Smoking in mental health – time to quit

Why is it that smoking in mental health settings is still taken for granted, and that smokers with mental health problems are rarely offered comprehensive support to address their tobacco dependence? Contrary to common perception, mental health patients' motivation to quit can rival that of the general population, and they can give up smoking successfully when given appropriately tailored support (Banham & Gilbody, 2010; Siru et al., 2009). Given the high rates of smoking in this population and the resulting levels of smoking-related illness and premature death (Brown et al., 2000; Joukamaa et al., 2011) – with smoking being a major contributor to the immense health inequalities present in this group – one would naturally expect tobacco dependence treatment to be part of the standard care package for patients (West et al., 2000). However, even since the implementation of the smoke-free policy, there is very little evidence of comprehensive smoking cessation support for patients in NHS acute or community settings (McNally et al., 2006; Ratschen et al., 2009).

A pilot project aiming to implement a comprehensive tobacco dependence support and treatment service on inpatient wards and in the community, funded by the Department of Health as part of a bigger programme addressing smoking-related health inequalities, is currently carried out at the University of Nottingham. At the start of the project, we found that the treatment of tobacco dependence received very little (if any) attention in the settings covered. Hardly any standard instruments or procedures were applied to ensure that addressing smoking was part of the care pathway, and essential resources, such as protected staff time and routine stocking of nicotine replacement therapy, were missing. Additionally, common staff attitudes such as 'they can't quit,' 'smoking is all they have got' and 'it's not a good time for them to stop', combined with using cigarettes as an engagement tool, often meant that patients were not receiving comprehensive education and advice to enable them to make an informed choice about smoking.

Although it is early days, we feel the project has already made an impact. We have found that when given sufficient information on smoking, patients often make the choice to address their smoking. Our two smoking cessation advisers have experienced great interest in their service and successfully helped an encouraging number of patients to reduce (in a structured way with clear goals) and quit smoking in both acute and community settings. This, along with information sessions for staff (some of whom have

Ethics and sexual orientation

We are responding to Josh Schwieso's response (February 2011) to Sylvia Kapp's letter '"Treating" homosexuality is unethical' (December 2010). Dr Schwieso's position that the moral majority should determine what forms of sexual identity, behaviour and desire are deviant, pathological and warranting of correction is deeply disturbing.

Firstly, Dr Schwieso misquotes Ms Kapp as contrasting the broad spectrum of human sexual behaviour (including homosexuality) with that which is deviant and pathological; he misses the critical statement from Ms Kapp that homosexual identity and behaviour 'is, in itself, not problematic'. Clearly, there are behaviours, such as sexual violence, which are covered by the criminal law and occur in both heterosexual and homosexual contexts, but these are problematic because of the nature of the act rather than the sexual orientation involved. Further, Dr Schwieso conflates and confuses the terms ethical, criminal, deviant and pathological and argues that 'what is accepted as appropriate and desirable in society is measured against ethical norms'. However, rather than advancing any ethical principles to measure behaviour against, he refers instead to 'widespread criminal and pathological behaviours that *most people* [our emphasis] would see as needing some form of treatment'.

Secondly, Dr Schwieso argues that evidence that a treatment is ineffective does not mean that effective treatments should not be pursued. He compares homosexual desire with 'serious personality disorders' which are also 'resistant to cure'. Clearly, the wish to continue to search for an effective 'cure' for homosexual desire only makes sense in an internal world where such desire is

t taking it for granted


Tim Sanders

also quit successfully) on the links between mental health and smoking has fired up support from staff for our project, which has in turn had a positive impact on patients. We are really encouraged by our success so far and, supported by the mental health trust, we are working hard to make the service even more accessible and tailored to the needs of mental health clients, and to get clinicians on board. If we continue to make an impact, then we hope the initiative may last beyond the end of this nine-month project.

Our success to date highlights the question: Given that quitting is arguably the single best thing someone can do to improve their quality of life, why are mental health patients not given the opportunity of support to achieve this? Tobacco dependence and mental health/illness are intricately interwoven and we believe that tobacco dependence treatment should be given as much consideration as treatment for mental health problems. Could and should psychologists, with their expertise in behavioural support and mental health, begin to systematically challenge smoking in mental health and thus help to halt the increasing health inequalities their clients are facing?

Camilla Parker
Elena Ratschen
University of Nottingham

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seen as pathological.

Thirdly, he accuses Ms Kapp of focusing 'only on those forms [of non-heterosexual sexuality] approved by liberal societies'. We can see no references in Ms Kapp's letter to specific sexualities or behaviours and we are left to wonder what the forms of sexual desire or behaviour are that Dr Schwieso sees as exclusively homosexual and which cannot be characterised 'as anything other than deviant'.

The reasons for rejecting the practice of 'treating' homosexual desire and identity are clearly laid out in Ms Kapp's letter and are supported by the APA, the RCP and the BPS. The BPS Code of Ethics and Conduct (2009) states: 'Psychologists should respect individual, cultural and role differences, including (but not exclusively) those involving… sexual orientation.' The Professional Practice Guidelines for the BPS Division of Counselling Psychology (of which three of us are members) state: 'Practitioners will challenge the views of people who pathologise on the basis of such aspects as sexual orientation.'

We believe that the values and principles of respect, which are integral to our profession as psychologists, should extend to a celebration of the diverse forms of human experience, behaviour and identity and that any professional practice should be built on the goal of supporting each of us in achieving a positive identity and in being able to celebrate our differences as well as our similarities.

John Waite
Victoria Clarke
Andy Halewood
Naomi Moller
Department of Psychology
University of the West of England
Bristol

Persistence of neuromyths

Paul A. Howard-Jones's article ('From bran scan to lesson plan,' February 2011) provides an inspirational model for using neuroscience to develop teaching methods in school. However, as an educational psychologist I share the concerns expressed in the article about widely accepted 'neuromyths' within education and elaborated in Marc Smith's letter (March 2011). Marc Smith wonders 'why this kind of misinformation persists despite research to the contrary'.

I can start to answer this from my early experience as an educational psychologist. I picked up a range of neuromyths, including teaching to match learning styles and brain gym to integrate left–right hemispheric functions, from experienced educational psychologists and community paediatricians. Although not included in my training, I initially assumed them to be evidence-based, until I was asked by a teacher whether I would recommend brain gym. I tried to find some research to back up a recommendation and could find none. It was a salutary experience.

Marc Smith also asks how we as a Society might start to address misconceptions. From my own experience, I would suggest starting with initial training courses for psychologists so that they are fully prepared to tackle the misconceptions they will soon encounter. Another place to focus is the teaching of psychology in schools. Whereas subjects taught as part of the main curriculum are carefully designed to engage students in critical thinking, psychology – in the guise of study skills or social/emotional skills – can slip things in as 'fact' rather than scientific claims to be interrogated. Perhaps this is an area where the Division for Teachers and Researchers can raise awareness of issues, along with the Division for Child and Educational Psychology, and new generations of students could be equipped to critically evaluate psychological claims made in all spheres of life.


ARTICLE
From brain scan to lesson plan

Rachel Ingram
Wray, Lancashire

NOTICEBOARD

I am a trainee counselling psychologist at Regent's College. My doctoral dissertation is examining the experiences of counselling psychologists **working in English as a foreign language**. It focuses on the process of communication between the psychologists and the clients. I wish to interview (trainee) counselling psychologists who practise in English, but for whom it is not their mother tongue.

The study has ethical approval. The interview will take place at a convenient location for approximately one hour. If you would like to participate in this research, please contact me.

Anastasiya Golovina
golovina@cantab.net, 07746 746708

A group of researchers from a consortium of universities are researching the **relationship between the science and practice** of the profession. This is key to the identity of much applied psychology and central to the work of occupational psychologists. In order to help further our understanding of the way in which we work as scientist-practitioners, we are currently conducting a survey exploring the extent to which we adopt an evidence-based form of practice and the ways in which we bridge the scientist-practitioner divide. If you are a psychologist working in the field of business, industrial, work, organisational or occupational psychology we would be very grateful if you could take just a few minutes to complete it at the following link: tinyurl.com/483wcnq

The results will provide valuable information about how we operate as occupational psychologists and a summary of the main findings will be made available via the Division of Occupational Psychology website. Please also pass this request on to relevant colleagues and ask them to complete the survey for us as well.

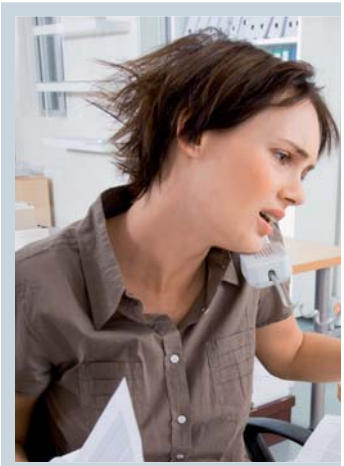
Jan Francis-Smythe
Centre for People at Work
University of Worcester

Is IAPT the only political option

Recent concerns about the sustainability of the Improving Access to Psychological Therapies (IAPT) initiative, in a context of dramatically imposed fiscal savings, provides us with the opportunity to have a hard look at the rationale for psychological interventions. We are of the view that the model enthusiastically embraced in the UK and now being adopted in Australia reflects a medical, not psychological, approach to common human unhappiness.

The prevailing design of services centres around the notion of delivering the optimal 'dose of treatment' to those people whose symptom scores are outside the normal range on standardised tests. Self-referrals to services are relatively uncommon. Those who miss appointments are followed up with letters reminding them of their missed appointment and admonishing them that they may be discharged from the service. People who stop attending before the clinician thinks treatment has ended are described as treatment 'drop-outs'. Those who do not fully embrace the activities the clinician presents to them are described as 'non-compliant', 'difficult to engage', 'treatment resistant' or 'lacking insight'. These practices exist despite the fact that recognising people's right to self-determination (including their right to withdraw from the receipt of services) is one of the core ethical values of the British Psychological Society (BPS, 2009).

These observations point up a medicalised approach to conceptualisation and intervention whereby, unquestioningly, unhappy people are turned into patients (Dowrick, 2008). But supposing that not everyone with 'presenting symptoms of anxiety or depression' is 'wasting their lives' (London School of Economics, 2006): what if they are experiencing a normal and intelligible variation on experience (human suffering)? Our suffering can be endured or comforted but it is not self-evidently a 'mental illness' to be 'cured', this time by conversational rather than chemical 'treatments'. Moreover, an original premise of the IAPT treatment ideology was that if we are able to 'cure' 'mental illness' then its 'sufferers' will return to work and incapacity benefits expenditure will be reduced. What if it is the oppressive work setting that needs fixing and not the individual? This is akin to treating shellshock in the First World War, with the hope of sending people back to the violent setting of their experience.



What needs fixing?

And does the economic rationale of this medicalisation

FORUM TWITTER DEBATE

This month's question via @psychmag –

If you were conducting a census to assess the psyche of the nation, what would you ask?

Who is responsible – you or 'them'? (@KarenPine)

Do you class yourself as in love with a partner? (@maddiebartlett)

How many friends do you have that you consider 'close'; how many friends do u have on SNs (fb etc) (corr'd w efficacy/well-being) (@aleksk)

Do you feel you have a purpose in life? (@peterkinderman)

Which 5 emotions do you feel most often? (@CraigHarper19)

What do you think is your key motivation in living your life? (@celticchickadee)

What are your top 3 Guilty Pleasures? (@realdaveakerman)

Honestly: do you hear voices? If so, what do they say? (@bluetreehouse)

Fake royal wedding invite? Tick boxes for yes/no. Invite for 'reception only' so it looks authentic. (@Jo_hockey)

Join the debates by following @psychmag at www.twitter.com/psychmag

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even make sense? Based on the evidence that about one in five or six people report symptoms of a common mental disorder in a 12-month period (London School of Economics, 2006) and less than half of those people access professional services for these problems, we have invested a large amount of public funds in increasing the services available. However, only a proportion of those people experiencing symptoms of a mental health disorder express a perceived need for treatment. In an Australian survey conducted in 2007 about 20 per cent of respondents reported experiencing symptoms of a mental disorder (Meadows & Burgess, 2009) and approximately 65 per cent of those people did not access any services. However, those who reported symptoms and had a perceived need for treatment and were not accessing services made up only 2 per cent of the sample. Whether we set our target on 65 per cent or 2 per cent of those people reporting symptoms of a mental disorder has enormous implications for public spending, especially as the cut off between normal unhappiness and a professionally codified disorder is not easy to make in the general population (Wakefield & Schmitz, 2011).

Perhaps a truly biopsychosocial approach is now warranted, rather than the type of model described above with its medicalised character (Pilgrim, 2002). A proper adoption of this would pay close attention to the individual and their interactions in the social contexts that they occupy. We would prioritise the agency of individuals and would recognise the fundamental importance of people being able to control what is important to them (Mansell & Carey, 2009). Moreover, we would not presume that the technological fix assumed in the IAPT approach to mental health policy is the *only* option for society. Unhappiness happens to us all, to varying degrees, during our lives for a large variety of reasons: being 'treated' for it is only one of many political and ethical scenarios.

Timothy A. Carey
Centre for Remote Health and Central Australian Mental Health Service
David Pilgrim
University of Central Lancashire

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FORUM WEB CHAT

Recent funding announcements made by several of the UK's main research councils prompted Jon Simons, a psychology lecturer at Cambridge University, to post an item on his blog in February headlined 'Is there a cognitive neuroscience funding crisis?' His question triggered a flow of comments, some even questioning whether the field deserves the funding it gets.

Simons compared the funding available when he became a lecturer in 2007 to today's situation in which the BBSRC, the Wellcome Trust and the ESRC have all either announced re-prioritisations away from psychology or ceased specific grant schemes, especially for budding researchers.

'It is obvious that new researchers are the most vulnerable and in need of support in developing their research careers,' he wrote. 'If such individuals feel that the UK funding bodies are making it simply impossible for them to do that, they will either go abroad or leave science completely. And if that happens, a cutting edge field in which the UK has been one of the world leaders within only the last few years, will face a future of rapid and inescapable decline.'

Several commenters shared Simons' concerns. Among them was Mark Baxter, a cognitive neuroscientist who studies the neural mechanisms of learning. Until recently he was based at Oxford University but he's relocated to the Mount Sinai School of Medicine, New York. He warned: 'In certain research areas (like mine) it's essentially impossible to find personnel in the UK with appropriate training, and once a base of well-trained research staff is gone, it's gone forever.'

Another commenter, Jon Roiser at the Institute of Cognitive Neuroscience at UCL, added the British Academy's Research Development Award to Simons' list of newly lost opportunities for early-years researchers.

But not everyone was sympathetic. David Colquhoun, an esteemed pharmacologist at UCL, said the question that needs to be asked is whether brain-imaging experiments 'are starving cheaper, more basic, studies of funds'. He suggested that focusing resources on cognitive neuroscience at the expense of more basic sciences is an example of 'trying to run before one can walk.' He also criticised a landmark paper in the field – Eleanor Maguire's demonstration that taxi drivers have enlarged posterior hippocampi. 'I felt ... that the discussion [of the paper] failed to consider properly the many confounders that bedevil the interpretation of this sort of observational epidemiology,' he said. 'It does worry me slightly that cognitive people did not seem to appreciate some of these problems.'

This drew a robust response from one of cognitive neuroscience's big beasts, Geraint Rees, based at UCL. He argued that it's unwise to judge the quality of science based on intellectually lazy newspaper reports (Colqhoun later retorted that his criticisms were of the journal paper itself). 'I don't think the kind of intellectual chauvinism that David espouses is very helpful,' Rees wrote, 'because it presupposes that one particular level of enquiry is right and that we can determine that in advance. This seems to me to be a very dangerous strategy when trying to understand a complex organ like the brain unless you are blessed with the power of God-like prescience.'

I Read and contribute to the debate at tinyurl.com/6fbka6x

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

MORE NEW DEADLY SINS

In the February issue, Christian Jarrett's article on The Deadly Sins proposed six new sins for the 21st century and called on you to fill the vacant spot. Here are some more of your suggestions.
If you missed the article and the subsequent 'sin week' on the Research Digest blog, see tinyurl.com/sinweek.

Exaggerated self-esteem with facebook obsession. The first symptom of this is usually shown by the loud exclamation 'Oh, didn't you know that Bob/Bill/Sam/Kate/Emma had broken her leg/got drunk/been potty trained/been on holiday? I put it on facebook.'

The person will seem confused. As their understanding of the world is that (a) everyone is on facebook and (b) everyone wants to know what is happening in their lives.

Tracey Jones
Stourbridge

'Fraping', otherwise known as facebook rape. The practice of obtaining another's password and posting photographs or comments on their wall, with the intention of causing for instance, hurt, embarrassment, ridicule or amusement. Some teenagers willingly divulge their password to 'friends' in order to participate in the 'game'. Since postings cannot be deleted, this could have serious consequences in an age where potential employers check on people's facebook pages, and where defamation of character online or cyber bullying are growing issues. Unwise postings could also invite unwanted attention, resulting in child protection issues.

Teenage emulation. Adults causing teenagers to cringe by attempting to emulate their mode of dress, musical tastes, pastimes or slang, including their manipulation of the meaning of words (e.g. 'blood', 'bro', 'wicked', 'shut up!'). This emulation is blindly carried out by adults with the aim of either hanging on to their youth or gaining credibility. Inevitably, this entails treating all teenagers as a socially homogeneous group. The reductionist characteristics monopolised on are predominantly those stereotypes portrayed in the media and popular culture.

Ros Napper
Andover

Over-expression of feelings in the media. This is often, but not always, committed by a celebrity letting the public know their response to an upsetting event, which can consume the media for days. Of equal concern/irritation is the misappropriation of the word 'devastated' to describe feelings more accurately described as disappointed, annoyed, etc. It would be considered devastating to lose a child but not, for example, to regain weight lost by dieting.

I blame Oprah.

Marie Stewart
Preston

Acquired a-manners – being too busy for common courtesies. Simple and quick acts of gratitude are declining in modern society. It is thought that these act as Skinnerian positive reinforcements for good behaviour. If, for example, another driver is courteous, you thank them and this encourages similar behaviour in the future.

Communal-agnosia – ignoring the importance of community. There is a definite loss of community in the modern world; particularly in urban areas. Community spirit shouldn't be underestimated as an important factor in any life. 'Neighbourhood Watch' schemes appear to me to be trying to readjust this deficit, but their effectiveness is, to my knowledge, unknown.

Ben Hunt
Undergraduate, Bournemouth University

High time for men?

With strange logic, Peter Branney and Brett Smith argue against the establishment of a 'Male Gender Section' because it would supposedly continue an entrenched idea that there are 'simply two sexes' (Letters, March 2011). In that case the Psychology of Women Section should be discontinued as well.

On the BPS website the Psychology of Women Section there are the following stated aims: 'Bring together everyone with an interest in the Psychology of Women; Provide a forum for the Psychology of Women in research, teaching, and professional practice; Increase awareness and action around gender and inequality issues within the British Psychological Society, Psychology profession, and the teaching of Psychology'.

There is no reason there should not be a Section with similar aims, focusing upon men rather than women.

Indeed, either there should be both Sections or there should be neither. If there is just one, how is this not discriminatory and sexist? It also needs to be pointed out that there are 11,508 men and 35,741 women who currently have BPS membership, very far from equal numbers. Moreover, university entry generally, but especially in psychology, is now increasingly dominated by young women, and boys lag behind girls in exam results in school. How are these facts not the result of anti-male sexism, at the very least in institutionalised form within the educational system in Britain?

It seems high time there was a Psychology of Men Section, to 'increase awareness of and action around gender and inequality issues'.

Ian Wray
Sheffield

The interesting debate over the need for a Psychology of Men Section continues. Most recently, Peter Branney and Brett Smith question this need on the basis that a male section would entrench dualism with respect to constructed gender categories of 'male' and 'female'. I was very happy to see such theories discussed within the pages of the psychologist as they are not widely understood and offer important insights into the fluidity of 'gender'. However, I felt that their argument actually strengthened the case for a Psychology of Men Section, as opposed to their view, that such a Section would reinforce dogmatic assumptions.

They suggest an online forum for the topic, but I would like to know what they would call this and whether it would be possible to avoid reference to men? I would also be interested in their opinion on the existence of a Psychology of Women Section. Like Peter Branney and Brett Smith, I am of the view that we exist in a society with entrenched and unhelpful views of gender but, without a Psychology of Men Section, how can we address issues such as the significantly higher suicide rate in men, the lower life expectancy and the higher rates of drug abuse and likelihood of imprisonment? Male terminology for such a section is not ideal, but it would offer a starting point and the space to address many issues, including those expressed by Peter Branney and Brett Smith.

Tom Grange
The Northgate Clinic, Edgware Community Hospital

Forces children: both seen and heard

Lynne Hipkin expressed her interest in hearing from 'any psychologists currently working with forces families' (Letters, January 2011).

Contrary to the assertion that the Ministry of Defence (MoD) does not acknowledge that service children may need support, we can assure her that this is, of course, recognised by the MoD. The MoD employs clinical, occupational and other applied psychologists, whose jobs involve psychological research, professional advice, policy development, and treatment of serving personnel and their families.

For centuries, the military has understood that fighting power is influenced by the well-being of the immediate family of service personnel. Indeed, current Army Welfare Policy states: 'The British Army recognizes that supporting soldiers' families contributes directly to a soldier's operational effectiveness. The British Army is therefore committed to ensuring that all Army families are provided with additional support, both during their soldier's deployment and in the event of a family emergency.'

The importance of the family is not simply an Army issue. Tri Service policy acknowledges the central role of the family too: 'The critical connection between welfare and operational effectiveness affirms that the support provided for Service personnel and their family is "core" Armed Forces business.' Furthermore, the MoD has a Director Children and Young People, whose team's function is to provide support and promote the well-being of service children.

As the military acknowledge that family welfare is core business it is not surprising to learn that military psychologists, from different disciplines, conduct a considerable amount of work involving families. In addition, the MoD commissions work from independent psychologists and collaborates with others in the UK and overseas, consequently the MoD has access to a huge body of research in support of service families.

The psychological research underpinning MoD support for families is varied. For example each service conducts Service Families Attitude surveys (developed and analysed by psychologists) so that the views of spouses can be heard and family policy can be evidence-based. Recent work commissioned by the MoD, conducted by Haldane-Spearman Consortium psychologists, includes: work on the impact of separation on serving personnel, which identifies the impact on children and suggests measures that the MoD should make to improve their well-being; a study into the provision of welfare support to families during separation, comparing the MoD with other employers of personnel deployed overseas; and a literature review of support to parents with young families.

In addition, the King's Centre for Military Health Research (KCMHR) has conducted a number of studies, funded by the MoD, looking at communication with service families, the impact of the deployments to Iraq on service families and negotiating work–life balances in the armed forces. Currently, KCMHR is engaged in a major study on the impact of children of having a father in the military. The study will help policy makers provide better for the needs of children of military personnel.

Military psychologists work routinely to provide advice to service personnel who deal with support to service families during bereavement; military welfare organisations; chaplains; and teachers at schools that educate service children. In British Forces Germany (BFG) educational psychologists and social workers work directly with children and families and work closely with BFG Health and Psychiatric services which includes clinical psychology. In the UK, MoD social workers provide support to the families of patients and work closely with all military mental health professionals, including clinical psychologists, in care planning and with the delivery of mental health services.

Finally, it should be noted that research involving service children as participants requires ethical approval and an independent MoD Research Ethics Committee scrutinises research protocols.

We trust that this reply has reassured readers of *The Psychologist* that the MoD does understand that 'a serving soldier's family is perhaps the most valuable resource in terms of his or her well-being' and that we consider that this is 'significantly recognised in terms of psychological research'.

G.J. Walker-Smith
Head of Profession for Occupational Psychology, MoD
J.G.H. Hacker Hughes
Head of Profession for Clinical Psychology, MoD

Normal reporting

I read with interest the letter by Alexis Makin ('Deadly normalisation?', March 2011). Makin responds to a 'Media' page I had written, on behalf of the BPS Media and Press Committee, about a seminar on improving the mental health among UK military personnel. Makin raised the idea that this 'Media' page, in addition to an advert for the Royal Navy that appeared in the same edition, may have inadvertently contributed to the normalisation of state violence.

I would like to pick up on Makin's comments about the necessity of speaking out against institutions that may be seen as morally responsible for the suffering of military personnel. Such political comments are beyond the usual scope of the media page; its job is simply to report on psychological topics that have attracted some degree of media attention or are to do with the promotion of psychology as a discipline. The goal is not to discuss political issues such as the legitimacy of foreign conflicts. This is not to say that political issues are not important, but that there are other forums in which to discuss them.

Makin's own letter demonstrates apparently strong personal opinions against the idea of foreign conflict (e.g. referring to 'imperial violence in Afghanistan') and the need for psychologists to speak out against this (e.g. by following a more 'preventative approach'). I applaud the strength of these convictions and I believe that psychology does indeed have a role to play in politics (such as the APA's comments about torture: tinyurl.com/4tke96q) but a 'Media' page reporting on an event designed to help UK service personnel is not the place.

Mark Sergeant
BPS Media and Press Committee

obituary

Fay Fransella (1925–2011)

Professor Fay Fransella, who has died aged 85, was a passionate advocate of personal construct psychology (PCP). Indeed, she considered that her life was transformed when, while working on her PhD at the Institute of Psychiatry, she came across the writings of the originator of this approach, George Kelly. At the time, she considered that she was in a 'psychological desert', but found in Kelly's theory a psychology that, unlike those to which she had been exposed, did not treat people as objects but rather as inquiring men and women, who need not be victims of their biographies.

Fay's whole life exemplified the exploration of alternative constructions of the world, and the capacity thereby to reinvent oneself, that is central to PCP. She was born in Jersey, but her childhood was disrupted by the death of her mother when Fay was six years old, and the family's evacuation prior to the German invasion. After leaving school before the sixth form, she trained as an occupational therapist, obtaining her first job at Horton Hospital in Epsom, where by the age of 30 she was head of the largest occupational therapy department in the country. She was nevertheless dissatisfied, and took evening classes to obtain the O- and A-levels necessary for acceptance on a psychology degree. She completed this degree at University College London and then trained in clinical psychology at the Institute of Psychiatry, remaining as a lecturer.

During this period, she met Don Bannister, with whom she introduced PCP to a whole generation of psychologists by lectures and inspiring books such as *Inquiring Man* and *A Manual for Repertory Grid Technique*.

Fay, Don, and others formed the 'Kelly Club', and in 1964 she met Kelly for the first time when he visited Brunel University. She was later instrumental in organising the Second International Congress on Personal Construct Psychology (having decided that the 1975 Nebraska Symposium on Motivation, focusing on personal construct psychology, should be designated the first such congress), an event that has continued biennially ever since. In her opening address to the Congress, she made no secret of her ambitions, asserting that 'We are making a take-over bid for the discipline

obituary

Ann Davies (1938–2010)

It was with enormous sadness that friends and colleagues received the news of the death of Dr Ann Davies on 22 December after a two-year battle with cancer. She continued to work full time as a Consultant Clinical Psychologist until shortly before her death, and the courage with which she faced the challenges of her illness was inspirational.

Ann had been a leading light in psychology of ageing since the 1970s. She was a true scientist-practitioner, qualifying whilst an academic as a clinical psychologist, conducting applied research capable of making a difference to older people's lives, and bridging the gap that too often exists between academia and clinical practice

Ann's career began with a first class honours degree at the University of Liverpool in 1961, after which she joined the prestigious Research Institute for Studies on Occupational Aspects of Ageing, in Liverpool. After her doctorate she acquired a lecturer then a senior lecturer post in the School of Psychology. Her contribution to psychological studies on ageing was recognised by the granting of the status of Fellow of the BPS as early as 1977. The many undergraduate and postgraduate students who worked on research projects with her will remember their initial trepidation upon realising the high standards and attention to detail which were required of them; but all would eventually be swayed by the genuine care Ann invested in developing their academic thinking styles, most particularly an appreciation of the multifactorial complexities involved in studies of the psychology of ageing. Over the last few years her research into Parkinson's disease, heart failure, stroke and depression focused on caregiving, which she conceptualised as a complex dynamic, dyadic process, paying attention to both positive and negative interactions.

On retiring from the University of Liverpool in 2002, Ann became a full time Consultant Clinical Psychologist split between older people's mental health services and stroke services. She continued in this role, mainly with Mersey Care NHS Trust, until her death, engaging brilliantly with the roles of clinician, teacher, supervisor, mentor, inspirer, researcher and dogged service developer. Many would say that she was the hardest working

of psychology' and that (at the time of the 'cognitive revolution') 'If behaviour therapy is up for grabs – we must be in there doing the grabbing!'

In 1971 Fay was appointed Senior Lecturer, and subsequently Reader, in Clinical Psychology at the Royal Free Hospital School of Medicine, University of London. On retirement, she set up the Centre for Personal Construct Psychology. She was a founder member of the UK Council for Psychotherapy, and offered the first UKCP-accredited training courses in personal construct psychotherapy, as well as a 'diagnostic research' approach to organisations. It was later transferred to the University of Hertfordshire, where Fay was awarded a Visiting Professorship. She generously contributed to the university's Doctorate in Clinical Psychology until well into her eighties.

Fay's achievements were recognised by the British Psychological Society with the award of a Fellowship and by her being one of 12 psychologists invited to provide reminiscences in a book marking the Society's centenary. Her chapter in this book is but one of over 100 publications. She is perhaps best known for her research demonstrating that stuttering is the stutterer's 'way of life', whereas fluency is relatively meaningless. Her PCP analysis of, and therapeutic approach for, this condition has a much broader applicability. Indeed, it is clear that for Fay PCP was her 'way of life'. She is survived by Roy Hodson, whom she married in 1968.

David Winter
University of Hertfordshire

person they have known, putting in many hours more than she was contracted for.

As a clinician, Ann imported the keen, analytical, empirical, knowledgeable, rigorous and deeply inquisitive mind of a researcher. Crucially, on an interpersonal level, she also had a really good way of being with service users. She had empathy, warmth, commitment, the capacity to actively listen, the ability to get to the heart of the matter quickly. She had a rich appreciation of the interweaving factors influencing ageing, which she applied to her clinical formulations. In her last year she wrote, 'My style of therapeutic intervention is broad-based, but rooted in life-span developmental, inter-generational, cognitive, behavioural and neuro-psychology.'

Ann's professional legacy rests with all the people she taught, influenced, inspired; and in her massive contribution to what she called 'the literature' – the corpus of research papers and book chapters.

She is survived by her husband, three children and five grandchildren, and will be greatly missed.

David Powell
Consultant Clinical Psychologist, Merseycare NHS Trust
John Downes
Reader in Clinical Neuropsychology, Chair of the School of Psychology SMT, University of Liverpool

obituary

Roger Holdsworth (1935–2011)

I am deeply saddened to write that Roger Holdsworth died on 6 February 2011 at the age of 75. Roger and I were business partners for over 25 years, first meeting at a BPS Occupational Division conference in London in 1974. We established Saville & Holdsworth Ltd (now SHL group) in 1977, Roger working from his house in Putney and in my home in Esher, Surrey, before we moved into our first office in 1980.

It was true that we together personally packed our original test materials from our proverbial garages in the early stages of our business. Roger was a man of enormous energy, enthusiasm and intellect, speaking five languages fluently. He had tremendous capability to write effortlessly. One of the first in-trays in the UK for use in assessment centres, called Hexagon Taps, was written by Roger, despite its complexity, in just a few days and is still in use at this current time. He invented many original cognitive ability test formats and provided the structure to the company that was essential for it to grow. This enabled the flotation of the company on the London Stock Exchange in 1977, which he personally organised and drove forward.

Roger was born in Birmingham on 12 September 1935 and was educated at Marlborough and Christ Church College Cambridge, where he graduated in natural sciences specialising in psychology. He spent seven years with the Institute of Applied Psychology in Sweden. He then joined the National Institute for Industrial Psychology (NIIP) in London and then left to work as an independent consultant assessing senior executives.

Roger always felt that the NIIP would be overtaken by more commercial rivals. He would tell the story that when he asked the then Director which NIIP tests sold most widely the reply came back: 'We are not in trade, you know!' He was capable of working 100 or more hours per week, and we caused quite a stir when in 1978 we actually had the audacity to produce a professionally designed brochure of our services as occupational psychologists. Despite the reaction 'Should Psychologist be doing this sort of thing?' – we pushed on. Roger was always the first to see the funny side of an issue, and I personally never saw him down or in bad spirits. He could overcome even the most difficult of problems with buoyancy. In 2002 we were removed from the SHL board when we believed that the wrong strategy had been employed and the share price had collapsed. Roger then went on to form a new company Talent Q.

Roger was a founder member of the BPS Division of Occupational Psychology, a Fellow of the British Psychological Society and a visiting Professor at Hangzhow University in China. Roger Holdsworth revolutionised occupational psychology in the UK and globally. In the 1970s jobs in occupational psychology were extremely rare, yet he had the fortitude and intelligence to progress the profession. Many have commented upon his enormous contribution to applied psychology and, as they have said, it is the end of an era. He will be sadly missed.

Our condolences go to his wife Marina and his three sons by his first marriage, Mark, James and Chris.

A memorial for Roger was held on 10 March at the Russian Orthodox Church in London. The family have requested that any donations should be made to Cancer Research UK.

Peter Saville
Esher, Surrey