Psychologists against austerity

We are concerned about the impact that government 'austerity' policies are having on the lives of those who use our services. A series of reports have demonstrated clear links between economic policies and mental health, and there is strong evidence that widening gaps between the richest and poorest in society have long-term detrimental effects (Marmot, 2010; Wilkinson & Pickett, 2009). Despite this evidence, government policies have had disproportionate effects on the poorest in society via cuts in welfare benefits and cuts in educational, social and healthcare services.

It seems to us that the policies of the major political parties are largely aimed at reducing public expenditure rather than addressing the widely acknowledged causes of the 2008 financial crisis – poor regulation of the financial sector and an unbalanced economy – or finding alternative ways of raising revenue (e.g. countering tax avoidance by large corporations). As a recent New Economics Foundation (2013) report identifies these policies are justified by well-worn narratives that 'austerity is a necessary evil' and that society is composed of 'strivers and skivers'.

Psychologists who work with the poorest in society know that this rhetoric is inaccurate and blames the victims of the crisis. We think that the mark of the 'good society' is how it treats the worst off in society. As a result, we feel that we have a responsibility both as professionals and as citizens to speak out against cuts to welfare benefits and to public services and to advocate for fairer economic and social policies to improve public mental health.

We know that many members of the Society and other readers of *The Psychologist* may share these views but feel they are powerless. However, there will soon be a general election campaign. If we act in a concerted and collective manner our efforts can have more impact than acting on an individual basis. We propose that readers inform local politicians and their constituents of the damage these policies and narratives are having and to advocate on behalf of those marginalised in society. We suggest they:

- write a brief personalised letter to their MP giving examples of the detrimental effects of 'austerity' policies and advocating for a fairer approach both in terms of policy and rhetoric;
- write to electoral candidates making similar points – for example, the criteria by which you will you be judging their policies; and
- write to local newspapers making similar points.

In addition, we call on all member networks of the Society (especially the Divisions representing applied psychologists) to consider developing a non–party political statement identifying the problems of current 'austerity' policies and proposing criteria by which manifesto commitments will be judged.

In order to support such action we have set up a website – https://psychagainstausterity.wordpress.com – with links to further resources, an opportunity to share experiences, key issues to address in letters to MPs and candidates, etc.

David Harper
University of East London
with Sally Zlotowitz, Aaron Roberts, Carl Walker, Vanessa Griffin, Laura McGrath, Edward Mundy, Tamsin Curno, Sam Thompson, Katie Wood, Mel Wiseman-Lee, Chris Jones, Dilanthi Weerasinghe, Luke Hendrix, Jonathan Buhagiar, Aayesha Mulla

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Off the Record, now in its 50th anniversary year, provides free, confidential mental health advice and support to young people in Bristol. As its chief executive, I see increasing numbers of at-risk young people coming through our doors.

There's no magic wand for someone experiencing a mental health difficulty save timely access to appropriately resourced services. And since we lack the political introspection to ask more profound questions about the health of our increasingly unequal socio-economic world and the aetiology of mental ill health more specifically, this basic issue of resources seems to me the most urgent place for our politicians to fix their gaze.

It's encouraging to hear leading politicians now talk and pledge openly about mental healthcare. It's a scandal that it has taken near

systemic collapse to achieve this, and when even Minister of State for Care and Support Norman Lamb is able to conclude that children's mental health services 'are not fit for purpose' (after three years under his watch) it is clear we're about to hit bottom.

Multiple investigations and reviews have found the same failings, the predictable result of chronic long-term underinvestment in the face of growing demand and complexity (have a read of last year's Centre For Social Justice report (tinyurl.com/kuahap2) and the recently concluded inquiry by the House of Commons Health Committee (tinyurl.com/qf8ge83) if you want to understand quite how bad things have got).

Last summer the government established a task force to look at the way in which child and adolescent mental health services are commissioned, but a quick glance at a few headlines will tell you what's going on.

Despite the fact mental health issues represent about a third of our overall burden of disease in the UK and cost us over £100 billion a year, spending on these services accounts for only 13 per cent of the total NHS budget (NHS England, 2014). Worse, given half of all adult mental health problems (excluding dementia) start before age 15 and three quarters by age 18 (tinyurl.com/ok9gkwt), it's hard to understand why only 6 per cent of these already limited monies go toward child and adolescent mental health. These are services that have also had to manage cuts of £50 million since 2010 (see tinyurl.com/oqlysg2). Finally, it's worth noting that funding for mental health research represents a mere 5 per cent of overall health research spending (see www.researchmentalhealth.org.uk).

It is this basic poverty of resources and new learning from which all other challenges flow; both for young people who experience unbearably long waits for limited treatment options, and for services with diminished budgets trying to manage the increasing demand for them. Imagine for one moment if we resourced physical health care to the same extent and with the same lack of interest in new or better treatments.

In anticipation of the predictable groans about austerity, deficits, and doing more with less – an unprecedented upward redistribution of wealth has taken place since 2008; I humbly suggest that the arithmetic is simple.

Dr Simon Newitt
Chief Executive, Off the Record (Bristol)
www.otrbristol.org.uk

Editor's note: See our opinion article on how austerity is having an impact on researching, teaching and practising psychology (September 2013) and our special feature on austerity (April 2014). Visit www.thepsychologist.org.uk/archive

Easy speaking

Many of us in higher education are funded by taxpayers' money, and so it is understandable why the research councils have increasingly asked grant applicants to include strategies to disseminate research findings (known as 'pathways to impact'). Public engagement (PE) activities are also part of the marketing strategies of institutions that seek to promote their academics and raise awareness. And of course, PE is one way to generate impact that featured prominently in the latest REF exercise. All the signs indicate that PE will continue to play a critical role in academic life.

These are all very practical reasons, but I would argue that there is a much more personal benefit for PE. The typical professional life of an academic is one of intermittent reinforcement that is often more negative than positive. Papers and grants take ages to write, go through review and, more often than not, be rejected. If we do give a seminar on our research to colleagues then the expectation is that it will be critically evaluated which, after all, is what scientists do.

In contrast, giving a public talk can be a delightful, positive experience where the appreciative crowd is genuinely interested in what you have to say and, in general, less critical of the points one might make that one would never consider speculating on in a professional setting. The talks are often given informal settings, such as the backroom of pub, which makes the atmosphere more relaxed for obvious reasons.

Many voluntary organisations cannot possibly afford professional speaker fees, and yet in my experience many academics would be all too willing to talk about their expertise. With that in mind, I have just launched SpeakEzee.org – a searchable database of voluntary academic speakers that connects experts with audiences. It's an open-access system that can allow anyone to organise a pop-up lecture so long as they can find a reasonably sized group of fellow enthusiasts and a venue. Pubs are good as most are empty mid-week, but also student societies and village halls can work well.

On the website, speakers create a profile page with a brief bio, areas of expertise and a suggested talk for a general audience (they can also provide a professional talk for colleagues trying to organise departmental seminars). If they have a video example, then there is a show-reel section as well. Organisers can search by topic, location and availability. They can then make a request with further information that is either accepted or declined by the speaker. Eventually the system will enable feedback and comments on both speakers and organisations.

With 12m adults educated to degree level in the UK, SpeakEzee.org could stimulate the expansion of pop-up lectures for general audiences. Not only would SpeakEzee.org be a positive experience for both speakers and audiences, but speakers will eventually build up reputations for communication that becomes rewarding in terms of professional development and public recognition. And who knows, maybe an invitation to give a prestigious lecture on television.

Professor Bruce Hood
University of Bristol

Stopping sex offending

I have been so delighted to read the correspondence in *The Psychologist* about working with sex offenders (Hossack, October 2014; Duff, Pilgrim, November; and MacLeod, January 2015). However, there is one inaccuracy in the correspondence that I would like to put right, and that was in MacLeod's letter:

> 'As I see it, the main stumbling block for unconvicted and would-be offenders seeking psychological support lies in our mandatory reporting laws. These laws bind social, medical and mental health professionals into compulsorily contacting police if they believe that a crime has been committed or is likely to be committed, superseding all confidentiality clauses.'

It is true that anyone working for the NHS or social services is under a duty to report suspected child abuse; yet this is not a legal requirement, it is something that employees agree to through their contract of employment. For those practitioners working in private practice there is no legal obligation to report. Psychologists and psychotherapists may feel that ethically they need to report, but that is a different matter, and brings some element of choice with it. This means that, here in the UK it is legally possible to provide confidential therapy to those who are at risk of offending, or re-offending. In fact there are many therapists doing just that, making their own risk assessment and then working with the client if they feel able to.

There is no law that stops someone in private practice from seeing a client they know has broken the law around sexual behaviour. The only time a counsellor or psychotherapist is legally required to breach confidentiality is if a client is making money through drug trafficking (Drug Trafficking Act 1986), you have a belief or a suspicion that they are engaged in terrorist activities (Terrorism Act 2006), if you know someone is unsafe to drive (Road Traffic Act 1988), or they are money laundering (Money Laundering Regulations 2007).

Indeed, one colleague wanted to check this, so contacted the Home Office for clarification. The reply from the Criminal Law Policy Unit stated: 'With regard to your question: If a client confides in you during the course of therapy that they had been viewing child pornography on the Internet, whether you would be obliged to disclose this to the authorities. There is no specific requirement in The Protection of Children Act 1978.'

This knowledge has enabled the organisation StopSO, the Specialist Treatment Organisation for the Prevention of Sexual Offending, to spread in the UK. StopSO is a not–for-profit organisation, that has a network of therapists who are willing and trained to work with sex offenders, and welcomes new members providing they have the appropriate therapeutic qualifications. StopSO offers training to enable those experienced therapists in private practice who feel ready to engage with this client group, a way to prepare themselves. Through StopSO psychologists and psychotherapists can also access specialist supervision where necessary.

If we can treat one person successfully then we may save many people from becoming victims. Good therapeutic intervention for sex offenders is a child protection issue!

Juliet Grayson
UKCP Registered Psychotherapist

Social and material causes of distress

We welcome the recent debate between John Cromby and Vaughan Bell on whether understandings of mental illness are mired in the past (January 2015).

We agree that it's time to do away with the unhelpful assumption that psychological distress is mental illness with primarily biological causes. We feel it is important to point out, however, that at no stage did John Cromby say that biology plays no role in psychological distress, only that it is often not the primary causal influence. Vaughan Bell's response appeared as though he had taken John as denying any role for biology at all. But as long as we consider biology to be the fundamental cause of distress, antidepressant and antipsychotic medications will continue to be the go-to remedies. However, such medications frequently cause real mental and physical harm, including exacerbating rather than alleviating distress.

We also believe that overly 'psychologised' approaches can be equally unhelpful. For example, the over-prescription of cognitive behavioural therapies – a case convincingly argued by Peter McKenna and Keith Laws in a recent Maudsley Debate (tinyurl.com/kmbp3en) – as a treatment for distress again reflects the misplaced assumption that the causes of distress are to be found within the person. Just as biological explanations wrongly attribute distress to neural or hormonal imbalances, psychological explanations wrongly point to 'faulty thinking patterns' or 'maladaptive behaviours' as the source of psychological suffering.

John Cromby's argument that it's time to more adequately address the social and material causes of distress, and the structural inequalities that give rise to psychological suffering, makes perfect sense. Thus the call for a more sophisticated approach to understanding and alleviating psychological distress in the 21st century is prudent and timely.

Nick Caddick & Martin Willis
Loughborough University

No right to be forgotten for PhDs?

Ten years ago, I was one of several researchers targeted by a small group of cyberbullies. The main bully was convicted under the Harassment Act and the bullying stopped. I thought it was all over but have recently found that colleagues who Google me now find the old posts and without knowing the context, jump to conclusions. There's no warning that the URL was part of a campaign of harassment and that the author was convicted, so those who don't know me assume that the criticisms of my professionalism were made by a rational and well-informed individual. They've stopped asking me for my opinion, and any reputation I had as a competent and honest psychologist has been severely damaged.

I asked Google and Bing to remove the links to the posts as they fell under the European Court ruling and later guidelines; that is, they were old, defamatory, caused distress, allegations were untrue, most arguments were irrelevant (they had linked me to a trial that I was not involved in) and I was not a public figure. Google rejected my request, stating that as I was a professional and that my potential patients and clients needed to know. It was, in their view, in the public interest. I pointed out to them that I didn't have potential patients or clients as I had retired.

Bing never responded.

The UK regulator, the Information Commissioner's Office (ICO), rejected my complaint because I have a PhD, which in their view makes me a professional engaged in a professional debate. Like Google, they felt that the public would benefit from being aware of the conflicting views amongst health professionals. The inaccurate information about me and my work that dominated the posts was dismissed as a professional disagreement and the authors had a right to freedom of expression as enshrined in the Human Rights Act.

The 'debate' was not about the causes or treatment of an illness and it was not a professional disagreement. None of the bullies were colleagues engaged in research into the illness and none had published in a scientific journal at that time. Three of the four were not patients with the illness in question. Some of their 'evidence' about me had been fabricated. I sent the ICO evidence from others who had been targeted, showing that there had been a campaign by individuals who cared little about accuracy, let alone science.

On their website the ICO notes that it will consider links to comments that constitute hate speech, slander, libel or similarly offensive content targeted at the complainant. This was true in my case, but the fact that the main bully was convicted under the Harassment Act wasn't relevant as harassment is 'not covered by the DPA' (Data Protection Act). I was advised to sue the authors under sections 10 and 14 of the DPA. Independent legal advice recommended I avoid a court case as it was a minefield, and while I had been defamed the freedom of expression argument tends to protect cyberbullies.

The message I wish to convey is that having a PhD in psychology excludes you from the EU Court's ruling and we therefore don't have the right to be forgotten. My case also means that we need to be more careful what we write and say, because the village gossips can now spread their bile all over the world in a matter of seconds. And as I learnt to my cost, the assumption that intelligent people can distinguish between fair comment and cyberbullying may not be valid.

Name and address supplied

NOTICEBOARD

Bipolar Research Study: The aim of the study is to understand more about **suicidal thoughts and feelings in people who experience bipolar disorder**.

The project involves a 30-minute telephone interview about bipolar-related experiences. Next, a series of online/posted questionnaires (maximum 1.5 hours). For more information, please contact the researcher.

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Anonymous contributors

I have just read a piece on your Research Digest blog that was attributed as: 'Post written for the BPS Research Digest by Neuroskeptic, a British neuroscientist who blogs for *Discover Magazine*.' I have no issue with what was said in the piece, but I am concerned that this is being published anonymously. It is vital that the reader is able to place the published material in the context in which it is written. To appraise a piece, it is helpful to the reader to know something of the previous work the author has published and whether there are particular views held by the writer, on theory for example, that might flavour or bias the piece.

There is then the issue of declared conflict of interest, about which the reader would be more reassured if the author was named. I am all for 'disseminating psychological science far and wide' but it is a central tenet of such science that the provenance of a finding or an opinion is attributed.

Jim Stevenson
Emeritus Professor, School of Psychology, University of Southampton

Editor's reply: *The Psychologist* and Research Digest policy is that we are comfortable publishing anonymous writers in principle, although each case is judged carefully. In the case that prompted your letter, the author is a British neuroscientist who the Research Digest editor and I have met and know the identity of. This person has published in *The Psychologist* and Digest, on a widely read blog, and even in scientific journal articles under this pseudonym. This enables the reader to appraise the work and place it in context as much as a real name would. Increasingly in the 'blogosphere' psychologists are, for whatever reason, choosing to write anonymously, and we feel that decision should be respected unless there is a good reason to avoid it; for example, if there was the sense that an author was choosing to hide behind a cloak of anonymity in order to express particular views.

However, we will revisit the policy at the next meeting of the Psychologist and Digest Editorial Advisory Committee.

Outsider psychologists

I picked up my copy of *The Psychologist* when it arrived this morning and randomly opened to page 111 where there was an image of an elderly white couple. I immediately thought 'How many images of black people appear in the magazine?' Then stumbling across Jeune Guishard-Pine's letter 'Where have all the BAME psychologists gone' prompted several musings for me.

As a former social worker, entering the psychology arena has been like stepping into a 'timewarp' in relation to how black and ethnic minority people are (not) represented in the mainstream literature of psychology as a whole. Is it, I ask myself, that psychologists do not view themselves as 'agents of change' on a social level compared to (old school) social work practice that had at its core value's of inclusion and challenging injustice and inequality?

As a black woman I have found that belonging to a profession where images of myself and issues that speak to my experience are made explicit alongside issues pertinent to white, middle-class people gives me a sense of validation and inclusion. I am sad to say, unlike my experience of being a social worker where I could own my professional identity in a professional home, I have struggled to do so since qualifying as a psychologist. What this has meant is I have a sense of apathy about getting involved. In fact I have joined the APA black psychology section, which goes some way to providing some affirmation despite the cultural difference that exists.

I can admit in answer to Jeune's question of 'Who would bother to fill in this form?' that I was certainly one of those who couldn't be bothered, for some of the reasons stated above – not least of all the deathly silence that exists within the profession in relation to these issues. Truth is I feel like an 'outsider psychologist'.

Margaret Jordan CPsychol
Clinical Director

The fitness of the fitness to

The most recent annual 'fitness to practise' report from the Health and Care Professions Council (HCPC) makes interesting reading. In 2013–14, there were 18 allegations about practitioner psychologists that reached the stage of having a 'case to answer' and were therefore considered to be put forward to a hearing. Five were discontinued through lack of evidence and three led to suspensions of registrants on health grounds. Five complaints were found to be 'not well founded'. One registrant was suspended for rude and insulting behaviour and one was suspended for inadequate clinical skills. Therefore, only two were sanctioned for incompetence, suggesting that this method of regulation cannot possibly be an efficient means of ensuring that professional standards are upheld.

According to Barlow (2010), 5–10 per cent of therapists leave their clients in a worse off state than when they first entered therapy. In two of the 18 allegations, it was claimed that the registrant's relationship with a client was inappropriate. In a total of 19,919 registrants this represents 0.01 per cent. This figure is either highly laudable or gives an inaccurate estimate of the actual state of affairs.

The norms governing a violation of boundaries in psychotherapy are highly contested and instances are probably best decided on a case-by-case basis by supervisors or a board of independent professional peers. The HCPC's quasi-judicial system is not fit for this purpose. It is also expensive: HCPC receives £1.5 million annually from practitioner psychologists' pockets.

Richard Hallam
Visiting Professor of Psychology
University of Greenwich

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In response to Richard Hallam, we are writing to address some of the points raised in relation to our fitness to practise (FtP) process.

The Health and Care Professions Council's (HCPC) FtP proceedings are designed to protect the public from those

POPULATION PRESSURES

Graham Pluck's urgent article on street children (January 2015) makes the next questions for psychologists – Why are they homeless and what can be done to stop it? Are they part of the problem of families with children they do not want or cannot care for? The refugees from Africa to Europe seeking jobs, and the people daring desert crossings to reach the United States are also part of the problem.

Why are there such large families with unwanted children or teenagers who cannot get jobs? Now that modern medicine and hygiene prevents high child mortality, large families in poor countries mainly survive, and can help parents by working as children until they seek to become parents too.

What can be done about political and religious pressures to have large families?

The West sees a problem in Western small families, but the world problem is in a population explosion that is greater than can be sustained. China's solution was one-child families, but two-child families seem better for all concerned.

This is a complex question for psychologists to attend to.

Valerie Yule
Mount Waverley, Victoria, Australia

Editor's note: We do in fact have an article in the pipeline on just this issue.

practise process

whose fitness to practise is impaired. It is not a process for resolving general complaints, and it is not designed to resolve disputes between registrants and service users, or to punish registrants for past or 'one-off' minor mistakes that are unlikely to be repeated.

So how exactly does our FtP process work? Any concerns are initially assessed to determine whether they meet our Standard of Acceptance, which sets out a modest and proportionate threshold that allegations must normally meet before they will be investigated by the HCPC. We recognise that employers and managers must deal with circumstances of staff misconduct, lack of competence and ill health, and that this can include situations with our registrants. In many cases, this can be effectively resolved by the employer at the local level. As such, it is unlikely that there will be evidence to suggest that the registrant's fitness to practise is impaired, and therefore if it is referred to us we would normally close the case without taking any further action. So for example, issues relating to professional boundaries can often be managed through clinical supervision, and would therefore not need to be referred to us. Of course we would take action if the issue raised public protection concerns, such as improper relationships with service users.

The number of FtP cases that the HCPC manages should be viewed in context. In 2013–14, we received 157 cases relating to practitioner psychologists. This equates to 0.79 per cent of practitioner psychologist registrants being subject to an FtP concern. Practitioner psychologist cases also have a higher rate of case closure on the basis that they did not meet the Standard of Acceptance when compared with some of our regulated professions with greater registrant numbers, including physiotherapists, radiographers and occupational therapists. Of the cases referred to our Investigating Committee panel, approximately half record a decision of 'no case to answer' and do not reach final hearing stage.

267 final hearings across all professions concluded in 2013–14 – a small total in comparison to the 322,021 professionals on our Register – and only 0.06 per cent of registrants were subject to a sanction imposed at a final hearing. This small number of cases that reached final hearing stage reflects the fact that the FtP process focuses on those registrants where there is strong evidence to suggest that their fitness to practise is impaired.

It is also important to recognise that registrant fees are not only used to finance the fitness to practise process, but also to fund all our statutory functions including, for example, our registrations and approvals processes. However, we are very mindful of the cost and emotional impact on those involved in an FtP hearing. For that reason our processes are designed to ensure that only those cases that really need to go to a final hearing, do. We also have provision to dispose of certain cases by consent, whereby the HCPC and the registrant can seek to conclude a case without the need (and cost) of a contested hearing by entering into either a voluntary removal, conditions of practice or caution agreement. Cases can only be disposed of in this manner with the authorisation of a Panel of a Practice Committee.

The HCPC is committed to working with employers and others, as well as the professions themselves, to ensure that they understand our FtP proceedings, including what should be referred and when they should refer it. Along with producing more detailed guidance, we are constantly looking at ways of quality assuring the work that we do, as well as reducing the length of time and cost attached to the FtP process.

John Barwick
Director of Fitness to Practise
Health and Care Professions Council

Addressing experiences of brain injury

I read with dismay, coupled with some sympathy, Niamh Lowe's experiences at the hands of neuropsychologists ('Viewpoints', February 2015).

Having worked as a neuropsychologist for over 15 years, I am only too aware of the possibility of appearing cold, clinical and lacking in empathy for a brain-injured person when conducting an assessment. Formal tests present a considerable challenge to testees, and they often appear completely irrelevant to the individual's needs. Results are often withheld and feedback on test performance is often lacking. Testees themselves often know that they're performing poorly in spite of encouragement, and these factors can have a demoralising effect on the individual at the very time that they need optimism and hope.

In the private sector I am fortunate to be able to delay formal testing until I have got to know the individual and relatives. In this way I can form a picture of what the person was like before the brain injury and how far away from that premorbid person they currently are. I do, however, conduct a wide range of formal tests and always feed back results, together with reassuring explanations and realistic hopes for recovery. In addition, I invariably address issues such as anxiety, depression, low self-esteem, self-efficacy, recovery, locus of control, and attitudes towards and acceptance of disability. These have been formalised in a 55-item questionnaire known as the Nottingham Adjustment Scale (NAS), a reliable and valid instrument that we developed at the Blind Mobility Research Unit way back in the 1990s.

Although I never imagined for one moment that I myself would employ this research tool in clinical practice, I have found it invaluable in addressing the psychological and emotional factors alluded to by Niamh. The scale has been translated into a number of languages, and the factor structure has stood up well, suggesting that the experience of acquiring a disability may be a human universal independent of the actual disability itself. The scale enables one to evaluate psychological progress as rehabilitation proceeds and to compare the effectiveness of various interventions. Copies of the NAS may be obtained by e-mailing me.

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MORE ONLINE

Other letters, plus a complete archive, can be accessed at: www.thepsychologist.org.uk/debates

Stubbing out smoking

I volunteer at Lancashire Care Foundation Trust (LCFT) where smoking, or rather, 'not smoking' is a hot topic! So I was pleased to read the article 'Stubbing out smoking in schizophrenia' by Theodore Lloyd (January's 2015), which posed the question 'What can mental health professionals do to help people with schizophrenia who smoke?'

In January LCFT went 'smoke-free'. A positive change for everyone; especially those with a diagnosis of schizophrenia and other serious mental illnesses (SMIs), as these individuals have a life expectancy that is 15–25 years shorter than the rest of the population, due in part to high prevalence of smoking (Bradshaw et al., 2014).

To successfully help people stop smoking, we must know what barriers might present themselves. Some common concerns that people with SMI have around quitting smoking are: possible effects on anxiety levels, loss of an important coping resource, the fact that smoking is strongly linked to socialising – people worry that stopping could have a negative impact on relationships, giving up something that is pleasurable and also the risk of a deterioration in their mental health (Kerr et al., 2013). Being aware and informed about the worries clients may have about stopping smoking means we are better placed to provide support.

It isn't just our clients who feel anxious at the prospect of stopping smoking. Ratschen et al. (2009) found ward staff were concerned about damaging the clinician–patient relationship, dealing with aggression when challenging patients who were smoking, increased risk of fire due to 'covert smoking' and the possible exacerbation of clients' mental health problems. Interestingly, however, none of the respondents could cite any incidents to justify their fears. A professional's own smoking status might also influence their health-promoting role and cause missed opportunities to engage clients regarding smoking cessation (Kerr et al., 2013).

Making Every Contact Count (MECC: see http://makingeverycontactcount.co.uk) encourages conversations about lifestyle change; focusing on diet, exercise, alcohol and tobacco. LCFT plans to conduct research into whether training staff in MECC changes the way they interact with clients. If behaviour isn't changed after training, the study will aim to identify barriers to change. This information coupled with what we already know about the barriers clients face when considering stopping smoking will hopefully result in more helpful and successful interventions.

I hope this goes some way towards an answer to the question Theodore poses.

Rebecca White
Manchester

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The autism label

Professor Rita Jordan (Letters, February 2015) replies to my letter published in the December issue about the usefulness of the autism label. This is a response to some of the points she makes.

Firstly, can I say that it was never my intention to disrespect her 'lifetime's work' or that of any of the many hard-working researchers in the autism field. I think this research has been very illuminating in investigating social and mental processes. My 'lifetime's work' has been as a clinical psychologist with people with intellectual disabilities, which is why I confined my original letter to this group.

My original letter had questioned whether giving someone who already has an intellectual disability label the additional label of autism adds anything to our treatment approaches. I still wait to be convinced.

Professor Jordan's main point is that people on the autistic spectrum lack 'instinctive social understanding', and that this is qualitatively different to others with intellectual disabilities. Obviously in the constraints of a letter it has not been possible for her to explain this term, but what she says seems to imply that others with intellectual disabilities will 'acquire naturally' social behaviours. This seems to ignore our personal experience and the research evidence that social deficits are common in people with intellectual disabilities. Here are a few examples.

Many studies have shown social skills deficits for children and adults with intellectual disability (e.g. Agaliotis & Kalyva, 2008; Pina et al., 2013). In another example, Matson et al. (2008) carried out an empirical study to compare symptom patterns in adults with severe intellectual disability with or without a diagnosis of autism. They *did* find that the adults with autism showed a clear and distinct symptom profile compared with matched controls; however, there was a lot of overlap between the groups, with many people without the autism diagnosis also showing deficits in social behaviours.

To me the issue still is whether this categorisation of people actually has treatment implications. I fully accept Professor Jordan's premise that not everyone learns in the same way, and that we have to understand the individual's own profile of difficulties, but I think this applies to everyone whether given the autism label or not. There seems to be more heterogeneity within the categories of autism and intellectual disability that there are differences between them.

I do have concerns that by categorising people we risk setting up a two-tier service for people with intellectual disabilities. I have seen in practice some people being given extra support worker time or better staffed day centres because they have an autism diagnosis, when others with intellectual disabilities just as great a need have not had access to these services.

A few years ago I said to Lorna Wing at an autism conference: 'I still don't understand what giving someone an autism label does for them.' She replied: 'If I think the label will help the person get better services, I will give it.' Is this right?

Graham Collins
Alfreton, Derbyshire

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Thinking in context

Dr Alan Dodds response (Letters, February 2015) to our article 'The "strange death of Radical behaviourism' repeats the often cited, but nonetheless incorrect view that Skinner was not interested in cognitions. So to be absolutely clear on this point, in spite of various misrepresentations to the contrary, Skinner and radical behaviourism have always considered thoughts and feelings as important psychological phenomenon that must be included in any scientific analysis of the human condition. Watson didn't, but Skinner did. It's that simple really. Asserting the contrary in the face of the evidence is not likely to add to the quality of any discussion.

There is a more interesting issue in Dr Dodds's response, however, and it relates to using quotations or anecdotes out of their broader context. We don't know the interview with Skinner that Dr Dodds refers to and do not dispute the words used, but we do question the meaning he ascribes. One of Skinner's central criticisms of the cognitive theories advanced during his day was that they frequently took common metaphors and turned them into explanatory models. Consider the metaphor of 'thoughts going through our heads' that Dr Dodds refers to. Do thoughts literally go through our heads? If so, what is actually moving and through what? For Skinner phrases like these were everyday metaphors for *thinking* and not the basis of a scientific understanding of cognitive processes. So when asked if thoughts were going through his head, he may have provocatively said 'No' because it was just a metaphor for the experience and not a scientifically precise statement. Skinner frequently made this type of argument. Had the interviewer asked Skinner if he 'thinks' he would almost certainly would have replied 'Yes' (as all radical behaviourists would, though he probably would have also gone on to deconstruct what we mean by thinking too!)

There is a more interesting debate to be had about the use of metaphors in our theories that is being missed when we selectively present quotations or anecdotes about Skinner out of their wider context.

Freddy Jackson Brown
Duncan Gillard
Bristol

Brown and Gillard ('The "strange death" of radical behaviourism', January 2015) make an excellent case that one should not ignore theoretical approaches, such as behaviourism, merely because many have declared them 'dead'. Yet, one might argue that the assumptions of behaviourism are still alive and well within contemporary cognitive approaches. Cognitive researchers still subscribe to a model that a stimulus in the environment leads to a response, albeit through various intermediate 'mental processes'. Maybe psychologists should pay more attention to a 50-year-old theory – perceptual control theory (PCT) – that has not even yet been regarded as 'alive' by mainstream psychology, never mind 'dead'.

PCT proposes that behaviour is the process of controlling sensory input within a closed loop. So, when we see a 'response' following a 'stimulus', this is actually the emergent attempt by the organism to maintain its desired sensory goals (e.g. to keep a glass of beer steady on a swaying ship!), despite the ongoing disturbances in the environment. Because behaviour emerges dynamically, it cannot be learned in the way that Skinner described; only the parameters of the control system that utilise behaviour can be modified.

Returning to the recent article, Brown and Gillard draw the analogy with Darwinian evolution to explain selection of behaviour within a lifetime, but they do not extend the analogy to the distinction between genotype and phenotype. The phenotype is a complex product of the genotype and the environment, thus while it determines survival, it cannot be the unit of selection – this is the genotype. Similarly, from the PCT perspective (Mansell et al., in press), behaviour is a complex product of what the organism is attempting to do, and of the features of the environment that either permit this (e.g. a post on a swaying boat used to stabilise oneself) or disturb this (e.g. the movement of the boat). Clearly, none of these features of the environment that define and shape the behaviour as it is happening are passed on *within* the organism; yet the systems that utilise these are – these are known as control systems in PCT.

Warren Mansell
University of Manchester

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obituary

Barbara Tizard (1926–2015)

Barbara Tizard, who has died aged 88, was an eminent developmental psychologist, a Fellow of the British Academy and of the British Psychological Society. In her memoir *Home Is Where One Starts From* (2010) she explained that her research was driven by important theoretical questions and the desire to challenge 'widely held beliefs or theories bearing on childcare or education which…were held dogmatically without adequate evidence' and to 'work for human betterment'.

One of Barbara's projects, published as *Early Childhood Education* (1975), questioned the early theories of John Bowlby that deprivation of maternal care in the first two years led to 'affectionless psychopathy'. The study followed two-year-olds in residential nurseries until 16 years, comparing those who were adopted with those who were not. Results showed that children spending their first two years in residential nurseries, with little or no parental contact, did not usually grow up affectionless or even disturbed.

A later study on the conversations of four-year-old girls with their teachers in nursery school and their mothers at home (*Young Children Learning*, 1984) generated controversy. Contrary to commonly held beliefs that working-class mothers failed to stimulate children, it found a relative paucity of talk at school and a rich learning environment in the home. Barbara considered that 'the changes that have since occurred in nursery schools are not those we had hoped for. Instead they resulted from government pressure to introduce literacy and numeracy at an ever earlier stage.'

In the 1980s Barbara was part of an international group of child psychologists and psychiatrists opposed to nuclear

weapons and convinced that children would be damaged by the nuclear threat. Her research found this was not the case. Another of her concerns was with racialisation. She published a paper in *Nature* in the 1970s showing that there were no differences in the IQs of black and white pre-school children. In the 1980s she directed a longitudinal study of black and white children at infant school (*Young Children at School in the Inner City*, 1988), and in the 1990s a study of black, white and mixed parentage pupils in London schools (*Black, White or Mixed Race?*, 1993). After retirement Barbara researched retired academics and found that most suffered a marked loss of status on retirement.

Barbara's achievements were remarkable. She embarked on her research career in what she describes as the fiercely competitive, critical, yet very stimulating atmosphere of the Maudsley Hospital, Institute of Psychiatry, while raising a young family during a period when there was little sharing of domestic responsibilities and little help from employers or the state. She worked in a series of part-time positions until she was 50, when she finally achieved a senior academic position (Reader in Education at the Institute of Education, later Professor) and, following Jack Tizard's death in 1979, became Director of the Thomas Coram Research Unit (1980–90).

Julia Brannen
Peter Moss
Ann Phoenix
Institute of Education

obituaries

Robert G. Andry (1923–2014)

Professor Robert Andry had a multifaceted international career as a clinical and forensic psychologist.

Following active service in New Guinea in WWII, he completed his undergraduate and master's degrees at Melbourne University. Upon graduation as a clinical psychologist with a special interest in forensic psychology, he held the position of Psychologist-in-Charge at the Melbourne Court clinic (1949–1953), alongside the post of Secretary (Victoria section) of the recently established Australian branch of the BPS.

In 1953 he moved to England to read for a PhD at the LSE under Hermann Mannheim, a leading criminologist. His thesis challenged John Bowlby's theory of the mother–child relationship as being the main causal factor leading to delinquency, and his research suggested both parents played an influential role. His thesis was subsequently published under the title of *Delinquency and Parental Pathology* (Methuen, 1960). This was followed by *The Short Term Prisoner* in 1963 (Stevens & Son).

In London, he held a dual appointment as Lecturer in

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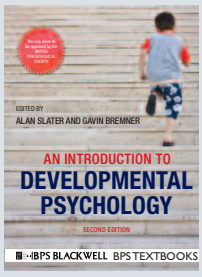

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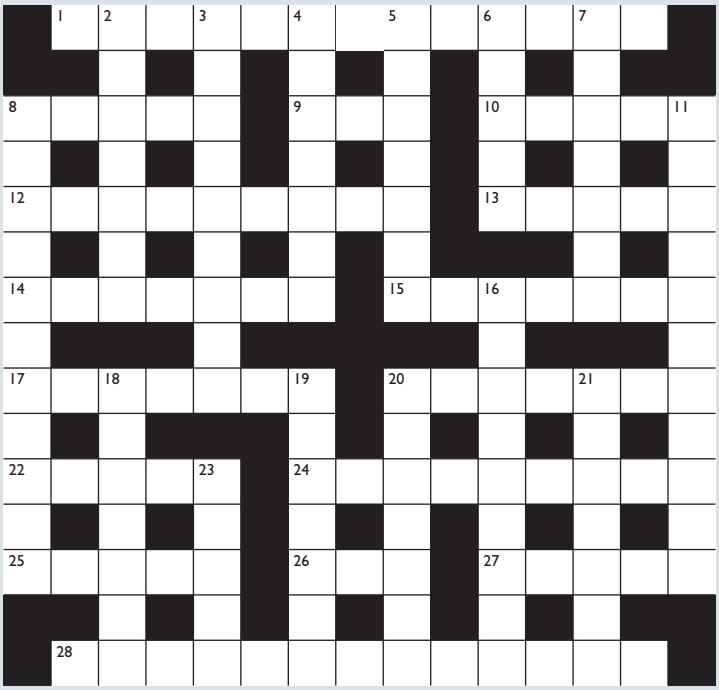

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deadline 13 April 2015. Winner of prize crossword no 79 Angela Silverman, St Albans

no 79 solution **Across** 1 Rescorla-Wagner, 9 Paris, 10 Millstone, 11 Estonian, 12 Abyss, 14 Sine, 15 Umwelt, 17 Err, 18 Run, 19 Malady, 20 Ague, 23 Night, 25 Internet, 28 Work ethic, 29 Cheer, 30 Mental hospital. **Down** 1 Repress, 2 Serotonin, 3 Orsini, 4 Lamia, 5 Will, 6 Gestalt, 7 Ebony, 8 Censer, 13 Lead, 16 Mole, 17 Eigenwelt, 18 Renown, 19 Mitwelt, 21 Enteral, 22 Teacup, 24 Gorge, 26 Nacho, 27 Dhal.

Psychology at the Institute of Education and as the Clinical Psychologist-in-Charge at St Thomas' Hospital. He represented the Australian Branch on the Council of the BPS and helped separate the APS from the BPS. While in the UK, Andry played a big part in setting up the British Association of Psychotherapists and acted as its Chairman between 1968 and 1973. He was also a Fellow of the Group Analytical Society. During this period he acted as a Consultant to UNESCO, the Council of Europe and the UN.

In the mid-1970s, Andry moved to take up a position as Professor at the University of Montreal with shared duties at McGill University. He acted twice as a UN Consultant to the Hong Kong Government to advise on setting up psychological and rehabilitation services in the Correctional Services Department. In 1982 he moved to a full-time post on the invitation of the Hong Kong government. This proved to be a fruitful period as he set about installing and overseeing all the psychological services and research projects, rehabilitation programs, staff training and administration. On his retirement from the Correctional Services, he was appointed a visiting Scholar in the Psychology Department of the Chinese University and an Honorary Professor to the Department of Criminology at the University of Hong Kong. When he finally retired, he came to live in Sydney.

In 2003 he was made a Member of the Order of Australia, for 'Services to International Forensic and Clinical Psychology'.

Ann Andry
Woollahra, Sydney

across

1 Knee-jerk reticence to concept coined then rejected by Skinner (6,7)
8 Old paper measure used by printers frequently (5)
9 Agree ends about plane's first take off (3)
10 Peg keeps points tight (5)
12 Minx devours last of layer cake (9)
13 Celestial body – animated one with a tail (5)
14 Spring festival in London district (7)
15 Office worker is in Paris storm (7)
17 Apparel let out without end (7)
20 Laboratory glass mostly improved around old city (7)
22 Unknowns keep large amount of money (5)
24 Taking legal action? That's cute (9)
25 First name in children's literature left in way (5)
26 Spare time's not certain to produce garland (3)
27 Hibernian flag on hospital (5)
28 Mad Bedlam care last month for love delusion man (2,11)

down

2 Hospital department slightly unwell suffering decline into disorder (7)
3 Mould a gel until it's tongue-shaped (9)
4 Kiss female thespian with indefinable quality (1,6)
5 Say, copper bit of kettle (7)
6 French art to beat legal ban (5)
7 Opening flower is risky business (7)
8 Mostly, race cars zoom around to display philosophical law of simplicity (6,5)
11 Doctor her test with gong's capacity to maintain identity (3,8)
16 Cocktail, a small measure served up by lovely lady in a Beatles song (9)
18 Segregate one very much behind schedule (7)
19 Movie preview of mobile home in America (7)
20 Graduate to sit up in afternoon for initiation rite (7)
21 Pursuit may be time to get opponent to accept one (7)
23 Sing lines in outskirts of Yeovil (5)

Michael Humphrey (1926–2014)

UK clinical psychology lost one of its pioneers recently with the death of Michael Humphrey.

Michael studied psychology and philosophy at Balliol College Oxford after serving in the RAF for three years. After graduating he completed a research degree in neuropsychology supervised by Oliver Zangwill. Clinical neuropsychology was to remain one of Michael's two major interests throughout his career. He then worked as an NHS clinical psychologist at the Warneford and Park Hospitals, starting to work there only a year after May Davidson, in 1951. In 1954 he moved to Reading but returned to the Warneford and Park Hospital four years later.

In 1964 he fulfilled his aspiration to obtain an academic post, first as a research fellow in the Sociology Department at Essex University and then as a lecturer at the Department of Mental Health, University of Bristol. In 1969 he was appointed Senior Lecturer in Psychology at St George's Medical School. In 1977 he was appointed Reader in Psychology in recognition of his contribution to psychology and the Medical School.

Michael was a man of wide interests and skills. His experience as an NHS clinical psychologist embraced learning disability, adult mental health, child mental health, clinical neuropsychology and what would now be considered health psychology. He took a broad perspective on neuropsychology, for example, at a time when most psychologists in the field focused on cognitive deficits alone. He was interested in the rehabilitation of neurological conditions, their impact on the family and psychological adjustment to disability. He inspired his three PhD students (myself, Andy Tyerman and Glynda Kinsella) to take such a perspective. In addition he guided many clinical trainees at Surrey University through their dissertations.

Michael's other main research interest was infertility and adoption. His own PhD was a study of childless marriage as a basis for adoption. He and his wife Heather, who was a collaborator in much of this work, adopted two children, Fiona and Mark, who together with Heather survive him.

Michael was an impressive man, and his formidable intellect was obvious, but, as his daughter has commented, 'he never left those with a lesser intellect feeling out of our depth'. Fiona also mentioned Michael's tendency to raise quite personal issues: one could never take offence or really be embarrassed because he did this with such disarming interest and concern. I remember one example that occurred when I was helping him teach medical students. It was around the time when he was disappointed not to be appointed to the newly inaugurated Chair in Psychology at St George's. He asked me to role-play a psychologist interviewing him in the role of a deputy bank manager who had failed to be appointed branch manager and was complaining of depression. This role-play was to be conducted in front of the large group of medical students! Typically I was the one who was embarrassed, not Michael at all.

Heather speaks of four main strands to his life: people (including psychology interests), music (he was a highly talented pianist), writing (both academic and fiction) and cricket.

As for the profession of clinical psychology, he was one of the early post-war psychologists, who pre-dated formal clinical training. However, through wide-ranging clinical experience and debate with colleagues he helped forge a new profession and develop the firm basis upon which it has subsequently grown.

Michael Oddy
Horsham