Psychology and the media – dawn of

It was most refreshing to read the Media page article in July's issue highlighting the need for psychologists to have a professional input into the media in light of the uproar surrounding Susan Boyle, who was frequently ridiculed on *Britain's Got Talent*, in scenes that bore an uncomfortable likeness to the Victorian 'freak shows' of days gone by. Clearly there is enormous public interest, and consequently a demand for 'expert' remarks; indeed, charities such as Mencap, and even the Prime Minister, have commented. So, as our professional body, where is the BPS in all of this, given that the psychological well-being, health and safety of the public quite clearly falls within our remit of expertise? It is unacceptable to continue to rely on individual psychologists to keep flying the flag for our profession.

Historically, the Society has argued that 'the BPS ethics committee is not in the business of approving or disapproving any [media] proposal' as it would be outside its remit (John, 2002). Yet it is precisely this absence of any official statement that gives rise to unqualified charlatans commenting under the banner of 'psychologists'. To the lay public, it is these people who are 'bringing psychology to society' and not the Society itself – in fact, we would go as far as to argue that the majority of the general public do not know of the existence of the BPS, unlike bodies such as the British Medical Association.

We fully acknowledge the relationship between psychology and the media is intrinsically delicate, and that the Society must be careful not to 'bite the hand that feeds us'. However, failing to campaign – or at least comment – in such circumstances, is incredibly damaging to the Society's credibility and the profession as a whole; the lay person can only presume we condone this sort of behaviour – or worse still, that we have no view on the matter. Is this really the message we want to convey? Surely headlines such as 'Simple Susan', and coverage legitimising the mocking of children and those with learning difficulties, cannot be deemed acceptable by the Society, given that one of our primary objectives is to 'protect members of the public'?

The nature of the mass media is currently evolving in response to the demand for reality television, and the emergence of 'overnight celebrities' such Susan Boyle and Jade Goody. Similarly, as the BPS has acknowledged, its own role will inevitably alter now the HPC has taken over regulatory matters. Consequently, there is no better time for us to re-address the Society's stance on its relationship with the media, given the media's power to convey our message across the world. Not only do we therefore 'have to have a presence in these media', as Graham Powell, former BPS President concluded (Sutton, 2005), we have to have the right presence. Statutory regulation can only protect the public if they know who we are, what we do and, crucially, what we do not do. If we are ever going 'to raise public awareness of psychology and increase the influence of psychological practice in society, industry and the economy', as outlined in the Society's 2004–2009 Strategic Plan, we must demand a higher – and better – media profile, and re-open the debate as to how best to pursue this.

The time is ripe, so we ask, what are we – the BPS – going to do about it?

Helen Hughes
Rose Challenger
Leeds University Business School

References

John, M. (2002). An even Bigger Brother is watching. *The Psychologist, 15*, 104.

Sutton, J. (2005). Meet the President. *The Psychologist, 18*, 204–205.

Response from Fiona Jones, Chair of the Media & Press Committee:

We are pleased that the issue of how the Society interacts with the media has been raised. These are exciting times for the

Tim Sanders

For the last five years we have been providing psychological services to television programme makers. We have worked with many production companies/channels and have found that growing numbers of producers and executives have begun to think about the psychological impact of their particular programme/series on its contributors. In fact, at the moment there is increasing emphasis being paid to psychological issues and most programme makers are striving, despite considerable cuts to budgets, to take the well-being of their contributors into account at all stages in the production.

We have been asked, for example, to think about the ethical and psychological implications of different programme formats in the early stages of production. This has included ensuring that contributors give sufficiently informed consent at the beginning of filming, especially in programmes that include an element of surprise (a 'reveal'). It has also involved consultation regarding the best way to support contributors in

a new era?

Society. As we move into the post-statutory regulation era there is great potential for repositioning the organisation as the voice of psychology in the UK. Throughout the development of the new five-year strategic plan the Trustees have listened to members, and there is an overwhelming view that communication will be an important focus for the future.

The Society has always been well respected and well used as a resource for journalists wishing to find psychology experts from its comprehensive media database. This reputation has been built up over 25 years. However, the fast-evolving media environment constantly presents us with new communication challenges, such as those highlighted in this letter.

Work has started already on improving our communications systems, including proposals to establish a spokespersons panel to help the Society have rapid statements on topical issues; improving the Society's website; improving support on ethical issues for those working with the media; and planning new promotional campaigns about the benefits of membership. However, this is just the beginning of a huge task.

Colleagues on the Publications and Communications Board and its subcommittees continue to work hard with our professional staff to help us make the most of the communication opportunities we have. We hope to report back on progress with these developments in future editions of *The Psychologist*.

Dancing without Freud?

I am surprised to read that John Waller's very interesting article ('Looking back', July 2009) contains no reference to the most important writer on hysteria and mass psychology. Freud, in collaboration with Breuer in *Studies on Hysteria* (1895), describes the causes and mechanisms of hysteria with many case examples. In *Group Psychology and the Analysis of the Ego* (1921) he explains how hysteria can lead to mass outbursts by identification with other people who are in the same position.

Wilhelmina Kraemer-Zurné
Fellow of the British Psychoanalytical Society
London SW2

John Waller responds: There are three reasons why Freud went unmentioned in my article. First, the notion that bouts of collective insanity can be shaped by ideas and beliefs is much older than Freud; indeed, several 19th-century attempts to explain the dancing manias (e.g. those by Hecker & Davidson) relied on just this kind of logic. Second, the name Freud is strongly associated with ideas of psychosexual development which have, in my opinion, little or no bearing on medieval or early modern outbreaks of mass psychogenic illness. Third, the theory articulated in *Studies on Hysteria* (1895) that hysterical symptoms in some fashion reproduce or express the nature of the original trauma is of little help in explaining the onset of medieval manias. Because Freud played such an important and often brilliant role in challenging the biological paradigm of the late 1800s I do, however, discuss him in my book on the dancing plagues, *A Time to Dance, A Time to Die*.

formats where they are voted off, and how to safeguard children's well-being in any format that includes separation from parents or carers.

We are also frequently asked to provide in-depth pre-show assessment (screening) of potential contributors including an examination of mental health and overall resilience to the issues inherent in filming and transmission. We have supported contributors during filming and provided aftercare and onward referral in programmes that have raised psychological issues for people after filming.

This is not to say that there is not room for improvement, and those of us currently involved in television are working hard to ensure that programmes meet the highest possible standards around consent, safeguarding and well-being.

We would therefore request that psychologists do not promote the general idea that programme makers are ill-informed or lack awareness. There may be some that are, but there are many who aren't. As my law tutors used to say, hard cases don't make good law, and the issues surrounding Susan Boyle are not necessarily representative of participants' experiences in 'reality TV'.

Thus, whilst television needs to continue to practise responsibly around the psychology of the contributors,we believe that psychologists might also benefit from learning a little more about the complexities of television and the processes involved in working creatively to make successful programmes. Perhaps psychologists might also like to talk to participants who have had good experiences of making television and report back on those as an important part of the overall picture.

Kate Alexander
Rachel Swann
www.screendoctors.co.uk

COMMUNITY NOTICEBOARD

I am researching the history of old age psychiatry 1940–1989 at the Wellcome Trust Centre at UCL. I am trying to find **copies of PSIGE newsletters starting in 1980**. Unfortunately the BPS library at Senate House does not hold any early issues. If anyone has old and now unwanted copies, I would be pleased to hear from you. I have arranged with the BPS library to let them have any copies I receive once I have finished with them.

Claire Hilton
020 8424 7715, claire.hilton@nhs.net

I am a writer and I am trying very hard to research 1970s mental health care, but from a user's point of view. In essay question form, my query is this: **If I were a 22-year-old, educated gay woman in 1975, living in the north of England, who was self-harming and depressed, what would be the path of care I would receive?** Who would I be referred to, how would I be treated as a person, and how would I be treated by medical and health professionals (who would not know I was gay)?

I have read everything I can find but have found nothing to help me answer this question specifically from the patient's viewpoint. Can anyone help or direct me to published sources that would help?

Anna Morris
say.hello.to.anna@googlemail.com, 0161 343 3371

Are you or have you been in individual psychological therapy/psychotherapy? Did you experience physical contact or touch with your therapist (a hug, holding of hand, stroking of head or upper back, etc.)? Was this an important and meaningful experience? Was the touch very positive or very negative?

I am a counselling psychology trainee at the University of East London. My research thesis is an exploratory study that aims to gain an insight and understanding of **the experience of physical touch (non-sexual) within individual therapy from the client's perspective and the meanings attributed to this experience**. I am seeking to recruit participants to interview about their experience. All information given during the interview will be confidential.

If you would like to participate or find out more, or if you know of anyone who might be interested, please contact me.

Sarah Page
0798 627 6684, sarahazelynne2004@yahoo.com

Campaigning questions

I am a campaigner on a number of issues where I seem to have hit some sort of unseen roadblock in trying to move things forward. To me, some of the ways seem straightforward, for example the social and economic benefits we might enjoy through regulating house prices and rents or the case for combining the government departments of health and sport because of their mutually beneficial roles. To that end I set up two website based campaigns (www.housepricecontrol.org.uk and www.fiftymetrepool.org.uk).

I have tried my very best to see my suggestions taken up by specifically saying that I do not need to be mentioned; that is, along the lines of the idea attributed to President Reagan, that you can get anything done so long as you do not want to get the credit.

But there seems to be some other issue involved in this. I would like to ask readers whether part of the difficulty in moving things forward is to do with ego and self, and whether, even if a solution is suggested, those with the means to implement it may be loath to use it, purely because they didn't come up with it in the first place.

Credit Reagan?

If this is the root problem, is the way forward to in some way imitate someone like Derren Brown, so that people 'think' of the idea themselves, meaning that they might be more motivated to run with it? And where does such a tactic end, and manipulation begin?

Bob Goodall
St Albans

IAPT – the clinical realities

Perhaps Clark et al. (Forum, June 2009) are right to say that Marzillier and Hall 'caricatured' IAPT and 'its place in the full range of psychological therapies' in their articles in the May issue. I don't know if this is so. What I do know is that Marzillier and Hall struck a cord with many clinical psychologists with whom I work and who are struggling with the clinical realities of a newly created IAPT service.

The most serious and problematic of these clinical realities is the refusal to acknowledge that people with complex psychological difficulties do not fit with the IAPT model, and that this represents a significant proportion of referrals to secondary care psychology services. The rigidity of the therapeutic model as applied is also a source of concern: I and many of my colleagues would struggle to recognise the authors' claim that IAPT in practice involves 'respect for the role of the therapeutic relationship' and a 'broad-based person-centred assessment'.

More important than challenging or refuting individual points the authors make, however, is the overall tone of the letter, which seems to be about silencing the critics. It is clear to many of us that IAPT is not allowed to fail – there is too much at stake politically and financially. One does hope, however, that over the next few years (if, as is likely, IAPT is still with us), a process of adaptation and modification can occur within services, so that the good and worthwhile aspects of IAPT can continue to be available alongside a recognition of the limitations of the model and the value of other therapeutic approaches. For this to occur, we need to have a culture in which criticisms can be voiced openly and taken seriously.

Noel Hess
Camden Psychotherapy Service
London WC1

Dementia diagnosis explained

Clearly, the author of the letter 'Testing delays in Alzheimer's treatment' (July 2009) has not received a helpful assessment or explanation of the procedures undertaken by their local NHS memory service. I will attempt to provide some information explaining the guidelines in this area.

First, the 'anti-dementia drugs' such as Aricept (donepezil) can (and should) only be prescribed to people who have been given a diagnosis of probable Alzheimer's disease. It would be inappropriate and unethical to prescribe such medication inappropriately as (1) it costs the NHS about £1000 per year per person; and (2) these are potent medicines with significant side-effect profiles.

A diagnosis of Alzheimer's disease is not easy to make. In fact, even the most rigorous assessments and skilled clinical teams only get it right about 80 per cent of the time. In fact, a definitive diagnosis can only be made at autopsy! Diagnostic investigations involve a complex range of procedures, which include a thorough clinical interview with the patient and a relative or carer in which a history of the symptoms and past medical history are considered against the person's personal background; blood tests and sometimes further medical investigations are needed to rule out potential medical conditions that may mimic the symptoms of dementia; and a brief cognitive assessment will also allow the clinician to establish whether any gross deficits are evident. Often, a brain scan and/or more detailed cognitive (neuropsychological assessments) are required if the clinician needs more information to make an accurate diagnosis. Detailed neuropsychological assessments will usually be conducted by a chartered clinical psychologist or clinical neuropsychologist. This involves between two and five hours of face-to-face testing depending on the number of tests given and the pace at which the person being assessed can work!

Therefore, it is not unusual for the assessment process to take a number of weeks, if not months.

Guidelines state that the commencement of anti-dementia medication should be prescribed by specialists in the field of dementia care. Once treatment is established, and has been found to be of benefit (in about 60% of cases), ongoing prescription arrangements can be made with the patient's GP.

This letter of enquiry raises an important issue about how memory clinics, which have received a significant boost in the recently published National Dementia Strategy (NDS), address the psychological needs of service users. Clearly, the author has been given insufficient time, consideration and support in coping with the emotional impact of this procedure; with all of the implications that these investigations and decisions bring. The NDS makes provision for psychologists as key members of memory clinics and memory services and this letter provides a case example of how important it is for psychologists to be employed as an integral part of such services. We need to ensure that service managers act on this recommendation.

Steve Boddington
Consultant Clinical Neuropsychologist
South London and Maudsley NHS Foundation Trust

FORUM WEB CHAT

The blogosphere is already abuzz in anticipation of the publication of the *Diagnostic and Statistical Manual V* (DSM-V), even though it's not due until May 2012. The American Psychiatric Association (APA) book generates so much interest because its contents dictate who is 'officially' ill rather than just odd or vaguely troubled. In the US this influences who can and can't make insurance claims for their psychological complaints, and often, whether people are prescribed medication or not. Pharmaceutical companies therefore have much to gain and lose according to which conditions are included or not in the new manual (*USA Today* reports that more than half of the 160 experts on DSM duty have industry links, and it seems a cap of $10,000 on contributors' industry-related earnings has done little to assuage concerns about bias). Even in the UK, the inclusion of a diagnosis in DSM can still have far-reaching social implications.

According to a debate at the APA's recent convention, one new condition that's apparently a contender for inclusion in the new manual is 'post-traumatic embitterment disorder'. The possibility has left at least one blogger incredulous. Writing online for *Psychology Today* (tinyurl.com/lfv8kj), Christopher Lane, author of *Shyness: How Normal Behavior Became a Sickness*, said there was plenty of reason to feel bitterness in the wake of the Bush era. 'But when justified anger at such incompetence is discussed as a sign of mental illness,' he said, 'it is borderline insulting, especially because half the reason for the discussion is to ensure that drug companies – anxious to prod their faltering revenues – can promise relief from the alleged disorder with yet more pharmaceuticals.'

A useful round-up of changes expected in DSM-V is provided by John Grohol writing at PsychCentral (tinyurl.com/n966ew). He says the most significant change will involve the addition of dimensional assessment of depression, anxiety, cognitive impairment and reality distortion, which are associated with many mental conditions. Overall, however, he warns that any changes to the new edition are likely to be modest. 'Why? Because the APA recognizes that you can't retrain 300,000 mental health professionals (not to mention the 500,000 general physicians) in the field to completely relearn their way of diagnosing common mental disorders.'

Never mind which conditions will be added or dropped, some bloggers have raised profound questions about the whole diagnostic process. For example, child psychologist Nestor Lopez-Duran, writing for Child Psychology Research Blog (tinyurl.com/n6pcqe), says the elephant in the room is impairment – the near universal requirement in DSM for a person to be impaired before they can be diagnosed. 'Does a person with asthma only have the condition when he or she is functionally impaired?' she asks. 'Why would a person with depression need to wait until the depression affects her work, personal life, and/or education before he/she is able to receive treatment and a proper diagnosis?'

Our own Vaughan Bell, writing for Mind Hacks, questions the value of diagnosis itself (tinyurl.com/mhvhhz). 'It's interesting', he says, 'that the public debate is currently focused on whether certain diagnoses should be included or not, rather than whether diagnosis itself is useful for psychiatry.' Drawing an analogy with the evidence-based cut-offs used to treat physical conditions like obesity and hypertension, Bell wonders why a similar psychometric approach can't be used for mental health. 'It is perfectly possible,' he says, 'to treat someone based on continuous measures of distress, impairment and functioning using evidence-based cut-off points to judge whether a particular treatment should be applied.'

Christian Jarrett is staff journalist on The Psychologist.
Share your views by e-mailing psychologist@bps.org.uk.

Assessing the Delphi method

While I enjoyed the description of the Delphi technique by Susanne Iqbal and Laura Pipon-Young (July 2009), I missed any detailed evaluation of its accuracy. I noticed that they cited the Haggard and Haste 1986 piece forecasting the state of psychology in 2010. I would think an evaluation of the accuracy of that forecast a year early might have been appropriate.

I also recall participating in a similar exercise (alas I forget the name of the principal investigator) run by the BPS in 1971 or 1972 when I was at the London Business School. How well did that forecasting exercise turn out?

Martin G. Evans
Cambridge, MA, USA

Editor's note: We are indeed hoping to publish a follow up next year! The other exercise was a 30-year delphi published by J.M. Smith in the *Bulletin* in 1975, so it might be one to return to in 2035.

Offensive language?

I continue to be dismayed and offended by the convention of *The Psychologist* to use phrases such as 'with schizophrenia' rather than 'with a diagnosis of schizophrenia'. The former reflects an epistemic error of confusing reality with what those with the power to do so call reality. A diagnosis is a social negotiation with unequal power relationships determining the outcome. It contributes to the stigmatisation of people labelled and in the case of neo-Kraepelinian categories evinces a form of pseudo-science.

Essentially you are reproducing a medical, not psychological, discourse, in a way that would not be acceptable if you were to reproduce a sexist or racist discourse.

David Pilgrim
Department of Social Work
University of Central Lancashire

Editor's note: Our current policy does indeed guard against sexist or racist discourse, but we tend to reflect the author's preference or the source we are reporting when it comes to 'with schizophrenia'. We would be interested to hear the views of other members prior to any eventual discussion at our Policy Committee.

And our survey says...

I have read Peter Murphy's letter 'Improving the science and practice of psychology' (Forum, July 2009). One of his suggestions is to ask people generally what are 'the 10 big concerns in their lives'. In fact, YouGov publishes monthly in *The Telegraph* a tracking study about people's concerns and their perception of the economic outlook. Horsesmouth (www.horsesmouth.co.uk) has a panel of over 15,000 people in the UK. It offers an extremely useful service whereby mentors help mentees in three main areas: Life, Work and Learning. The software Word Cloud can be used to present people's concerns visually; the larger the word, the more frequently mentioned, as in a current study of verbatim comments on addiction by FlyResearch, using mobile phone and internet samples.

I suggest that readers interested to know more about which issues are causing the most distress and how people discuss those issues would do well to check out the survey research world (e.g. Market Research Society: www.mrs.org.uk).

Liz Nelson
FlyResearch

Plausible rubbish

Deborah Cameron's article on male–female differences ('A language in common', July 2009) was a breath of fresh empirical air, cutting through the myths to which both men and women seem happy to subscribe. The multi-tasking myth, the hemispheric myth, the verbosity myth may all be a bit of fun in the pub, but when psychotherapists buy into the same myths, we need to be really worried. A personal experience illustrates this.

Notwithstanding being a rather convergent positivist cognitive psychologist, after a series of violent dreams which threatened what sleep therapists nicely refer to as my 'bed partner' (i.e. my wife) I was persuaded by my GP to see a psychotherapist at a clinic with an extremely high profile for treating the addictions of the rich and famous. So I had a session in which this man actually recommended me to read *Men Are from Mars…* as an informative text and seriously offered me a drawing to illustrate that women are hearth-carers, men are hunters. He diagnosed PTSD (related to the death of my first wife) and prescribed a bizarre mixture of NLP and that eye-movement quackery. I do not think he had heard of CBT.

I came away from that and subsequently self-diagnosed, quite wrongly, REM sleep disorder – which is potentially rather nasty. I paid for a proper all-night monitoring, and it turned out that my big psychological problem was sleep apnoea (otherwise known as a blocked nose).

What concerns me is that while I as a long term member of BPS and a natural sceptic could quickly see through this tomfoolery, how many people out there are being taken in by this plausible rubbish about male–female differences, when it is being promulgated by qualified (by someone) psychotherapists? And this in turn leads to the current debate about how psychologists should be registered…

Philip Adey
Developing Intelligence
London SW18

obituaries

Alastair Heron (1915–2009)

I first met Alastair as a newly qualified enthusiastic educational psychologist in Sheffield when he had been appointed to his last major job as a psychologist in 1975. At the age of 60 he had become director of a project in Sheffield intended to develop innovative services for people with learning difficulties. Alastair brought to this role a wealth of experience in different branches of psychology, having specialised in parenting and ageing in earlier posts. He had also been much travelled both as a child around England and to Canada for his secondary schooling and first jobs, and then across the continents. Alastair had worked in Zambia (or Northern Rhodesia as it was when he arrived), Melbourne and at the OECD in Paris.

The Sheffield project was flawed, and Alastair was appropriately critical: missing a wonderful opportunity for real innovation the funding was used particularly to finance buildings. His critical appraisal was very much in tune with the thinking of the group of educational psychologists who had just entered the profession and were starting their careers in one of the most progressive services.

Subsequently, I got to know Alastair personally when we were both members of the Division of Educational and Child Psychology Committee. Meetings were held in Birmingham, and we took turns to drive to meetings from Sheffield. This provided me a wonderful opportunity to discuss a wide range of issues with a senior member of the discipline who was not only very knowledgeable but also had a sympathy with the professional journey I was undertaking. I am forever grateful for those journeys and the learning that came from them.

Alastair was one of that generation of psychologists who had a wealth of experience, moving between fields of psychology and, in his case, between continents, being able to contribute to the early development of the new Zambia providing advice to Kenneth Kaunda, the new President, as well as working in Melbourne in a more conventional role as head of department. Alastair also contributed to the discipline as Treasurer of the British Psychological Society and President of the Australian Psychological Society.

From our discussions, and also from reading his book *Only One Life: A Quaker's Voyage*, which I strongly recommend, the importance of the Quaker influence is very clear. It shaped his thinking and his professional work, as well as his private life, which were driven by a clear set of values. His conscientious objection to fighting in the Second World War led him to become an ambulance driver in London and then to serve in the Friends Ambulance Unit in Italy. One posting was to Capri where soon after the war ended he encountered refugees who had been in the Dachau concentration camp.

Alastair described himself thus: 'Intellectually I have never been "top drawer", just a pretty adequate "upper-second"… A "Jack of all trades and master of none".' Perhaps so, but Alastair really did make a difference in many ways, and that is a legacy for those who knew him to celebrate.

Geoff Lindsay
Centre for Educational Development, Appraisal and Research
University of Warwick

Edgar Anstey (1917–2009)

Edgar Anstey died in his sleep at his home overlooking the surfing beach of Polzeath during the night of 1 June; he was 92. His son had been across from Sweden where he is an academic and had returned the day before. Although frail he was in good health, as feisty as ever, bemoaning the absence of a standing UN Peace Force and still writing to *The Times* and senior politicians about it, chairing the North Cornwall LibDem Constituency Party and playing a mean hand of bridge. It looks as if he had made his goodbyes then, an event he often said he joyfully anticipated, departed life to rejoin his wife Zoë, to whom he was utterly devoted.

After leaving Cambridge at the beginning of the war he became an infantry officer but soon, in 1941, was allocated to the newly established Army Directorate for the Selection of Personnel, where he did ground-breaking work on officer selection and understanding and increasing morale through team-building. After the war he applied this work to the selection of senior civil servants, helping to set up and running the Civil Service Selection Board. Becoming Head of the Behavioural Sciences Research Division enabled him to undertake and publish long-term follow-up validation studies of the effectiveness of these selection methods, his findings now providing the basis of and justification for contemporary management assessment centres. His work on morale led him to investigate staff appraisal processes, making a film with professional actors (including 'Bernard' in *Yes, Minister*) to show how the staff appraisal interview should be done.

The work of all the Army, Navy and Air Force psychologists during the war was impressive and led Edgar and others who had stayed in government service to push for the establishment of a permanent 'Psychologist Class'. This was achieved in 1950, providing careers for hundreds of psychologists as psychologists! Edgar subsequently became Chief Psychologist and held the post until his retirement in 1977.

His final years in government service were within the Ministry of Defence. He was always very cagey about what he was up to. The impression I had was that he was working on the psychological, social and economic implications of peace breaking out. But one anecdote he was proud to relate. During a visit to the British Embassy in Washington he was suddenly called to a meeting at the White House where President Kennedy and his chiefs of staff were debating the Cuban missile threat. After being advised by the generals to 'nuke Cuba' JFK turned to Edgar and asked for the British view. Edgar said he replied, 'That would be the end of civilisation.' Kennedy kept his cool and averted the crisis. There was always a hint in his eyes when he related these events that Edgar thought that he helped to save the world from catastrophe, a psychologist's crowning achievement!

G.A. Randell
Keighley

David Duncan (1926–2009)

I write to record the sad passing away of David Duncan on 12 March 2009, aged 82, of a sudden heart attack. At the time he was posting BPS chartership applications for those he had been assessing.

I had met David and his charming wife in his house in Ruislip just a few weeks earlier to be recorded by him for the BPS History of Psychology Centre's Oral History Project. I was met with the kindness, welcome and warmth that one always experienced with David. He was in his usual good spirits, looking forward to giving a paper at the History and Philosophy of Psychology Section conference and to becoming President of the local philatelic society, and going on a family holiday to Orkney in May. We were supposed to talk for about half an hour, but I stayed for more like three, laughing and enjoying ourselves, discussing numerous areas of psychology. David was a man who would put over a point with a twinkle in his eye and one would come away thinking 'I never quite saw it like that before!'.

As with many other young psychologists, David had a great influence on my career when I joined the Test Division of the National Foundation for Educational Research, as a young and still wet-behind-the-ears psychology graduate, in my first job. He was always one to offer me sound and wise advice.

David Duncan was a professional occupational psychologist for over 50 years. He joined the National Institute of Industrial Psychology (NIIP) in 1953 and the British Psychological Society in 1957 as a member of the Industrial Psychology and Social Psychology Sections. He was Senior Investigator and Tutor of the NIIP, responsible for running courses in psychometric testing. Later he was statistician, Manager of Surveys, Market Research and Selection for MSL, becoming General Manager of the Dublin company in 1965.

David was widely and actively involved in the work of the British Psychological Society, writing the first *Guidance for Directors of Courses in Personality Questionnaires*. This led eventually to the Society Steering Committee on Testing and Level A and Level B regulations. He also was Secretary of the Society Standing Press Committee and a member of the Council of the Society. He was a founding member of the BPS Occupational Psychology Division in 1971.

But more than this was David the man. Warm, generous, friendly and enthusiastic, but most of all a kind, good-humoured, softly spoken gentleman of the highest integrity, who always sought to empower others. As many people have communicated to his daughter Marjorie (herself an distinguished occupational psychologist), after his untimely passing away: 'He was one of the nicest people I have ever met', 'Full of ideas with deep ingrained values, always willing to put others first'. He could not but enthuse all he came into contact with.

Our heartfelt condolences go to his wife and family at this time. David Duncan, a remarkable psychologist, a remarkable man, and a deep loss to psychology.

Peter Saville
Saville Consulting

Douglas A.F. Conochie (1928–2009)

Psychologist, administrator, committee man, jazz pianist, cook, bon viveur, bridge fiend, and loyal friend, Douglas died on 14 April after a short illness.

His health had been failing for some time, but he had been able to celebrate his 80th birthday in September in style. This was typical of the man whom I knew as a respected, successful educational psychologist, but also as my big brother. When as a sixth former, I had shown an interest in becoming a psychologist, he encouraged me to follow in his footsteps and study at Aberdeen University, where we both came under the influence of the legendary Rex Knight.

Douglas set out on the route to psychology via the Med, and his first psychology post in 1958 was as an assistant at Ayrshire Child Guidance. From there, in 1961 he moved to a vacant post in Cambridge, where I was already ensconced as the sole child clinical psychologist. I was very happy to hand over the baton of educational work, but am sure to this day that some head teachers thought I had had a change of sex, since there were not many tall rugged Scottish psychologists called Conochie around.

From Cambridge, Douglas returned to take up the Principal EP post in Aberdeenshire and Kincardineshire, and by 1985 had become Regional Educational Psychologist for Grampian, a post he held until retirement in 1992.

Douglas was a keen organiser, as was said at his funeral, 'Someone has to be in charge, so why not a 6'3" Shetlander.' The BPS benefited from this talent. He served on numerous BPS committees and working parties, the Professional Affairs Board, the Scientific Affairs Board, the Executive and various committees of the Scottish Branch, and the Scottish Division of Educational & Child Psychology. He became a BPS Fellow in 1979. His final venture was as a patient representative member on a research group into post-stroke care.

Friendship meant a lot to Douglas. He always retained strong ties to his childhood friends, and to our immediate family. Wishing to practise what they preached, Douglas and his first wife, Pat had adopted their daughter Helen and then their son Peter, before welcoming the birth of their second son Iain. The family are now well established in their own lives and careers.

After Pat's far too early death in 1980, he married his friend and colleague Cairine Petrie. Douglas, both an excellent cook and host, enjoyed entertaining in Aberdeen and at their holiday home in Pennan. Cairine predeceased Douglas some years ago, but he retained these interests to the end of his life.

Though I could whack him at Mozart, I was always jealous of his ability to play jazz and swing piano. It was a huge regret to him that his restricted mobility in recent years, robbed him of this pleasure. As a young man he was always in demand at parties and had belonged to several bands long before the present trend for teenagers doing the same thing.

He will be missed by a wide range of friends, and colleagues, and family, and by none more so me. We could have our differences professionally – after all, a group of two psychologists means three opinions. Mostly however, I will miss him as a strong, supportive brother.

Jean Bechhofer
Edinburgh

Eric Bromley (1939–2009)

Eric Bromley, who died in hospital on 29 May shortly after his 70th birthday, was born in Stretford near Manchester.

Eric could have been an exceptional academic psychologist but chose instead to pursue his twin interests of patient care and politics. He qualified as clinical psychologist in 1967 and from that year on became a member of the Whitley Council staff side team that represented psychologists. His passions for health care, trades unionism and socialism led also to long tenures on the TUC Health Services Committee and Mersey Regional Health Authority. In the 1980s, as a national negotiator, Eric was instrumental in improving the career structure, pay and conditions of psychologists beyond recognition from what they had formerly been. In so doing, the profession of clinical psychology and psychotherapy became significantly more attractive careers, thereby ensuring that much larger numbers of patients enjoyed access to therapies.

Eric cared for patients. He established jobs, developed careers and inspired those around him. He taught on and helped develop the Liverpool University training course. He wrote a number of scientific papers and chapters in books. He was in the forefront of the move to establish clinical psychology as an autonomous profession. Eric was simply 'the main man' for psychology in the Mersey Region for many years and widely known nationally. He was elected Fellow of the British Psychological Society and at one time chaired the Psychotherapy Section at the national level.

From 1983 Eric was a founder member of the Mental Health Act Commission, later becoming Chairman of the Commission's North West Region and sitting on the Central Policy Committee. It was only last year that ill health forced him to resign from his duties as Mental Health Act Hospital Manager.

Eric retired from his post as Head of the Liverpool Psychology Service in 1994 although he continued working in a consultancy capacity until 2003. Retirement enabled Eric to become more actively involved in local politics: from 1995 he was a councillor in Warrington, and was made an Alderman of the town in 2007.

A lifelong friend of Eric's once referred to his 'quixotic impracticality' and those who worked with him tolerated timekeeping and a sense of direction that were not always immaculate. The profession, however, owes him a huge a debt and should appreciate the enormous contribution that Eric Bromley made to secure its current status. Thank goodness he found his way to meetings and represented us so well.

Eric was a good friend, a wonderful human being and an exceptional psychologist. He always impressed with his intellect, his interest in all aspects of psychology and philosophy, his problem-solving skills, his humanity, both individual and collective, his compassion for individuals with problems, and his fighting spirit. He was a truly inspiring person to know.

Eric is survived by Linda, his wife and partner for 45 years, their two sons and four grandchildren that he loved dearly. He was a gentle and wise man and will be deeply missed.

Peter Booth
St Helens
with Barrie Ashcroft and Barrie Jones