Learning to teach more reflectively

We are delighted to read Professor Knapper's letter 'Who teaches the teachers?' (July 2015), which highlights the current state of teaching practice in the higher education sector. While the letter implies a paucity of teaching professionalism, which we do not agree with, we would like to add that a national focus is needed to ensure that research into teaching practice forms a solid foundation for effective delivery in the lecture hall.

There are many established drives to increase teaching quality throughout the UK HEIs. These schemes go beyond the 'induction courses' highlighted in the correspondence and allow teachers to reflect on how best they can develop their own practice to ensure innovation in delivery and assessment is both integral and continuous.

Initiatives such as the Higher Education Academy (HEA) Fellowship accreditation schemes have seen a significant rise in HEA Fellows throughout the sector. Here, excellence in teaching practice is regularly celebrated with Fellows, Senior Fellows and Principal Fellows finding themselves in positions where they can direct, drive and even determine teaching excellence in their own institutions.

The celebration of such teaching excellence is not an example of the facile 'adoration of excellence' – an inexorable movement that has been identified in the modern-day university borne out of the drive to marketise the HE sector (Halffman & Radder, 2015). Rather, such schemes see the rise of an altogether more reflective and informed teaching practitioner encouraged to embed their own learning and teaching research into a more complete reflective account of their individual teaching practice. Indeed, we have previously stated that the field of psychology is pre-eminently positioned to benefit from such a reflective approach (Senior et al., 2015). Yet, more could still be done.

Ultimately, the modern-day university is a large organisation and like all other large organisations it is sensitive to various market forces. Such forces drive managerial strategy to divert resources towards high-impact research activities that are likely to be successful in subsequent funding exercises. Policy that recognises the importance of learning and teaching research and the role that it plays in the delivery of evidence-informed teaching practice in the classroom is needed before teaching excellence in the HE sector achieves the recognition that is deserves.

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CBT losing efficacy? – Not proven

In the July issue 'Digest' you report a meta-analysis of 70 CBT studies for depression conducted by Johnsen and Friborg (2015) and opined 'CBT doesn't seem to be helping reduce depression symptoms as much today as it used to when it was first developed in the 1970s'. But this conclusion may be premature, inspection of Table 1 of Johnsen and Friborg's study shows that from 1977 up to and including the millennium 85 per cent of studies were randomised controlled trials (RCTs) but from 2001 to 2014 the comparable figure was 65 per

Christopher Knapper in July issue is unfortunately right to bemoan the amateurism of much university teaching. However, he does us no service by picking out the lecture as a principal offender. There are good and bad lectures, just as there are good and bad seminars, workshops and supervisions. The lecture's great advantage is that it is highly economical of expensive staff time. Sadly, despite the efforts of all our staff development units there is a persistent culture that perpetuates the myth that no training is needed to give an adequate lecture. And it is often the brightest academics who see the least need to improve.

A good lecture is properly organised and signposted, relevant to the course studied, interactive and inclusive. It also requires very little extra effort on a trained lecturer's part. The other side of the coin is that students receive no help in engaging with and interpreting lectures. Many of them take extensive notes, which some of them even write up into fair copies afterwards. In fact, such note-writing actually distracts from following the live lecture. Any lecturer who doubts this should glance through the notes of one or two of their students; they would be horrified to see the unintelligible gibberish!

Of course, breaking the culture is difficult. Perhaps the best suggestion is for those of us who do deliver effective lectures to take every opportunity to demonstrate their skills to colleagues. But as Knapper says, the evidence-based practice they regularly preach is slow to reach our academics' own practice.

Asher Cashdan
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cent. One of the hallmarks of an RCT is blind assessment, using a standardised diagnostic interview. Thus there can be no certainty that populations treated post the millennium are comparable to those before. The results of Johnsen and Friborg's (2015) meta-analysis could more parsimoniously be interpreted as indicating that CBT does not work well when the population being addressed is poorly defined. Historically, CBT treatments have largely been diagnosis-specific, arguably failure to match disorder/difficulty with protocol will result in sub-optimal outcomes.

The authors of this meta-analysis did not analyse outcome in terms of loss of diagnostic status to determine whether this has changed since the 1970s – from a public health point of view changes on continuous measures, though important, are essentially surrogate measures. It would also be interesting to see a re-analysis of the included studies comparing outcomes in studies using blind standardised diagnostic assessments with those not using this 'gold standard'.

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Reference

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Psychology and religion

I was interested to read Ann Wood's description of her experience as a member of a spirituality group at a rehabilitation unit ('People first, science second', June 2015), not the least because articles in *The Psychologist* that deal with religion are almost as rare as the proverbial hens' teeth [although see tinyurl.com/psychreli]. Whilst there are academic journals in our field that specialise in religion, this dearth of articles suggests that psychologists prefer to keep religion very much in the background. However, Ann Wood's informative contribution illustrates how rewarding it can be to participate in the sort of group that she describes, even after her initial reservations.

One of the vocational guidance tests I used to administer to young people had the profiles of psychologists and the clergy next to each other in rank order. Invariably, when I came to give feedback and reported that the test had shown the best matches were with the profiles of psychologists and the clergy, the reaction from the parents was something like: 'Our little Johnny a clergyman – with the way he behaves, you must be joking!' I then had to try and explain that both these professions were concerned with helping people, enhancing their wellbeing, and life satisfaction. The only real difference is that the clergy base their approach on spiritual beliefs, and psychologists on evidence-based theory and practice.

Is it possible to have a foot in both camps? Do psychologists have to have personal a religious faith in order to consider that a client's difficulties might have a spiritual basis? Likewise, should clergy involved in pastoral counselling accept that there are times when the help they are able to offer is inadequate, and that a consultation with a psychologist would be advisable? Even more interesting are the questions 'Can both these roles be fulfilled by the same person?' and 'Would it then be professionally acceptable for one person to operate in this way?' No doubt the current climate of political correctness, human rights and fear of litigation would act as discouragements.

Likewise, there can be resistance from both to investigating spiritual and religious topics using the tools of the scientific method. Those with strong religious convictions may say that everything contained in holy books should be accepted as inerrant. In the other camp, the secularists will say that all can be explained rationally and nothing is supernatural. In my first book *The Gospel Miracles: What Really Happened?* (Resource Publications, 2014) I examined 35 miracles with an open mind and without any pre-suppositions. The findings will no doubt please neither the religious conservatives nor the secularists, but only those who value an honest attempt to arrive at the truth. I am continuing this unbiased inquiry in my second book *Suicide, Euthanasia, and Despair: Can the Bible Help?*, and my next will be on whether a religious faith can enhance mental and physical wellness in the third age.

Whatever our inner convictions may be, the fact that the lives of many people are influenced by their spiritual beliefs and religious convictions means that these must be taken account of by all in the helping professions, and not ignored. I look forward to seeing more contributions to *The Psychologist* on matters of religious faith.

Dr Michael Lowis
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Northampton

Fossil fuel divestment and the BPS


TIM SANDERS

Last year the British Medical Association (BMA), the representative body of doctors in the UK, voted to end its investments in fossil fuel industries, becoming the first professional health organisation in the world to do so. The move follows mounting evidence that climate change poses a major threat to human health and wellbeing through increased risk of severe weather events (storms, floods, droughts), global food insecurity, the spread of infectious diseases, forced migration and war (Berry et al., 2010; Costello et al., 2009). Among the United Nation's recent Millennium Development Goals a new goal has been added: Take urgent action to combat climate change and its impacts (see tinyurl.com/nasnrsy).

Avoiding the worst impacts of climate change will require substantial reductions in fossil fuel consumption. In order to have at least a 50 per cent chance of keeping below a surface temperature increase of 2°C above pre-industrial levels – the generally agreed threshold for dangerous climate change – 80 per cent of currently listed fossil fuel reserves will need to remain unburned (McGlade & Ekins, 2015). This is the goal of the divestment campaign. The campaign recognises our current dependence on energy produced from fossil fuels and argues for a transition to a low-carbon economy through moving stocks, bonds and other assets from industries whose primary business relies on fossil fuels, to investments in renewable energy.

The BMA's decision to divest from fossil fuels is analogous to its decision to divest from tobacco industries 30 years ago. Then, as now, the move acknowledges that for a health organisation to invest in and profit from industries that are directly harmful to health is inherently contradictory. Over the past year hundreds of universities, cities, counties, businesses and public organisations have committed to end their fossil fuel investments. Within the health sector groups of health professionals and students such as Medact and Healthy Planet UK are calling on UK health organisations to divest. The BMA's decision has set a historic precedent – but where is the BPS in this debate?

The BPS has previously demonstrated its eagerness to engage with the threat of climate change by publishing relevant articles and letters in *The Psychologist* and responding to consultations about the potential health impacts of climate change (e.g. BPS, 2007). Yet the question of whether – or to what extent – the BPS

The presidential term of office

When reading Gene Johnson's article in the March 2015 edition of *OP Matters*, I considered my experiences with the BPS, and Johnson's discussion of the BPS Strategic Plan 2015–2020. As I reflected, I pondered: if a FTSE 100 company changed its CEO every year, you might expect limited long-term development and success from that organisation. So why does the BPS change its leader, i.e. the President, every 12 months? The President and President Elect work as a team over a two-year period, but this does not change the fact that there is a new leader every year. As Johnson states, 'we know that changing the Society culture... will take some time' (2015, p.38), so why have five different people try to lead the implementation of the Strategic Plan?

Yes, the Society has a CEO, Professor Ann Colley, who has been in post since 2008. But I was unaware of this: the *Psychologist* editor had to point it out to me. A search of the BPS site for her name produces few results, she doesn't appear on the Society's Wikipedia page, and the Strategic Plan contains not a single mention of her or her position. This suggests that the leadership of the BPS resides within the role of President. So how can an organisation achieve significant and lasting change, as proposed in the Strategic Plan, when its leader changes so frequently? A quick comparison of similar organisations shows the Royal College of Psychiatrists elects their President for three-year terms and a President of the Royal College of Physicians averages about four years in post, although elections are held every year.

What then is the answer? Firstly, I hope this letter can kick-start a valuable conversation on the role and responsibilities of the President concerning the leadership of the BPS. However, if anyone says, 'Well, we (the BPS) are different', please shoot them. After you have called an ambulance, administered first aid and applied the safety catch to your weapon, try to find evidence of organisations and companies operating successfully when they have a continual turnover of leaders. We are not different and it's time to decide if we want to evolve and deliver on the Strategic Plan, or any plan for that matter. If so, we need long-term leadership from a visible leader, who I believe should be the President. I urge the BPS to analyse the evidence concerning the effects of long-term stable leadership and short-term changing leadership on the success of organisations, and decide if evidence-based practice is what we do ourselves, or just something we recommend for others.

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Reference

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Reply from Carole Allan, BPS Honorary General Secretary:
Our President is the figurehead for the organisation and chairs our Board of Trustees, which is

is invested in fossil fuels has, to our knowledge, not been publicly discussed.

Climate change poses an unacceptably high risk to human health and wellbeing and necessitates urgent action. The BPS has an important role in shaping public understanding of these threats and the potential to be a leader in tackling them by committing to divest from fossil fuels and encouraging other organisations to do so. We ask the BPS to publicly clarify its position on fossil fuel investments, withdraw any existing investments, and commit to not investing in these industries in the future.

Francis Vergunst
Bergljot Gjelsvik
University of Oxford

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Reply from Ray Miller, BPS Honorary Treasurer: The Society takes a range of ethical factors into consideration when making investment decisions about its funds. Investments are reviewed on a regular basis by the Board of Trustees in this context, as well as in accordance with charity legislation that requires we make adequate returns on invested funds for the benefit of the organisation and its members. The Society recognises the importance of balancing ethical and economic considerations and will continue to monitor investments closely with these matters to the fore.

the governing body. The President has no powers over and above those of other Trustees, who share the responsibility for the governance of the Society and its strategic leadership. The presidential position is taken as part of a three-year term to ensure continuity, but also to allow a period of gathering knowledge (the year as President Elect) and overlap (the year as Vice President) to ensure that there is cover for events or meetings that the President is unable to accommodate. The Chief Executive has the delegated responsibility for the administration of the Society's affairs, leads the Society's staff and represents the Society at relevant meetings and events with her counterparts in other organisations.

The issue of the term of office for the presidency has been raised periodically, and the pros (e.g. continuity) versus cons (e.g. the danger of restricting the field due to the enhanced load over a prolonged period) have been debated, but no clear mandate for change has emerged. Times have changed, and the Board of Trustees will again start the process of reviewing key positions within our governance structure as part of a review of governance that has been initiated. The conversation therefore has commenced, evidence will be gathered and more information will follow later this year.

NETWORK FOR NHS PSYCHOLOGISTS

The NHS network originally began in 2013 and regular meetings were arranged by me with qualified and trainee counselling psychologists that could attend, but mostly contact was via e-mail. From these beginnings I put forward an idea about opening this group up to other counselling psychologists and applied psychologists (clinical psychologists, health psychologists, and forensic psychologists) countrywide. With the Division of Counselling Psychology Executive Committee's support the NHS network was launched on 22 January 2014.

From this event new members joined and the membership has grown. Five meetings are scheduled yearly where the NHS network can meet at the BPS offices in London to develop the group further; there are also telephone conferencing facilities available during those meetings. Attendance levels at the meetings do vary but I do believe that this network offers a space where psychologists feel they belong and they are connected with other psychologists who also work within the NHS.

Psychologists who work in the NHS are a unique specialist group that contributes high levels of expertise through the delivery of psychology services to members of the public and the NHS organisation. One of the issues this network has thought about is 'How do psychologists look after themselves within a changing NHS?'. The NHS network has discussed and continues to have conversations about the impact of working in the NHS with its targets and reduced resources, and about how psychologists can take care of themselves. Network discussions are rich in content and we have talked about commissioning, clustering and the funding of services. As a network we have thought about the systems that are used to quantify what psychologists do and whether they are designed to really capture the way in which psychologists use their expertise to understand and formulate about the clients they see. Systems that are focused on numbers, and on ensuring that psychologists are seen to be doing, do not fully appreciate the time it takes to 'think' about the client. When psychologists need to 'be with' what the client brings, through reflection and other skills that help to make sense of the work; this is sometimes misunderstood as 'not doing' enough and 'not meeting targets'. An interesting figure of speech was used in the discussion I had with some members of the network to illustrate how this aspect of our work can be experienced as an 'attack on thinking'.

I am curious if you have any views on this topic. If you would like to join the NHS network please contact me via DCoPNHS@bps.org.uk

Dr M. McIntosh AFBPsS, CPsychol
NHS Network Lead

Why the 'new statistics' isn't new

Smith and Morris ('Building confidence in confidence intervals', June 2015) and Cumming (2014) encourage psychologists to move away from null hypothesis significance testing and to report effect sizes and confidence intervals instead without invoking significance (i.e. the 'new' statistics). We offer three points of contention.

First, confidence intervals (CIs) are based on null hypothesis significance testing (NHST). Calculating a CI as suggested by Smith and Morris in *The Psychologist* and by Cumming (2014) does not in any way differ from NHST. Indeed, the CI is obtained using the same underlying statistical method as the *p* value. For example, consider that the lower and upper bounds of the 95 per cent confidence interval are simply a function of the standard error of the estimate multiplied by the Z-score (i.e. the critical value for significance or 'alpha'). Changing the alpha level (e.g. from 5% to 1%) will change the Z-score (from 1.96 to 2.575) and hence the value range of the CI. Thus, the CI is directly based on a null hypothesis significance test. Using the CI will not help psychologists move away from this practice. In fact, researchers often treat the CI as a *p* value simply by judging whether or not the interval includes a '0' (Hoekstra et al., 2014).

Second, the true definition of a confidence interval is not very intuitive or very practical. Contrary to popular opinion, the values contained within the CI aren't necessarily that interesting. Why? Because they don't mean what most psychologists think they mean. For example, the 95 per cent CI does *not* mean that '95 per cent of the sample data lie within the interval' (a CI is not a range of plausible values for the sample mean). A CI also does *not* mean that 'there is a 95 per cent probability that the true population parameter lies within the interval'. In fact, the 95 per cent probability does not refer to the interval itself but rather to the reliability/confidence in the method that is used to obtain the interval. In other words, the CI does not refer to a specific sample but rather to the notion of repeated sampling (method).

A correct definition: *If this procedure were repeated on many samples (e.g. conduct an experiment over and over again), and a hypothetical confidence interval would be calculated for each individual sample, then 95 per cent of the time, the CI would contain the true population parameter.*

Note: this means that we have no idea if the CI calculated for a specific sample actually contains the true population value! The hypothetical nature of the interpretation of the CI makes it not very intuitive to meaningfully use or apply (hence the widespread misinterpretation). Also note that although it sounds like they might, exotic procedures such as 'bootstrapping' or 'jack-knifing' do not substantively change the interpretation of the CI.

Third, the real new statistics: beyond the confidence interval. We are not suggesting that reporting effect sizes and confidence intervals is bad practice. On the contrary, confidence intervals and effect sizes often contain more detailed and useful information than *p* values alone. However, there are other ways to construct confidence intervals that do not rely on NHST. One example is the 'credibility interval', which is based on Bayesian procedures and allows a researcher to actually express the obtained interval in terms of a real probability. The larger point is that if we honestly want psychologists to adopt a 'new statistics', we need to build confidence (not in) but outside the confidence interval.

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Breanne Chryst
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References

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DID THE SCOTTISH NATIONAL PARTY BENEFIT FROM INGROUP BIAS?

Following recent articles (May 2015) and letters (June and July 2015) in *The Psychologist* on the election and referendums, might psychological principles also help to explain the most striking outcomes of the general election: the extraordinary and surprising success of the Scottish National Party (a gain of 50 seats) and the equally extraordinary, but perhaps less surprising, failure of the Liberal Democrats (a loss of 49 seats)? Could such large changes in voting behaviour be due to political factors alone or might something of a more general psychological nature have been going on?

In spite of its result the Scottish referendum, by making more salient all things Scottish, elevated feelings of Scottish identity in Scottish minds and stimulated engagement with Scottish issues. This had repercussions for a powerful social phenomenon: they enhanced positive ingroup (i.e. Scottish) feelings, and perhaps also feelings of derogation towards an outgroup (the English).

For some, the pros and cons of Scottish independence played little or no part in their voting decision and an increase in ingroup feeling was sufficient for them to vote SNP. A second group had voted for independence in the referendum, or had become independence-minded as a result of the ingroup effect. The third group were uncertain about independence but wanted to see the SNP in action in Parliament, so as to turn their uncertainty into something more decided. But all were pushed in the direction of voting SNP as a result of an ingroup bias.

Could such a powerful swing to the SNP have occurred without engaging a strong psychological tendency like ingroup favouritism, and could this have happened without the strong stimulus of the recent referendum for Scottish independence?

The Liberal Democrat case is more complex but might their collapse also be explained in part by a very general and simple psychological process? Being a minority in a coalition government made their distinctive policies more difficult to detect, until the last few weeks before the election when the gloves were off.

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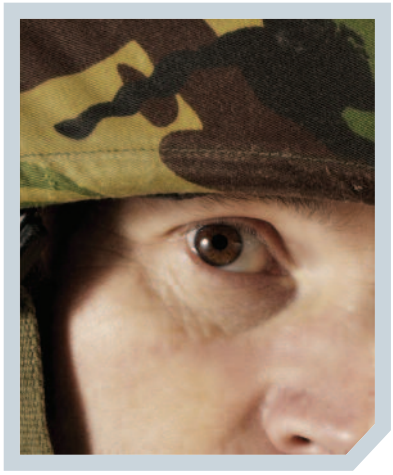
Helping our armed services veterans

We thank Professor Hacker Hughes for his interview ('From civvy street to theatre of war', May 2015) raising awareness of psychology in the armed forces and mental health risks faced with courage by members of the armed forces.

Regarding veteran mental health provision, we agree with Professor Hacker Hughes that there is a lot of room to improve. Veterans coming through our service often do describe negative past experiences of mental health treatment across the sectors, but they are equally often strong in highlighting the contacts that have helped and encouraging other ex-service personnel to make contact, acknowledge their needs and get help. Nobody is going to argue for complacency, and there are debates to be had about how far we have come and what most needs to change, but if the narrative remains relentlessly negative there is a danger of reinforcing perceptions that put veterans off even further when we need to build bridges.



Given the historical connection between clinical psychology and the NHS it is also a pity that the NHS veteran services were not mentioned. Ex-serving personnel can access the NHS via a network of regional veteran mental health services. Each operates to a different model according to their area's needs. In London, for example, we have an open referral service to make it as easy as possible to find a way in. For most people we offer assessment and assertive treatment advocacy to try steer to the right services and to improve engagement. Our follow-up audit data suggests that the approach works, as more are in treatment at follow-up when we refer compared to GP referrals. We also support the capacity across the sectors to meet veterans' needs with training and consultation. For instance, this year we have co-produced with veterans and expert speakers training for IAPT workers in offering evidence-based therapies in a veteran-oriented way. We offer specialist therapy for complex service-related trauma if that is not available in the local area. Most regional services offer, like us, a mixture of assessments, referral pathways, treatment and training.

Commonly, veterans are seen in mainstream NHS services, which will be fine when there is good practice and attention is paid to veteran status as a 'difference that makes a difference'. It helps to educate oneself, avoid assumptions, acknowledge differences in language and culture, appreciate the strong values system in the armed forces and how training, deployment, combat and transition can shape a person's experience. We find a lot of openness and enthusiasm from NHS professionals when offering veteran mental health training.

Veteran charities bolster the field with a wide range of further choices. A strength of the field is that NHS and charities work together to provide services and maintain networks and referral pathways; for example the London Veterans' Service has working partnerships with Combat Stress, the Sir Oswald Stoll Foundation, the Ripple Pond (for families) and many other organisations. There is also plenty of innovation, such as our recently launched prison in-reach service to HMP Wandsworth. Looked at from one perspective, there is a substantial range of decent provision, many veterans recovering and an improving trend in available help and de-stigmatisation. Many problems are not specific to veterans – like form-filling and waiting lists. The main challenge – again not specific to veterans, although arguably greater a problem for males – is people not being seen at all, which is why I think we should be realistic but also offer a bit more hope for people considering seeking help.

Dr Nick Hawkes
Clinical Psychologist and Co-ordinator
London Veterans' Assessment and Treatment Service
Camden and Islington NHS Foundation Trust

NOTICEBOARD

We would like to hear about your **feelings and emotions in your workplace and how these impact your ability to 'switch-off' after work**.

At the University of Surrey we are currently conducting a study exploring the relationship between perceptions of organisational justice, feelings at work and how individuals 'switch-off' after work.

You can take part in the study by just completing a 10–15 minutes online survey (http://surveys.fahs.surrey.ac.uk/Switching_Off) or by emailing me.

Evie Michailidis
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Psychology A-level the source of gender imbalance?

Over the years there has been frequent discussion in these pages about gender imbalance in psychology. In my own experience of psychology courses and clinical psychology departments from the 1950s to the late 1980s there were always roughly equal numbers of males and females. I suspect the change occurred gradually after A-level Psychology was introduced. As a school governor I became aware of the syllabus, probably around 1992/3 I would think. One topic must have been Infant Speech Development because I recall giving the sixth-form teacher a tape of infant speech, possibly prepared for teaching purposes, which I purchased from the BPS!

I suggest that a 'soft' topic such as this is unlikely to appeal to boys of 16 or 17. Steering clear of psychology at A-level, it is unlikely they would then opt to study it at university.

Perhaps the syllabus needs to be scrutinised and some adjustments made.

Incidentally it would be interesting to know the proportion of male A-level teachers of psychology; are there sufficient male role models to attract the next generation?

Pat Kingerlee
Wymondham
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In defence of the MBTI

In her critique of the Myers–Briggs Type Indicator (MBTI) ('New voices: Helpful categorisation or limiting label?', July 2015), Caitlin Cherry describes herself as an INFP (she also questions the value of this description) who, despite preferring Feeling, 'sometimes' likes 'conflict and debate'. Well, I too am an INFP who sometimes enjoys a debate and I'd like to offer some brief counter-arguments and elaborations.

First, I think Cherry misunderstands the central concept in MBTI theory of preference. Preference can be defined as 'feeling most natural and comfortable with a particular way of behaving and experiencing'. For example, although people who prefer Feeling tend to enjoy debates less than those who prefer Thinking and may therefore generally debate less often and with less comfort and sense of fulfilment when they do, we nevertheless, according to MBTI theory, can do it – hence my emphasis in the first paragraph on the word 'sometimes'. In other words, we each develop our non-preferences too but they are not, in normal development, as well-developed as our preferences nor, in MBTI theory, would this be desirable.

A possibility here is to help someone rank order both their preferences and their non-preferences in terms of development. An INFP for example, again given normal development, could be an NPIFSTJE or numerous other permutations. This level of description would be helpful for some people and the crisper, more manageable INFP level for others. A strength of the longer variation is that it explicitly recognises that the non-preferences are part of each personality too, as illustrated well in Cherry's analyses. It would also mean creating many more descriptions, and of course more still if further pairs of preferences were added to the standard four pairs. Anxiety, reframed as preference for Worried versus Calm, is a main contender (Bayne, 2013).

Second, Cherry states that the MBTI has a 'questionable scientific base', which in context I take to mean that the evidence for its validity is 'weak' or 'fundamentally flawed'. Many psychologists and textbooks make the same misjudgement. The simplest counter-argument is that the main measure associated with a rival theory of personality (Big Five theory) correlates highly with the MBTI, that the evidence for the validity of one of these theories therefore generally supports both, and that Big Five theory is currently the best researched and most widely accepted theory of the traits/preferences level of personality.

Third, I found Cherry Caitlin's vivid illustrations of the effects, both positive and harmful, of MBTI and MBTI-like personality test results, and of the related inaccurate descriptions of some of them, particularly powerful. I imagine that we'd agree that competent feedback is vital to enhance the positive effects and reduce the harmful ones and that competence includes the following: stating and meaning that it is the person whose results they are who decides on their accuracy; emphasising that the results are a step towards understanding part of their individuality; and suggesting other approaches to increasing self-awareness and self-respect, such as strengths, projects, values and life stories, which may complement the results or for the particular person be more helpful than them. I also think test results can be treated as too authoritative and that exercises and discussion can work well without them (Bayne, 2013).

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Reference

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Abandon autism as

Dougal Hare and Rita Jordan (Letters, July 2015) have helpfully attempted to allay my confusion about autism diagnoses (Letters, May 2015). However, I feel neither has entirely succeeded. Dougal Hare offers an interesting picture of autism suggesting something akin to a personality type with two psychological trait-components, representing social communication difficulties and repetitive/restricted behaviours, thus broadly reflecting the DSM-5 definition. Nevertheless, if I read him correctly, he still seems to think of 'autism' as naming some identifiable mental entity combining these components. Finally he says, rather puzzlingly, that issues of diagnosis are 'redundant' and that diagnosis provides a basis for determining service need.

Rita Jordan emphasises more clearly the need for diagnosis together with a thorough assessment of the individual's abilities and difficulties. One might think such an assessment would be sufficient for determining support services, at least if adequate individualised support were actually available for all who need it. Interestingly, however, she argues that, in the absence of a clear diagnosis, support should still be offered to children with similar needs 'as if they had autism'. This might imply that a correct diagnosis is not so important after all – if indeed we can ever definitely know when a diagnosis is 'correct'. And might this also encourage false positive diagnoses? So I continue to wonder what the difference really is between having autism and having an autism diagnosis, with no biomarkers for validating diagnoses.

Recognising ADHD in school

Underperformance at school is an increasingly prevalent issue for young people with ADHD. Why? I believe teachers are not equipped to distinguish ADHD from mere 'laziness' or 'bad behaviour'.

I was diagnosed at the age of 17. I always thought that concentration, retention and politeness were everyday challenges for everyone – not just me. As a child with undiagnosed ADHD, you are either put in the bottom classes at school, led to believe that you are 'educationally challenged', or you are put in the top classes and feel just as bad because you cannot keep up with your peers. As the unpleasant comments become common, you begin to think that maybe you are stupid, maybe it is your fault or maybe you are lazy. No matter how hard I thought I was trying, I was never good enough.

My diagnosis of ADHD was a huge relief. The 'fog' was lifted and things made more sense. I started medication, and the difference in my behavioural stability was incredible. Yet I would have to 'defend' my condition to people such as the 'matron' who handled all of my medical matters at boarding school.

Schools must take the appropriate measures to help and recognise ADHD, because it is not rare, and a worrying number of children are left to feel alone and misunderstood. Numerous e-mails from school were sent to my parents, complaining that I could not retain information or focus, and that I was disorganised, rude and outspoken. Everything pointed towards a child struggling with ADHD: my school just never made the

discrete disorder

Indeed, whether a child's pattern of behaviour meets the criteria for autism obviously depends on how we conceive this. As Verhoeff (2013) has shown in an illuminating review, conceptualisations of autism have changed substantially since Kanner's time, such that there is no good reason to suppose that there is one distinct condition underlying all its various definitions in successive diagnostic manuals. I can agree with Rita Jordan that its current incarnation in DSM-5 appears unsatisfactory, particularly the key criterion of restricted behaviours and interests, but will any satisfactory and stable definition of autism ever be attainable? Given all the evidence of heterogeneity and the changing criteria for diagnosis, one can surely ask (1) whether 'autism' represents much more than a general label for people with social cognitive difficulties, and (2) whether diagnosis simply functions as a conventional stipulation about what kinds of people might qualify for dedicated (and limited) support services. Perhaps the best approach is simply to focus on atypical social cognition generally, as could be suggested by Happé and Frith's (2014) review, and abandon the idea of autism as some kind of discrete disorder.

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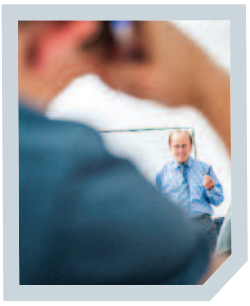

link because no-one had ever taught them how to help/recognise a child with ADHD.

Once at senior school, teachers place even more importance on a child being more mature, self-motivated, respectful; all the things that I (and many other undiagnosed teenagers) had not yet developed, due to being on average three to five years behind my peers in most things. I have been told that if I had been diagnosed at the age of seven, when my problems started, I could have gone to Oxford University. My reality now is struggling to meet grades that are much lower than those I would have needed to attend Oxford. That feels painful. Recognition of ADHD at an early age is of the utmost importance for children like me, and awareness must be raised.

If you are an ADHD expert in psychology, do you feel that you are doing enough to raise awareness for the condition? Do you believe that teachers are able enough to recognise struggling children in the school environment, or do they need to hear from you? Change will only come if experts bring attention to the issue. No one is going to listen to a teenager!

Ellie van Staden
agirlwithadhd.wordpress.com

obituary

Edgar Miller (1939–2015)

Ed Miller, who died on 22 May, was a distinguished academic and clinical psychologist, who was a past President of the British Psychological Society (1992/93) and the first clinical psychologist to be directly employed within the Department of Health.

He served as an officer in the Royal Signals before studying at the University of Hull, and after training as a clinical psychologist at the Institute of Psychiatry returned to Hull as a Lecturer when Alan Clarke was professor. He moved to Southampton in 1971 to become Senior Lecturer at the new Medical School, and then moved to Cambridge as District Psychologist and as Honorary Lecturer in the University. In 1990 he was seconded to a senior position at the Department of Health, having previously been Consultant Adviser in Clinical Psychology to the Chief Medical Officer. There he worked under both Virginia Bottomley and Stephen Dorrell, influencing policies on both clinical psychology and broader mental health issues. Meanwhile in 1992 he moved to the Chair of Clinical Psychology at the University of Leicester, where he led the clinical psychology training course, and introduced a number of innovative postgraduate courses.

Ed had a broad and deep knowledge of psychology, with an ability to apply its findings to matters of public concern. His clinical interests were in the fields of clinical neuropsychology and work with older people, and he published widely in both areas. The title of his Presidential Address: 'Psychological treatment: Nineteenth century style' reflected his long-standing historical interests in the history of both mental health services and the Poor Law, and after his retirement he completed a master's degree in local history at Leicester.

Ed was warm and friendly, with a sharp mind and an ingrained distaste for the pompous and pretentious, combined with a dry wit. He had a strong and ever-present sense of humour with a rich store of anecdotes, repeatable and unrepeatable! Ed and his wife Sally had enjoyed holidays on the Isle of Skye for many years, and after he retired they went to live there, but sadly had to return to live in Rutland because of his long-standing heart problems. Our sympathy goes to Sally and their three children, Andrew, Johanna and James. He was an outstanding example of a psychologist who combined both leadership of the Society and one of its professional branches, and will be remembered as a very significant figure in the history of clinical psychology in Britain.

John Hall
Oxford
David Griffiths
Cardiff
Geoff Shepherd
Cambridge
Mike Wang
Leicester

obituary

Emeritus Professor Maurice Chazan (1922–2015)

Maurice Chazan died on 29 May, aged 92 after a long illness. He gained an international reputation in educational psychology and special education, particularly in the area of children's emotional and social development and behaviour difficulties, compensatory education and special educational needs in early years.

He was a member of the Council of Europe working party on the evaluation of pre-school education, served on the board of directors of the International Council of Psychologists, and was a member of the International Study Group on Special Education. In the UK he served on the National Commission for the UNESCO Advisory Committee and on the Educational Research Board of the Social Science Research Council. He was appointed to the All Wales Advisory Panel on the Development of Services for People with Mental Handicaps and was a staunch supporter of the National Council for Special Education, having led its research committee for several years. He also served on the Fellowships Committee of the British Psychological Society.

Unusually, with a double first honours degree in classics he undertook a full-time training course in educational psychology, and then, within the context of working as an educational psychologist in Liverpool, he studied for a BA honours degree in psychology at the University of London. Afterwards he was appointed as a lecturer in the Department of Education at the University College Swansea, becoming a senior lecturer in 1964, and was awarded a Chair in Education in 1976, finally retiring in 1985, although continuing his activities long afterwards.

At Swansea he was involved, together with Professor Philip Williams, in the establishment of the diploma course in educational psychology by the British Psychological Society, from which many trainee educational psychologists in Swansea benefited. He and Professor Williams were also co-directors of the School Council research and development project in compensatory education, which was set up in response to the Plowden Report.

He published extensively on deprivation, social and emotional development and maladjustment. While some of his articles, books or contributions to books were theoretically oriented, others, such as his contribution to the book entitled *Helping Children with Behaviour Difficulties*, provided more practical guidance to teachers and other professionals. In his teaching and lecturing work he bought the same degree of commitment and meticulous planning as in his research. He was supportive, approachable, humane and trustworthy, and a fine public speaker with a rich resonant voice.

Combining formidable intellectual and communicative skills with a generous and supportive personality, he was widely respected and richly merited the award of Fellowship of the British Psychological Society. He leaves behind his devoted wife Hensha, a daughter (a second having pre-deceased him), and numerous loving grandchildren and great-grandchildren.

Dr Theodore Cox FBPsS and Dr A.F. Laing FBPsS
Swansea