction presents a biased view of the literature that supports the authors' conclusions. For instance, if you are interested in the relation between auditory deficit and children's language disorders, it is possible to write an introduction presenting this association as an established fact, or to write one arguing that it has been comprehensively debunked. I have seen both.

Is this just lazy, biased or ignorant authors? In part, I suspect it is. But I think there is a deeper problem, which has to do with the insatiable demand for novelty shown by many journals, especially the high-impact ones. These journals typically have a lot of pressure on page space and often allow only 500 words or less for an introduction. Unless authors can refer to a systematic review of the topic they are working on, they are obliged to give the briefest account of prior literature. It seems we no longer value the idea that research should build on what has gone before; rather, everyone wants studies that are so exciting that they stand alone. Indeed, if a study is described as 'incremental' research, that is typically the death knell in a funding committee.

We need good syntheses of past research, yet these are not valued because they are not deemed novel. Reviews also aren't rated highly in academia: for instance, I'm proud of a review on mismatch negativity in *Psychological Bulletin* in 2007. It not only condensed and critiqued existing research, but also found patterns in data that had not previously been noted. However, for the REF, and for my publications list on a grant renewal, I've been told to exclude reviews.

We need a rethink of our attitude to reviews. Medicine has led the way and specified rigorous criteria for systematic reviews, so that authors can't just cherrypick specific studies of interest. Through such reviews it has also encouraged us to think of research as an economical, cumulative, developing process, rather than a series of disconnected, dramatic events.

**Dorothy Bishop** is Professor of Developmental Neuropsychology at the University of Oxford. Read the full version of this column at http://deevybee.blogspot.com. This column aims to prompt debate surrounding surviving and thriving in academia and research.

# Psychosis – normal response to stress?

I read with interest the featured article by Helen L. Fisher titled 'Mind the gap – pathways to psychosis' (November 2013). It is very welcome to see the links between childhood maltreatment and psychosis being highlighted in current research, and the range and breadth of the material covered by Fisher demonstrates the complexities of evidencing causal pathways in this context.

Whilst the need to highlight the evidence linking childhood maltreatment and psychosis is clearly of great importance, there are some concerns that arise from this article which I hope to elucidate in this letter in the hope it might stimulate further discussion with other members.

The pursuit of causality, as discussed by Fisher, whilst of course laudable, risks obscuring the complaints people who experience psychosis actually describe in clinical practice. These complaints are the basis of meaning-making in psychological formulation and subsequent therapy and are usually clearly related to early developmental experiences. However, the perspective offered by Fisher, particularly in her concluding remarks, seems to suggest that background events and histories are merely peripheral to the problems people describe in association with psychosis, rather than of central importance.

Perhaps the first issue to clarify is that Fisher refers to childhood maltreatment and childhood sexual abuse (CSA) interchangeably throughout her article. Maltreatment clearly can refer to a wide range of experiences, including CSA, that can arise when taking detailed histories and developing psychological formulations working clinically with people who have experienced psychosis. Whilst not all clients describe traumatic experiences, close analysis of background histories and interpersonal experiences typically provide the keys to understanding the themes, directly or metaphorically, contained in psychotic content and associated distress. The focus on these key developmental factors therefore provides the basis with which we can make sense of psychotic experience and subsequently offer

Bring negative developmental experiences to the forefront of research

meaningful therapies. Thus, whilst Fisher accurately concludes that psychosis cannot be proven to be caused by CSA or maltreatment, this should not obscure the psychological significance of negative developmental experience in formulations relating to psychotic experience.

Thereafter in her concluding remarks, Fisher suggests we should not return to a 1950s and 1960s perspective where parents were blamed for their children's schizophrenia. Certainly, blame for psychosis is usually neither justifiable nor helpful, but again this emphasis on blame obscures the huge importance and significance of all forms of negative developmental experience in the understanding of psychosis.

Surely then, in contrast to Fishers conclusions, her impressive synthesis and summary of evidence should encourage us to bring negative developmental experiences to the forefront of research and clinical practice in psychosis.

It is a continuing and curious anomaly in adult mental health that background developmental histories are considered central in most manifestations of adult psychological disorder, but for psychosis there remains a resistance, even it seems amongst psychologists, to fully acknowledge that possibility.

Finally, the impressive body of psychological research in psychosis, surely now supports an important public health message: that psychosis is a normal response to stressful life events and that the task for us all is to try to understand such responses compassionately in the context of people's life stories.

**Dr Sean F. Harper**
*Consultant Clinical Psychologist*
*NHS Lothian*

## DEMENTIA – WORK TO BE DONE

In recent copies of *The Psychologist* there has been an outcry against the woeful lack of opportunities in the profession for well-qualified graduates/postgraduates. I believe that there has long been an over-supply of psychology graduates relative to the number of paid professional opportunities, so the lack of any apparent growth in the number of opportunities in the broad area of gerontology is puzzling.

In a recent BBC News report, Dr Doug Brown, from the Alzheimer's Society, said: 'If there is any low hanging fruit in dementia it is the care-based research. There's a lot we can do about researching the care and support we provide people with now so they can live as well as possible.' I can just about remember one article (some years ago now) in *The Psychologist* on this subject and believe that the Division of Clinical Psychology has some sort of subsection on the topic but little exposure beyond its own confines.

If the Prime Minister is serious about committing real money to dementia as an area, it is disappointing that there has been so little debate or evidence of serious action to demonstrate that psychology has something significant to offer. There is a clear need to research, design, implement and validate interventions that can maintain cognitive function or, at least, slow down the effects of the various types of dementia.

It is clear that drugs companies are struggling to come up with pharmaceutical answers any time soon. Is anyone making any effort to raise psychology's profile and to open up a new subdiscipline in this obvious growth area?

**Sandie Hobley**
*Sutton Coldfield*

# Adding 'my own small voice'

It was humbling when one's thoughts ('My manifesto in an age of austerity', September 2013) caused any reaction, let alone the strong emotions of Mareike Suesse (Letters, November 2013): enthusiasm at the message and a profound disappointment at my lack of detail on the implementation. Simon Stuart and colleagues shared a similar uncertainty on the 'how' of action, a critique of whether we have a collective voice and fears that we may be considered idealists (Letters, December 2013).

I share their uncertainties. My manifesto was as much aspiration as accomplishment, a daily test I seek to apply, made publicly to strengthen my resolve and maybe to strengthen the resolve of others. Living in Glasgow, it seems appropriate to reference Billy Connolly eulogising and quoting the Clydeside unionist Jimmy Reid: '…behind every one of these windows… a racing champion… a yachtsman… but he'll never know because… he'll never get the chance.' This reflects for me one of the great promises of our profession. We speak to the potential of people as well as the realities of lives and societies and the complex problems we face (climate change, technological change and balancing economic orthodoxy with human fulfilment).

Given this complexity, doubts about how (and how well) we do this are reasonable, though despair is not. Both Stuart et al. and Suesse ask who is listening or whether we have a voice (be that collective opinion or voices raised collectively). I believe we do. For example in the British Psychological Society's response to the new DSM (which saturated the evening news), the impact of Martin Seligman's positive psychology or Oliver James's 'affluenza' I see psychologists shaping and contributing to national and international debates.

So what I do is add my own small voice. I take every opportunity to speak and teach that I can (parliamentary groups, religious organisations, a select committee and professionals of all kinds). I have helped organise a response to proposed legislation and have written for *The Psychologist*! As many of my concerns are about powerlessness, I try to use my own power well and disperse it when I can.

If an individual is reasonably in disagreement with those in power ,one good place to practise presenting views is with a psychologist who understands how these systems work. Consequently I have role-played DLA tribunals and meetings with lawyers and medical consultants. I have supported individuals' arguments with government agencies and private companies. At times (I think) I have worked creatively with people, their families (and charities and social work departments and GPs and priests…) about how best to help those with psychological problems and make them part of a community. I have volunteered my time to organisations that would not otherwise have the input of a psychologist.

Maybe this is just normal clinical practice, though I remain optimistic that these small acts on my part, and bigger acts from colleagues, contribute to a vibrant and relevant profession.

**James Anderson**
*Glasgow*

# 1966 and all that

I read with great interest Emily Balcetis's article 'Wishful seeing' in the January 2014 issue of *The Psychologist*. I have always known that what we see is influenced by what we want to see, but imagine my horror when I read 'in the 1966 World Cup Finals, English soccer fans were certain they saw Geoff Hurst's shot fully cross West Germany's goal line even when the Russian linesman was equally sure that it had not'.

I was at that game and was standing behind the goal in question. Honestly, I felt the ball had not crossed the line, but to my immense relief, I'm sure I saw the Russian linesman signal that it was a goal. Have I been living a lie all these years? I believed that crucial goal gave England the World Cup and their finest sporting moment, but was it all just wishful seeing?

**Peter Thompson**
*Professor of Psychology*
*University of York*

***Peter Dillon-Hooper, Assistant Editor, replies:*** You are one of several readers who pointed out that it was indeed the Russian linesman who declared the ball to have crossed the goal line. This shows how the editing process can sometimes result in 'out of the frying pan into the fire'. The original referred instead to Frank Lampard's 'goal' against Germany in the 2010 World Cup. We saw this as not really a good example of wishful seeing because what the English fans thought they saw was what actually clearly happened. The replacement 1966 example was better, but we got part of it factually wrong. So don't worry – Bobby Moore really did lift the trophy that day!

## NOTICEBOARD

I'm a new *Psychologist* subscriber and was just hoping to obtain any copies of back issues of *The Psychologist* that anyone is willing to part with. I'm willing to collect them at their owner's convenience. I live in the southeast London area.

**T. Adigun**
*taofik.jr_adigun@yahoo.co.uk*

# Promoting psychology in public health

I was interested and encouraged to read the piece 'Increasing our influence on NICE consultations' (Society, December 2013). As both a psychologist and Director of Public Health I think the contribution of psychology to NICE, and to the field of public health, still has much untapped potential, and we have some inspiring leaders in academic and applied psychology (I won't embarrass them by naming them). And I think with the creation of the new public health system in England, and the increasing multidisciplinary vibrancy of the public health systems in Scotland, Wales and Northern Ireland, there is a significant window of opportunity for psychology to further and deepen its influence on better health outcomes for our population, from influencing NICE guidance to bringing insight to new ways of dealing with morbidity.

It seems evident that we are entering an era where the public health challenges facing us, from obesity to increasing prevalence of mental ill-health and the ever increasing reliance on healthcare services, need psychological not just biomedical interventions from the individual to the policy and social levels to impact on them.

Take for example, the issue of medically unexplained symptoms, the subject of Richard Brown's article ('Explaining the unexplained', December 2013) – significant cost to the NHS, an opportunity for psychology to guide good practice and even NICE guidance. Moreover, there are further research questions here. Richard's article made me ponder the seemingly intractable issue of reducing our ever-increasing spend in the UK on hospital readmissions for people with long-term conditions like heart disease. Could there be a psychological component linked to the same mechanisms of anxiety (etc.) as for medically unexplained symptoms? If so, could we do something on resilience and self-management to help people manage without hospital readmission when it's not strictly clinically necessary? This could save misery to patients and carers and millions to the public purse. And so far the reviews of evidence and strategies to tackle this subject are depressingly of common message.

It's surely right for us to engage more closely with the important work NICE does, but what about becoming a member of a NICE committee? Psychologists have strongly relevant skill sets. There are some psychologists who are members of NICE committees, but not enough.

The Society itself could usefully consider how it could do more to encourage stronger links between public health and psychology.

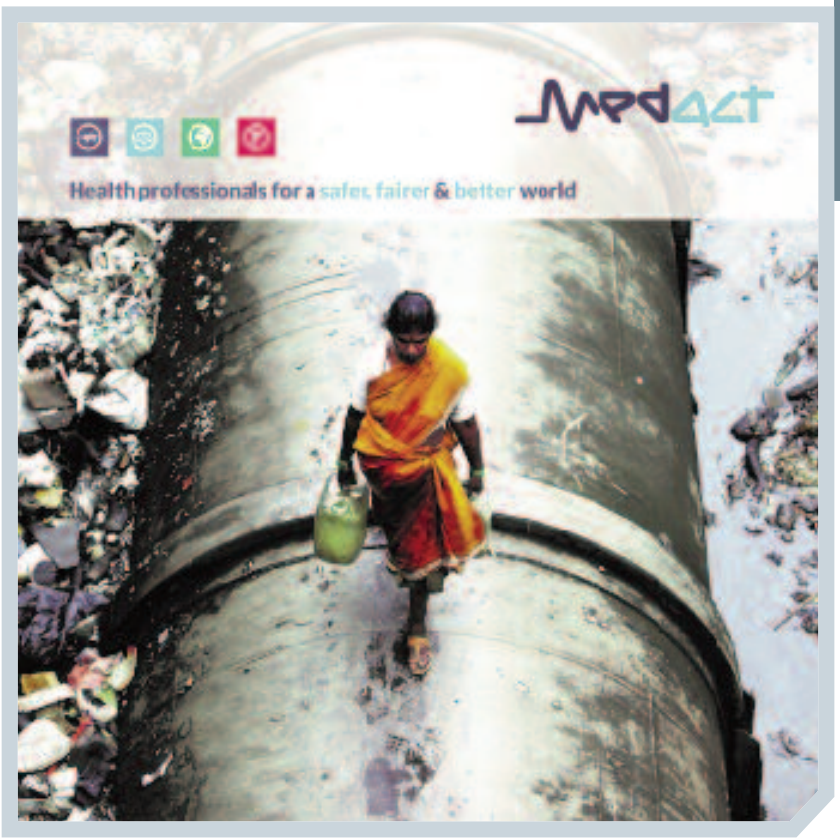
For my own part, I am busy trying to champion in a small way the importance of psychology in public health here in Hertfordshire, and to communicate to others some of the amazing work being done by psychology (such as Do Something Different – a psychological intervention which Public Health Commissioners are already taking up):

- A psychologist (Dr Falko Sniehotta) was our keynote speaker at a public health conference in December where over 300 local professionals heard the importance of psychology for people's health.
- A series of masterclasses on psychology and public health starts this year (the Division of Health Psychology and European Health Psychology Society have been enormously supportive).
- A network for anyone interested in health psychology and public health has now launched (www.linkedin.com/groups/Health-Psychology-in-Public-Health-5182547)
- We are including behavioural science and psychology in training for our public health workforce to designing interventions and programmes with psychological components.
- We are already commissioning resilience work for young people and, as we announced by advertisement in *The Psychologist* in January, intend to work with academic psychologists to create a behavioural sciences programme

There is more we could do, but perhaps the Society could bring a number of us together to identify how we can serve the interests of the public and further the aims of the Society.

**Jim McManus**
*Director of Public Health, Hertfordshire*
*Member, NICE Public Health Advisory Committee*
*(writing in a personal capacity)*

# Calling all health professionals for a safer, fairer and better world




The conference set health problems within a global framework connecting poverty, inequality, global warming, rise in infectious diseases, access to water, and war

Inequality erodes trust and breeds corruption, social pathologies which undermine health. Those with the knowledge, imagination and organisation should work to engender hope and courage – as social vaccines and treatments – for equality.

That was the message from David McCoy, a public health physician based at Queen Mary University, London, and Chair of the Board of Medact, a charity of health professionals for a safer, fairer and better world. He was speaking at its relaunch in November, as part of an impressive conference setting health problems within a global framework connecting poverty, inequality, global warming, rise in infectious diseases, access to water, and war, all massive threats to health in developed and less developed countries. It provided a platform for many single-issue campaigns with which MedAct is building alliances, among them London Health Emergency (Keep our NHS Public), and Spinwatch. As the speaker from War on Want said: 'Our choice is to stand up to power or to cosy up to power.'

In a session on torture, detention and human rights abuses, several speakers and audience members described writing medico-legal reports for torture survivors to support their asylum claims, and the deep injustices perpetrated by adjudication on asylum. There was criticism of the use of simple notions of PTSD, and concern was raised about very poor health care in UK detention centres, where inmates are retraumatised, and there are many incidents of self-harm and suicide attempts, and frequent hunger strikes in desperation.

Saving the NHS was a recurrent theme. The audience was encouraged to follow David Owen's National Health Service (Amended Duty and Powers) Bill to reinstate the duty of the Secretary of State to provide health care for all – that is, to restore the NHS. The day ended with a rousing speech by Dr Jacky Davis, co-editor with Raymond Tallis of *NHS SOS: How the NHS Was Betrayed – and How We Can Save It*, encouraging us to continue to fight for the NHS as the best healthcare system in the world.

A series of workshops is planned in 2014, on topics such as torture and human rights abuse, nuclear weapons, climate change and health, and tax and health. They aim to outline a programme of education and campaigning; develop policy and position statements; establish links with other NGOs; identify academics and experts who can serve as resources; and discuss possible funding for projects and campaigns.

Yes, the links of health to the various areas described here are complex, but we are reminded of the words of the Dalai Lama – 'Do good little by little; don't do nothing because you can't do everything.' Medact offers scope for action and influence alongside colleagues from all the health professions, and is holding workshops to develop policy and action plans. It would be good to see more psychologists involved. Go to www.medact.org to sign up.

**Dr Amanda C de C Williams**
*Reader in Clinical Health Psychology*
*University College London*
**Dr Danuta Orlowska**
*Clinical Psychologist*
*Guy's and St Thomas' NHS Foundation Trust*

# PsyPAG alumni

PsyPAG will have its 30th anniversary in 2015 and the committee has already started planning an interesting programme of celebrations during our 30th Annual Conference. The current PsyPAG committee feels that we have lost touch with our past representatives and would like to remedy this by inviting you all to get in touch with us and take part in our celebrations. If you would be happy to be interviewed about your career and the path you have taken or would be able to help us recreate the PsyPAG committee family tree, we are keen to hear from you! So if you know any other PsyPAG committee alumni, please encourage them to join our Facebook group, follow us on twitter (@PsyPAG) and join our alumni database to receive our annual newsletter and get the chance to network with other alumni.

**Patrycja J. Piotrowska**
*Chair of the Alumni Subcommittee*

obituary

# John Wattam-Bell (1953–2013)

Dr John Wattam-Bell, who was renowned for his research on the development of vision in newborns, infants and children, died suddenly on 30 December.

John's work contributed profoundly to our understanding of how this fundamental capacity emerges from early brain maturation as well as the ways in which it can develop abnormally in congenital disorders. His work was both practical and theoretical. He helped to develop many methods for assessing vision and visually guided behaviour in very young children, including eye-tracking and reaching tests, as well as pioneering 'video-refraction' techniques to measure long- and short-sightedness in babies and children. He developed innovative methods using electroencephalography and other techniques, such as brain imaging for measuring brain activity, and much of this research was concerned with building models of the early development of distinct pathways for processing 'what' and 'where' information in the brain. These pathways develop at different rates postnatally and are susceptible to distinct patterns of breakdown in conditions such as Williams syndrome, and John's research characterised these patterns in considerable detail.

Following training as a neurophysiologist in Oxford, John joined the Visual Development Unit at Cambridge and was a key member of the Unit for over 30 years. This world-famous research centre, founded by his long-time collaborators Professors Jan Atkinson and Oliver Braddick, moved to UCL in 1993 and had long-term support from the Medical Research Council and EU.

John's engaging personality and relaxed good humour made him a valued colleague and a thoughtful, generous source of advice and support for colleagues as well as for many collaborators worldwide, and he was an inspiring teacher. He played a significant leadership role at UCL as Head of the Developmental Science Research Department. John will be greatly missed by all who had the pleasure of working alongside him. He is survived by his wife Anne and sons Richard and Duncan.

**John Draper**
*Division of Psychology & Language Sciences*
*University College London*

obituary

# Donald Clive Kendrick (1934–2013)

Dr Donald Clive (Don) Kendrick, formerly a clinical psychologist at the University of Hull, passed away peacefully on 27 December 2013, aged 79 years, following a short illness.

After attending public school in Coventry (Bablake), Don studied psychology as an undergraduate at Liverpool University. He completed his clinical training at the Institute of Psychiatry, London, under Professor Hans Eysenck during the era of Sir Aubrey Lewis (viewed by many as the father of British psychiatry) and then took up an appointment as lecturer. He witnessed and was part of that revolutionary period in the early 1960s when British clinical psychology began to make waves by contributing major therapeutic breakthroughs in the treatment of anxiety, phobias, OCD and sexual dysfunction under the banner of 'Behaviour Therapy', centred on the Institute.

During the early part of his career Don worked in the animal laboratory (rats and cats) testing out animal learning theories which were the foundation of modern behaviour therapy. Much of the work related to the mathematical theories (concerning motivation) of the American psychologist Clark L. Hull. I wonder if this was an omen that Don's destiny would be in the city of Hull in the East Riding of Yorkshire. Don moved from his lectureship at the University of London to a similar position at the University of Hull in 1965.

Don was instrumental in founding the Hull Clinical Psychology training course along with the late Professor Alan Clarke and Mr Mike Wilde. The course was also revolutionary in that it was the first and only course to integrate the undergraduate psychology training with the three-year postgraduate professional training, creating a six-year programme quite similar in pattern to that of medical pre-registration training. Initially there was a fight with the conservative psychological establishment, who put obstacles in the way of official British Psychological Society recognition, and Department of Health accreditation. But the Hull aspiration was not to be denied and success was achieved in 1985.

Don was the founding Academic Director and led the course from its inception in 1983 until his retirement in 1996. The course continues as a tribute to its founding fathers, especially Don, training clinical psychologists for the NHS. This year marks the 25th anniversary of the course producing qualified clinical psychologists, and I calculate that more than 250 have been trained in Hull so far.

Don's other major achievement was the very well-known 'Kendrick Battery'. This was another pioneering breakthrough, this time in the diagnosis of dementia in the elderly. One of the challenges of declining cognitive function in older adults is the confound of clinical depression: depression can look very much like dementia. The Kendrick Battery is a set of psychometric tests that can diagnose dementia and distinguish it from depression. But this also provides a clue to Don's commitment to improving the lot of the elderly, which he did not only in his academic and research life but also as a clinician: he dedicated himself to working with people with dementia and other problems of later life.

Before his retirement he was a lively and well-known figure amongst the national clinical psychology training community. There are many hundreds of psychology graduates over many decades who have fond memories of his inspirational lectures and spontaneous oratory style. Many colleagues were first drawn to the clinical psychology profession because of Don.

**Professor Mike Wang**
*University of Leicester*