Adjectivally challenged

As a chartered psychologist without one of the adjectival titles, I am increasingly frustrated by the attitude apparent to those in my position amongst those supposedly representing my interests. I feel it is unacceptable for the Society to provide so little information about the position of those of us without a Divisional home, and I would like to ask some questions.

What evidence is the HPC likely to require in order to assess one's fitness to practise? Quite apart from needing to estimate the time required to put the evidence together, will there be an expectation that testimonials will be provided and, if so, from whom? Should the latter turn out to be the case, isn't this just a way of saying that original periods of supervised practice were insufficient? If that is the case, I'd like to know why I have paid for my practising certificate since the early 1990s as well as dutifully submitting evidence of CPD as required over the last few years.

Are those of us without an adjectival title at risk of being legislated out of the profession? While I do not offer services directly to individual clients in any helping context, under the current proposals I would be debarred from carrying out supervision and training to those working towards chartered status. My personal specialism (psychometrics) applies across a range of subdisciplines and is often not well understood at the 'sharp end'. What am I to tell my trainee colleagues when they come to me with a technical question? Indeed, will I still have a job to go to, since a fair proportion of my part-time hours are spent supervising quantitative research conducted by others?

While I may be semi-retired, I am not yet ready for the scrapheap – what is the Society doing to ensure that I and a significant minority like me are protected from the imposition of some 'not quite a psychologist' designation?

Sandie Hobley
Sutton Coldfield

Society President Liz Campbell replies: This case and many others like them is one of the key reasons why the Society's position is that the protected title should be *psychologist* rather than the seven adjectival titles – *counselling*, *educational*, *forensic,* etc. – proposed by the government. We have made this case to the Department of Health on many occasions in the past and will continue to press them to change their policy, so that members like Sandie Hobley are potentially included and so that the public is fully protected.

How the Health Professions Council is to assess fitness to practise remains an open question until it publishes its methods and criteria. However, what can be gleaned from their existing practice, in terms of the professions they already regulate, is that the HPC's detailed consideration of 'non-standard' candidates is to use two expert members of the profession to evaluate the candidate's application. There will also be a grandparenting period again for 'non-standard' applicants.

In terms of the numbers of chartered psychologists without an adjectival title – they exceed a thousand, and I assure you that the Society will do everything it possibly can to ensure that all those eligible are regulated and therefore can continue to practise proudly displaying their 'psychologist' badge.

Health Professions Council – time for a referendum?

David Murphy suggests (Letters, April 2008) that being protected by seven adjectival titles would be 'as good as it gets, and whilst it may not be perfect, it could be a whole lot worse'. In fact, I suggest it would be a whole lot worse, when compared with our current system of regulation by the Society.

Our last President was quoted (News, February 2008) as saying, 'We do not believe that the government's…policy of properly protecting the public will be achieved… Indeed, by failing to accept our policy of protecting the title psychologist, it will be perfectly possible and legal for anyone to call themselves a psychologist or use a new and unprotected adjectival title and practise.'

In her response to David Murphy our current President says, 'We have agreed that the D/12 level threshold standards of entry reflect the current standard for chartership.' So what happens to psychologists between obtaining GBR and

contribute

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However, see **www.thepsychologist.org.uk** to contribute to our discussion forum.

qualifying as chartered psychologists? Currently, The Health Professions Council (HPC) only has one qualification for registration – completing a vocational course that combines theory and practice. None of the 13 current professions registered with HPC have any higher or postgraduate qualifications that must be obtained before registration. An operating department practitioner or a paramedic is therefore judged to have as extensive an expertise, knowledge and skills as a chartered psychologist. The HPC website (www.hpc-uk.org) lets us see what company we would be in, and on what our fees would be spent. Their 13 professions deal only with individuals. In contrast, we deal with groups, individuals and organisations. They only deal with people who have physical problems. In contrast, we deal with people who have emotional, learning, mental, social or work problems. They work in clinics, homes, hospitals or rehabilitation centres. In contrast, we work in charities, education, prisons, sports centres or work places, except for some clinical or health psychologists.

> We have nothing in common with the 13 professions currently regulated by the HPC. Why then should we become the 14th? If psychologist cannot be protected by setting the generic level of qualifications currently proposed, then why should we hand ourselves over to the Health Professions Council? Instead, let the public and ourselves continue to benefit from the current system that catches and punishes our errant members.

On such an important issue, surely we need a referendum.

Joshua Fox
Crowborough
East Sussex

Hegemony and science education

I was pleased to read comments by Marie-Louise Hughes in her recent letter (May 2008) on science and applied behaviour analysis (ABA). The letter seemed to come out of the blue, in the sense that there were no recent target articles in *The Psychologist* that were being responded to. However, within Ireland as a whole the letter has a historical context that students of psychology may find illuminating. This historical context is important because of the implications in the UK generally for parents wishing to avail of services by people trained to international standards in ABA.

> Here is an accepted definition of ABA: Applied Behavior Analysis is the science in which tactics derived from the principles of behavior are applied systematically to improve socially significant behavior, and experimentation is used to identify the variables responsible for behavior change.
>
> (Cooper et al., 2007, p.20)

Training now has recognised international standards as outlined by the Behavior Analysis Certification Board (www.bacb.com).

The letter by Hughes is important for parents in the UK because the gross misrepresentation of a scientific discipline isn't just confined to professionals from Northern Ireland. I can honestly say though, that this is the first time I have heard someone with her standing and influence in Northern Ireland openly express her lack of understanding of ABA. Up until now, comments like these have been reserved for discussions behind closed doors by government-appointed bodies that have continually excluded ABA professionals. Because of this hegemony, normal scientific debate has been stifled.

Openness is one of the hallmarks of scientific practice and the peer-reviewed process plays an important role, albeit with its own limitations. However, in Northern Ireland government bodies are being persuaded to develop policy decisions that affect the lives of children, not on the basis of published peer-reviewed research literature, but on the basis of in-house reports. Comments by professionals on ABA in such reports challenge BPS ethical guidelines in that often these professionals operate outside of their own sphere of professional competence.

I am sure members of the BPS will acknowledge the ethical imperative of countering misinformation when it arises. The problem has been that attempts to deal with it have met with the sort of derision contained in this letter. Parents across the UK who have difficulty availing of people trained in ABA should be aware of political motives that contribute to this state of affairs. Readers who want to know what ABA is really about and what parents of children diagnosed with ASD make of it, should find recent research of interest (Keenan et al., 2007).

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Effectiveness and evidence in therapy

We would like to thank the Midlands Psychology Group for their interest in the newly formed Charlie Waller Institute of Evidence-Based Psychological Treatment (Letters, April 2008). We fully appreciate the importance of the service context and that the success of all therapies is predicated upon the formation of a good therapeutic relationship. We invite you to see this for yourselves in our wide range of workshops given by the world leaders in the field (www.reading.ac.uk/charliewaller).

We believe that people with mental health problems are entitled to be treated with interventions that have been shown to work, and we credit practitioners with sufficient skills to be able to apply the treatments appropriately in their service.

Roz Shafran
Craig Steel
Charlie Waller Institute
School of Psychology and Clinical Language Sciences
University of Reading

Health literacy

Antidepressants? Addiction? Depression? Psychosis? Hallucinations? What do you understand by these terms? What might these complicated words mean to someone with reading difficulties? People with mental health problems already face a number of challenges, and very little focus has been given in the UK to how health literacy – an individual's capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions – adds to these.

The mental health sectors rely heavily on written information, but not all will be able to read it. Mini Mental State Examination scores cannot be fully interpreted without consideration of the patient's literacy skills, and some scales are written at a reading level of tenth-grade or above (15-year-olds or older), which most patients with low literacy would not be able to read or understand.

Practitioners still generally fail to screen patients for reading difficulties, despite the availability of screening tools, such as the Rapid Estimate of Adult Literacy in Medicine (REALM). The REALM is quick and easy to administer, and I recently validated it for use in healthcare settings in the UK.

Beyond screening, information needs to be revised to a reading level that all patients can understand. There are guidelines available on how to rewrite consent forms and other documents for use by clinicians to help make information easier to understand (Institute of Medicine, 2004). Sentell and Ratcliffe-Baird (2003) suggest that materials written at the fifth or sixth grades (10- to 12-year-olds) should be easy for most individuals to read and understand. The use of graphics and improved formats would help make health information more user-friendly for individuals with literacy difficulties.

I would like to encourage psychological researchers and practitioners to bring this pressing public health issue to the fore. Healthcare for all is a basic human right: it needs to be comprehended by all for them to reap the full benefits.

Saima Ibrahim
London South Bank University

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obituary

Daud Ali (1943–2008)

Daud Ali was born and grew up in the Hiran region of Somalia in the mid 1940s. He overcame his poor background to become a teacher there before going to Beirut to study theology, where he happened to be living during the six-day war. Dr Robert Young, an American lecturer in educational psychology, came to Daud's aid and arranged for him to go to Germany, from whence he made his way to England, arriving in 1967.

Daud completed his training and went on to work as a teacher in Liverpool and St Helens. It was during this time he developed his passion for football and the fortunes of Liverpool FC in particular. Following study of psychology with Liverpool and the Open Universities, he undertook his professional master's degree in educational psychology at the University of Exeter, focusing his research on the experiences of Somali immigrants in Liverpool. His findings were sobering, presaging some of the major tensions that have subsequently emerged within minority Muslim communities, where adults who had moved to this country to find better opportunities for their children found themselves wholly alienated from the communities in which they had to reside but needing to engage at some level in order to give their children access to the very social capital which had led them to make immense sacrifices to come here in the first instance.

Daud then joined the Birmingham Educational Psychology Service in September 1988 where he continued to work until his retirement in 2004. He was always a passionate advocate for minority groups and chose to work in some of the most deprived areas of the city. His work was characterised by a quiet but dogged determination to help schools to meet the special educational needs of children with often complex difficulties and challenging behaviour. His particular detailed knowledge of Somali culture was invaluable to Birmingham teachers and psychologists working with refugees and asylum seekers from that troubled country. He also brought his knowledge and considerable experience to the city's initiatives to improve the educational performance of black boys from poor backgrounds, about which he felt deeply. Throughout his career, Daud was always a popular member of the EPS, his charming, courteous, laid-back manner, infectious smile and gentle sense of humour endearing him to all. Colleagues regarded him as a man of peace as well as of passion.

In spite of the extreme dangers due to political instability and warring factions, Daud opted to spend most of his retirement years in Somalia, working to put something back into the community that he loved. In the Hiran province he set about establishing a public library in Beled-Weyne, the first in the country, helped by donations and a grant from the British government. Then he began his great work of creating a purpose-built school from scratch, funded largely by donations from friends,

Dr Kanka Mallick

It has been brought to our attention that an incorrect date of birth was published in last month's obituary for Dr Kanka Mallick. Her correct year of birth was 1934.

colleagues and communities in the UK. This was completed in March 2008.

Tragically, Daud, along with three other teaching colleagues, was shot and killed by militant extremists on 14 April this year. Daud's death is deeply felt by members of the profession who knew and worked with him. He will be remembered as a brave, determined and wonderful man who touched many lives. His widow, Margaret, is determined that the school he founded will continue and will serve as a fitting legacy of his life as an educator and psychologist.

Francis Mallon
Birmingham Educational Psychology Service

COMMUNITY NOTICEBOARD

I am seeking **voluntary clinical psychology work in the area of Weston-Super-Mare**. I have both academic experience (Psychology BSc, Abnormal and Clinical Psychology MSc and currently undertaking a PhD) and supervised clinical experience in the NHS and private practice, particularly in the field of eating disorders and neuropsychology. I have developed and implemented structured programmes of work with clients on a one-to-one and group basis. Full CV available.

Elina Telford
Lin_telf@hotmail.com, 0796 827 1890

I would like **contact with individuals who have gained Chartered Forensic Status by undertaking Stage Two of the Forensic Diploma**. Having worked within clinical and forensic practice settings prior to completing BPS-accredited MScs (which exempt us from completing Stage One of the Diploma) within the last two years, I would really appreciate any advice from supervisors, fellow trainees currently undertaking Stage Two, those who have managed to complete this route and indeed those who have had training plans approved and/or even Exemplars 'passed'. I will be working within independent practices which deal with childcare proceedings, risk assessment and probation consultancy, with overall supervision being provided by a Chartered Clinical and Forensic Psychologist.

Zerine O'Keeffe
zerine-okeeffe@btconnect.com

CFS – challenging assumptions

I was interested to read in the 'Out now in BPS journals' section of *The Psychologist* (May 2008) that patients with chronic fatigue syndrome (CFS) cope with their illness by operating 'within a narrow "energy budget", which ultimately becomes self-defeating'. As a specialist in this field, I accept that most patients try to control their fatigue by restricting their activity levels. However, I am yet to be persuaded that this is maladaptive, and I'm concerned that the item may have given readers a distorted view of this disabling condition.

The claims made by the author of the paper in the *British Journal of Health Psychology* seem to be based on a number of assumptions. The first is that all patients respond to their symptoms in the same way, i.e. fear, avoidance and misattribution. However, studies have shown that the majority of people with CFS use a range of coping strategies and that most remain ambulant; and I've seen no evidence yet that this illness is linked to a general 'fear of fatigue' (Lovell, 1999). Moreover, it is difficult to reconcile theories focused on challenging somatic attributions when research has identified abnormalities in the cerebrospinal fluid, brain, muscle and immune system (Goudsmit & Howes, 2008).

However, the author's main assumption is that his approach to the management of CFS is superior to strategies such as pacing, where patients conserve energy to avoid exertion-related fatigue. In the case of graded exercise, the effects tend to be modest, and studies using objective measures have not found significant or sustained increases in activity levels. The second alternative is mindfulness. This has been tested in three small studies, and while it reduced fatigue, only the uncontrolled trial on nine patients found a significant improvement in physical functioning (Surawy et al., 2005). Most notably, the author recommends that patients adopt a third approach: to accept the 'symptoms and distress'. Firstly, this implies that the first two interventions don't work. Secondly, given the severity of the illness, is this best practice? Thirdly, the paper challenges homeostasis, yet we are asked to encourage acceptance. Isn't that homeostasis?

The essence of the author's argument is that pacing is associated with a poor outcome. However, this is speculation and there is no evidence from trials or surveys to support this negative view. A summary of the literature relating to pacing, plus a discussion of the abnormalities referred to above, can be found in the current issue of *Health Psychology Update*, also published by the BPS.

Ellen M. Goudsmit
Teddington
Middlesex

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