



## LETTERS

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# Critical psychology – Not critical enough?

**S**TEPHEN Joseph ('Are psychologists agents of social control?', July 2007) raises the issue of why psychologists are not more involved in addressing the social causes of mental distress, rather than acting at a personal level. This is indeed a fundamental, urgent and very interesting question. It might be relevant to note that, by comparison, the medical profession is very active in the promotion of safe sex, anti-smoking and anti-excessive alcohol measures. This is in spite of the fact that presumably, in the terms of the article, every new case

of AIDS, lung cancer, a traffic accident or liver disease serves to increase the profession's power. We certainly need to ask why, by comparison, our voice is at best feeble in its assertion that poverty, inequality and alienation have equally toxic effects on mental health. Following the logic of the article, it would seem that this is simply because psychologists are, egotistically, more concerned with power



and privilege than with scientific evidence. However, no evidence was presented to support this assertion, which must raise the question of whether the critical perspective might itself have fallen victim to the very same charge that it raises. In this regard, I guess that I am not the only one to be increasingly concerned by the constant exposure to insufficiently critical 'critical approaches'. These assert or imply that those of us looking at biological and cognitive levels are unaware of or unconcerned about the broader social context and are thereby merely serving the interests of the power-hungry establishment. **Frederick Toates**  
*Open University*

## The Oliver James paradox

**R**EAD Oliver James's piece ('Selfish capitalism and mental illness' July 2007) with a mixture of amusement and exasperation, which, to be fair, has been my response to Mr James's career to date. Known for mixing the personal with the documented, opinion with evidence and emotion with science, his approach has perplexed and angered many of us in the psychological community for years. For once I find myself in broad agreement with his overall conclusion, old-hat though it is: of course greed is linked with unhappiness – years of research support this. It is rather his mixture of politics, economics and personal opinion that doesn't sit too well with a more scientific approach to psychology. How can we possibly compare mental health in Nigeria with the USA completely fairly? Their cultures, economies and values are poles apart. Psychotherapy costs money, so it is most widespread where they can afford it, and indeed where it has been culturally enshrined over the years, such as New York. A 'no-brainer', surely?

Are we really saying that China is not a 'selfish capitalist' nation these days? And what about the Ukraine? I could go on, but it's all neatly summed up in a review of James's latest book by Daniel Ben-Ami in *Spiked* (see [tinyurl.com/33b4ne](http://tinyurl.com/33b4ne)). Ironically, *Spiked* is a left-wing magazine, but however left-wing one's views may be, James's dissection of capitalism is at best naive – at worst comical. After all, according to his Wikipedia entry, he once sat on a thinktank for Jack Straw and now does so for David Cameron. What more can I add?

It comes to something when you're faced with the paradox of agreeing with someone's conclusions but finding his argument wholly unconvincing.

**George Sik**  
*Epsom*  
*Surrey*

## The diagnosis debate

**P**ETER Congdon (Letters, June) says that my article, critical of psychiatric diagnosis ('The problem with diagnosis', May 2007) left him unconvinced and despondent; I can only say that his feelings were reciprocated when I read his response. It seemed to me a good example of the question begging, the taking for granted of what is in dispute, which I noted characterises much writing in support of psychiatric diagnosis and helps foster its uncritical acceptance.

In arguing that diagnosis is 'supposed to cause divisions between the normal and abnormal', Congdon ignores decades of literature on the problematic nature of these concepts, especially when applied to emotions and behaviour. His suggestion that we trust 'the specialist' to assess the 'nature and extent of the division' suggests so great a difference of view of the terms of this debate as to leave me wondering if constructive communication is possible.

However, the point I and

other authors in the special issue were trying to make is that when, by whatever criteria, behaviour and experience are deemed abnormal, we suddenly switch theoretical models from those designed to help us understand 'normal' behaviour, emotions and cognitions, to one developed for 'abnormal' body organs. We do this without any evidence that such a switch is justified and in the face of considerable evidence that it is not, so that psychological theories have to be distorted to fit a medical framework rather than being a primary theoretical resource. It is these processes, I argued, which have disadvantaged the study of human behaviour in general, whether we call it normal or abnormal.

Congdon similarly claims that I appear confused in criticising 'comorbidity'. I was, in fact, questioning the very idea of comorbidity; that is, diagnosing someone as having more than one disorder, as against the non-diagnostic analysis of how and why

particular behaviours and experiences are related. Simply then to claim that 'comorbidity does happen at times and why not diagnose it as such?' is not an argument but only a reassertion of the point at issue.

I also noted in my article that one of the ways supporters of the DSM ward off criticism is by claiming that they are not doing or assuming anything much really (diagnoses are just atheoretical descriptions).

Congdon goes even further than this, claiming that 'labels' used in diagnosis are 'neither descriptive nor prescriptive' but 'may help to pinpoint a condition' and are 'merely a guide'. Apart from how he knows that there is 'a condition' to be pinpointed, this encouragement of such an unreflective stance towards the assumptions underlying diagnostic theory and practice is deeply worrying; certainly many service users can attest that these 'mere guides' can turn out to be remarkably prescriptive in practice, while we are left wondering at the tenacious attachment of clinicians, researchers and drug companies to a set of labels which appear to mean so little.

What is so dispiriting about the responses of Congdon and others in the June issue – and about the popularity of psychiatric diagnosis – is the lack of confidence they suggest in our discipline's potential to manage its own subject matter and to set its own agenda in its relations with other disciplines.

Should we then be surprised that the public so often seems unsure of who we are and what we do?

**Mary Boyle**  
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*Editor's note: A longer version of this letter, together with further letters and contributions on this topic and others, can be read on our discussion forum via [www.thepsychologist.org.uk](http://www.thepsychologist.org.uk).*

**U**NLIKE some of the letter-writers in the June 2007 issue, I very much welcomed the special issue on diagnosis in *The Psychologist* (May 2007). Hence I was disappointed to read letters by other psychologists, such as Michael Scott and Peter Congdon, indicating their reluctance to engage with any critique of traditional diagnostic practices.

I am particularly puzzled by Michael Scott's unquestioning faith in the DSM, despite the widespread criticisms of this in the literature, and am mystified by his implication that the critics are 'totalitarians'. Perhaps he might do well to read Rachel Cooper's (2004) paper, which examines the conceptual basis and development of the DSM.

Cooper argues that value-judgements are necessarily involved in deciding which mental conditions are regarded as disorders. Although there are likely to be naturally occurring

kinds of mental disorder which can be distinguished from each other, she argues that the DSM is inevitably theory-laden and cannot be a neutral taxonomy of these disorders. Since the studies used by the DSM committees are mainly biological in focus, a largely biological explanation of mental disorder is implicitly assumed. Furthermore, Cooper explains at length how the shaping and use of diagnoses in the DSM has been influenced by pressures for treatment reimbursement from medical insurance companies. For example, PTSD was included in DSM-III partly as a result of lobbying from Vietnam veterans to allow them to receive treatment which otherwise they could not

specific diagnosis (e.g. autistic spectrum disorder) is necessary for a child to be given appropriate educational support. However, he does not question *why* a child should need a 'diagnosis' to receive this support. He has nothing to say about the service systems which encourage parents to put pressure on professionals to provide the required diagnosis, nor what effect such pressures might have on diagnostic and professional practices generally. Do we suppose that our services are not affected by this?

These are undoubtedly difficult issues, but they surely deserve more serious consideration than the letters by Scott and Congdon have offered.

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#### Reference

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**I** WAS thoroughly absorbed by the recent special issue on psychiatric diagnosis. I was encouraged to read that there were people working in mental health that were prepared to discuss in a succinct and coherent way the consequences, from a variety of perspectives, of joining with the dominant story around people's distress, that of 'illness', 'diagnosis' and 'medicalisation'. Perhaps it is indicative of the level of 'truth' status the diagnostic model has been afforded by many groups of workers in mental health services, that to suggest that there may be uncertainties, gaps or flaws within such a model invites such a vehement response.

I am unable to share the sense of apparent unconcerned acceptance that others appear to hold in relationship to the diagnostic model, and still

#### Vietnam veterans lobbied for the recognition of PTSD

obtain. Cooper concludes that the DSM is unlikely in the foreseeable future to provide an adequate description of mental disorders. So if Michael Scott still intends to use the DSM-IV to keep his consulting-room door open, many would agree that this is the best use for it!

What I missed from the articles on diagnosis was any extended discussion of the use of diagnoses with children. There seems to be an increasing tendency now for children to receive a diagnosis reflecting one or other of the DSM-IV categories. However, Peter Congdon seems unconcerned by this situation. Of course, as he notes, a diagnosis may have important implications, such as when a

If you read an article in *The Psychologist* that you fundamentally disagree with, then the letters page is your first port of call: summarise your argument in under 500 words. But if you feel you have a substantial amount of conflicting evidence to cite and numerous points to make that simply cannot be contained within a letter, you can write a 'Counterpoint' article of up to 1500 words, within a month of the publication of the original article. However, it is best to contact the editor about your plans, on [jonsut@bps.org.uk](mailto:jonsut@bps.org.uk). We hope this format will build on the role of *The Psychologist* as a forum for discussion and debate.

more people, such as Johnstone (2006), have described in detail the issues around the purported scientific validity and reliability of diagnosis. I would invite people to consider if the professions' ambitions and self interest in an evermore competitive business-driven framework of mental health services makes it increasingly difficult to resist, or even make space to question, the temptation to be drawn into

signing up to the individual pathologising and diagnosing of people's experiences.

Or perhaps in the construction of a world where the complex competing interests of groups fosters increasingly inequitable societies, it is unsurprising that the apparent professional certainty offered via the adoption of such models is rendered so attractive. After all I would guess it doesn't pay in business, health or otherwise, to say 'I don't know' or 'These are our limitations'. And of course in a business, sorry, health service world there's money to be made via diagnosis and the consequent selling of drugs to people; although it appears that ethical concerns are much reduced if the drugs are packaged, aggressively marketed and endorsed by 'big pharma'. This is why such questioning around how we make sense with people of their experiences is so important and not just in relation to what is described as 'science' or 'evidence', but also because it reflects the values and ethics that inevitably

influence everything about how we approach our work.

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**I**T was interesting to see how readily my prediction of defensive rhetoric, ad-hominem argument and sneer quotes was upheld in the replies by Johnstone and Pilgrim in their response to those with the audacity to comment on the easy ride 'critical' psychologists seem to get in *The Psychologist* (Letters, July, 2007). But it is good to know that one is contributing to ongoing intellectual debate, and we agree with Hans Eysenck that 'psychology is about people' (Eysenck, 1972).

Oddly enough, I also agree with a rigorous critique of much of DSM, and find it distinctly wanting in my own specialist areas of clinical and forensic psychology. Increasing our understanding of mental disorder via work of the kind done by Richard Bentall or Chris Brewin is vital for having models that go beyond descriptions of symptoms which do not necessarily hang together. (Nevertheless, we should not exclude the possibility that some symptoms *do* go together, and may reflect genuine disease entities.) Kirk and Kutchins (1992) are quite right in much of their critique of DSM; a system based on a hegemonic committee's ex-cathedra pronouncements rather than genuine scientific taxonomy is little help for anyone concerned with what lies beneath the labels, or the human experience of distress. But there seem to be a number of different hegemonies in

operation here, with proponents of 'critical psychology' being no exception. I am unconvinced that the solution to one extreme is another, and polarised debates in psychology limit the forward movement of the subject – if, of course, you believe that knowledge has a forward (or, at least, expansive) motion.

My concern about 'critical psychology' is more general. One issue is the intellectual nihilism 'critical psychology' seems to engender about any 'positivist' or 'scientific' model of mental disorder – unless the findings are in keeping with approved 'critical psychology' views. Then there is the false dichotomy between those who are apparently good and caring versus those who are apparently not. The latter would seem to include anyone who holds their nose and uses

DSM as a shorthand to communicate with other professions also entrusted with the care of 'people with problems', using DSM's sometimes convenient fiction as a way of introducing psychological formulation to other audiences.

It is also somewhat dismissive to imply that medical practitioners, psychiatrists, nursing staff, and perhaps even psychologists starting from different epistemological positions do not see and work with the person, recognise their uniqueness, and also the socio-economic forces that may impinge upon clients – or is it that persons who deviate from the normative orientation promoted by 'critical psychologists' do not care for the same individuals simply because they accept the

## MISTY AND MURKY

**T**WO fish with one harpoon! Thank you for publishing Lucy Johnstone's typically robust letter about diagnosis and the excellent item about Layard from the Midlands Psychology Group (July 2007).

With regard to the former, while agreeing with the message she conveys so strongly, maybe the following will help lessen her bewilderment that 'so many psychologists...buy into the diagnostic system'.

I am a clinical assessor for AXA/PPP Healthcare, an Employee Assistance Programme which offers, inter alia, counselling support comprising five sessions for the employees of its client organisations, plus a possible further two sessions if the assessment is accompanied by an appropriate clinical rationale. To access this support for those I assess, I (and the client) have to complete the Clinical Outcomes Routine Evaluation (CORE) therapy assessment form, part of which requires inserting up to four ICD-10 codes. Assessors were told in June 2007 that 'Failure to complete (the relevant sections of the CORE paperwork) will delay processing of the case and invoice payments'.

Faced with a distressed and complex client, and one who often works in a less than supportive working environment, (a) I invariably complete this section to the best of my ability, and (b) do so in the expectation that the person – possibly one of Lucy's doctorate students – who subsequently picks up the client will, as she expects, 'really listen' to the service user and explore frameworks which enable him or her to make meaning of their experiences and actions. However, no (a) equals no (b).

concept of diagnosis or medication? Are oncologists necessarily uncaring?

Psychology's pluralism is one of its strengths, with different aspects of the individual (if I am allowed to be so reductionistic as to suggest we are individuals) being explicable in terms of different levels of explanation; neonate perception is difficult to explain in terms of discourse or social construction, whereas unique life experiences may not lend themselves to the more mechanistic aspects of human experimental psychology. From what critical psychologists suggest, one might also think the brain is irrelevant to human experience. Those less dismissive of the importance of the central nervous system and its dysfunction to human distress would reject this – though

acknowledge that such physiological bases are subject to significant additional parsing via sociocultural and idiosyncratic experience (e.g. Caspi *et al.*, 2002), and it is at the multivariate end that psychologists may be most effective. With so many levels and different perspectives on individuals, it is hard for any psychologist not to be in some respects 'critical' and reflexive – if not critical and reflexive in the way some would like.

**Vincent Egan**

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Bad faith on my part? I do what I can and I feel OK about it and also about ticking the NOS ethics criterion on my CPD log.

As for the latter piece, I have sent copies to all my trainees and supervisees and asked them to pin them up in their respective settings.

In psychotherapy we don't prescribe courses of action for clients we haven't seen. Neither do we propose the same treatment regime for different people who have been given the same diagnostic label. Context is all in client work, and many of us believe that the idea that a person can be 'treated' ignoring his or her social and cultural milieu is risible.

I know a bit about Layard as an economist but nothing at all about his personal experience of psychological therapies, whether as an academic researcher or as a client. However I taught economics for a number of years, and one thing I have learned while doing so was that economics has about the same specifically predictive validity as weather forecasting of the kind often heard on the BBC's *Today* programme, viz. 'England and Wales will be rather misty and murky with occasional rain. Some more general rain with sharper, longer showers can be expected in the Pennines, the Welsh hills and the Scottish highlands.'

No doubt he consulted widely while drawing up his report, but to me, and the many colleagues I have discussed his findings with, his conclusions are naive. Were I marking his report as an end-of-term essay, I'm afraid I would return it with the comment, as Winnicott might have put it, 'Not good enough, yet'.

**Trevor Habeshaw**

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## INFORMATION

■ ARE you a student or professional wanting to expand your skills and experience? We are currently looking for **volunteer workers to help support people who have sustained a brain injury**. You will be working alongside a team of psychologists, tutors, and job coaches on our vocational rehabilitation programme, supporting clients in group sessions or on a 1:1 basis.  
**Rebecca Doherty**  
*rebeccadoherty@rehabuk.org*

■ I AM a psychology graduate who has an MSc in psychology and a substantial research training in both quantitative and qualitative research methods (PgDip, OU). I am looking

for a **voluntary position as a research assistant or similar in the London area**. I also have an AdvPgDip in Child Development and training in counselling and holistic stress management.

**Maria Popova**

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■ I AM conducting a national online survey covering demographic, work environments, attributes, satisfaction/attitudes of **technical staff in psychology** and psychology related departments/schools/faculties. Please see *www.survey.lboro.ac.uk/technical*.

**Peter Beaman**

*Loughborough University*

## Layard's contribution

WHAT a relief to see some public criticism of Lord Layard's proposals ('Questioning the science and politics of happiness' by the Midlands Psychology Group, July 2007). While the Improving Access to Psychological Therapies (IAPT) projects have moved significantly from the Layard plan, the assumption that many of life's miseries are an illness for which psychological therapies are the cure still appear far from consigned to the 'Slightly Embarrassing' drawer of the IAPT filing cabinet.

The directness with which Layard put this view may be uncomfortable to many clinical and counselling psychologists. For those who see themselves as hard-headed scientist-practitioners, Layard's uncritical use of diagnostic labelling and over-extension of the evidence on therapies and return to work compound the problem. Throw in a poor understanding of the rationale behind and evidence for therapies other than CBT and a lack of understanding of the limitations in applying the

evidence-base for therapies in reality and I can feel people shifting uncomfortably in their therapy chairs at the claims being made for them. Follow this with prominent endorsements of arguments that I would struggle to pass if offered by a trainee, and I was left wondering what was going on.

More Layard-friendly colleagues provide the answer in offering an essentially political counter-argument relating to the opportunities Layard has created for psychology, and the chance to place psychological interventions on a par with medical ones. (It should be noted that this is often accompanied by a knowing look and an acknowledgement of the 'limitations'.) It is also clear that there are attempts, not least the IAPT pilot projects, to place some of Layard's assumptions on a firmer basis. I don't really mind such pragmatism, and accept that it may be about offering a real choice of treatments (rather than being simply a power play with psychiatry). However, this 'It's a bit silly but we'll get

what we can from it' stance is worrying. For one thing it seem to stifle what I think is Layard's main contribution and which may actually come directly from the startling naivety of his arguments.

I'll use the notion of 'spitballing', from film script writing, to illustrate what I mean. This technique refers to generating ideas to develop or fix a story. Somewhat counter-intuitively it's the silly ideas that can be the most important ones. This is because the really wild ideas have the potential to make you think through why they're wrong and what you should be doing. Perhaps this could be the true value of Layard's contribution. By

stating such an uncritically approving position on psychological therapies so publicly Layard has provided us with a different opportunity: one for profound consideration of what psychological therapies are and what they can (and can't) achieve. The Midlands Psychology Group have taken this chance. The question is can the rest of us, or will we just settle for therapy for all?

**Lord Layard**

**John McGowan**  
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I DO hope that the very proper concern of the Midlands Psychology Group (July 2007) that greater access to cognitive-behavioural therapies is not used as a substitute for social reform, does not obscure the considerable merits of the work of the economist Richard Layard.

Layard starts from the finding that growing levels of disposable income do not produce greater happiness – indeed they may actually relate to more dissatisfaction. *Happiness*, his popular book on the subject, uses evidence drawn from a number of disciplines, including cognitive psychology, to argue a number of politically progressive points – that processes of psychological adaptation mean that consumerism is never going to make people happier, that income redistribution in unequal societies will make people happier, that status inequality is prejudicial to health, and so on. His proposed solutions to social malaise include political, social and

economic change as well as psychological therapies. To that extent his argument is very much the same as that put forward by his critics, particularly as regards the need to treat the distribution of wealth, rather than statistical measures such as GDP, as the proper measure of national well-being.

What then leads the Midlands Psychology Group to (mis)represent him as naive, superficial or even an agent of social control? Layard's work is, of course, foursquare in the utilitarian tradition, a philosophy which has, almost without exception, promoted an essentially egalitarian world view. It is part of an empirical, social democratic, tradition with little time for the arcane theorising of much psychoanalytic and Marxist scholarship. It is this, I suspect, which so distresses the writers of this article.

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## We're listening...

WHEN I saw that content from *The Psychologist* is now available at [www.thepsychologist.org.uk](http://www.thepsychologist.org.uk) to be downloaded in audio format, as MP3 files, I was delighted at the chance to listen and learn while undertaking daily chores. But when I actually listened to the material I was somewhat underwhelmed by the manner of the reading and the apparent lack of familiarity of the reader with the material.

The audio book of *The God Delusion*, by Richard Dawkins, or some of the psychology tapes provided by the Open University for their psychology courses provide good examples of well-presented and effective listening materials. Please do not tantalise us with the suggestion of quality

multimedia and then provide us with sloppy work.

**Olly Crofton**  
London

*The Editor, Jon Sutton, replies: Thanks for your feedback – this is a new service so I do want comments, and I have passed them on to the company who do the audio work for us.*

*The audio files are primarily put on CD and sent to visually impaired members, and we simply do not have the budget associated with 'talking book' production. We nevertheless thought it was worth putting the files on the website for all. If we can improve them and receive more evidence of a market, we could consider putting more money into, for example, multiple readers and time for familiarisation.*

## Engaging the public with psychology

IN the area of science, public communication refers to 'the use of appropriate skills, media, activities and dialogue to produce one of more of the following personal responses to science: awareness, enjoyment, interest, opinion-forming and understanding' (Burns *et al.*, 2003, p.183). This definition could easily be applied more widely to psychology, and over the last five years the ESRC has coordinated Social Science Week mirroring the well established National Science Week. Indeed, many of you will already have been asked to fill in a section about public engagement plans when applying for a research grant, or have been asked to participate in events at your university. This reflects the increasing importance of the public engagement agenda to universities, and individual

participation may even be an important aspect for career progression. We are writing to highlight the breadth of activities that can be considered as public engagement and that it does not just involve talking to the media. Importantly, many of you may be already doing such activities without labelling it as such.

To illustrate this breadth, we briefly describe three examples that took place in our own university during Social Science Week and Science Week in March 2007. First, a group of psychologists and neuroscientists ran hands on activities about the senses in the foyer of ASDA in East Manchester. For example, shoppers stopped to identify smells and carry out the Stroop task. This reached a broad range of people of all ages. Second, we invited 120 pupils

aged 14+ to an afternoon of interactive talks with the aim of introducing them to the kinds of research and work carried out by psychologists. Six psychologists brought along an object, for example a rubber hand, that they use in their everyday work or research and the audience tried to guess how. The psychologists then used their object as a starting point for a talk to explain aspects of their work. Finally, these activities can be contrasted with a more artistic and innovative project in which a psychology lecturer worked with a science communicator, an artist and pupils from a local school to demonstrate how social interaction shapes our brains. The children explored social networking over a number of school sessions and contributed to a giant model brain sculpture built by the artist. The finished brain was displayed at the Manchester Museum during Social Science Week.

Given the increasing emphasis placed on public engagement, we believe it is key that psychologists should share best practice and resources that have been developed in this area. One potential area for development, that is perhaps unique to psychology, is the opportunity for research that public engagement affords. For example, we can explore the changes in public attitudes produced by participation in an event as well as researching the process itself. We would be interested to hear other psychologists' opinions and experiences.

**Karen Lander**

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## Nutrition and IQ

ONE of the most important discoveries made by psychologists is that the intelligence of the populations of a number of countries has increased considerably during the last 90 years. The causes of this increase are a matter of considerable interest. James Flynn is a leading researcher on the increase and has given his opinion that improvements in nutrition have been of little significance and that 'better

education and smaller families are much more plausible' (Interview: 'The latest thinking on intelligence', June 2007).

The problem with the education theory is that the increases have taken place in infants aged two years (Thorndike, 1973). The problem with the smaller families theory is that there is no persuasive evidence that small family size has a stimulating effect on intelligence (see, for example,

Velandia *et al.*, 1978), and even if it has the reduction of family size has been far too small to have had any significant effect on the increase in IQ.

Patrick Rabbitt has also contributed to this debate. He writes: 'Growing exposure to and awareness of the kinds of problems found in intelligence tests is enough to account for the small increases observed' (Rabbitt, 2006, p.674). It may be wondered whether this can be a plausible explanation for

## Modernising the NHS – A marketplace agenda?

OVER recent years there have been a number of apparently unconnected developments relating to the health professions, which have experienced moves towards registration, and changes in training, in pay scales and in job evaluation and description. Why all at once, and is there in fact a governmental coherence at work here?

It is now apparent that there is a wider agenda and that these modernisations all hang together in the notion of the 'marketplace' – a way of talking that has been with us for some time. When thinking about the marketplace the government reveals its notion of competition as the sole and favoured device for improving efficiency.

Here is how one might reduce personnel costs whilst boosting efficiency:

1. reduce the costs of the workforce – especially expensive 'professionals' so...
2. attack the power base of all guilds or professions – in particular, open up access to doing hitherto preserved tasks (sub-parts of the profession) so...
3. it is necessary to analyse jobs in order to extract the relevant competences so...
4. these competences may be matched via – Knowledge and Skills Frameworks say – to various paybands so...
5. it will be necessary to refine the content of KSF (competency standards) – this should be done by any group *other* than the original professional body, for they have a vested interest (in standards, including pay!) so...
6. regulatory bodies are created who will be responsible not only for professional conduct, but also for training standards – such a body is the Health Professions Council so...

7. there remains one more requirement; to change the working culture that newly trained people will enter, so we develop New Ways of Working – some of the working groups established under this umbrella are producing basic competencies for particular modes of therapy...

Hence the real competition in the NHS marketplace is not really between health providers at all, but between the professional bodies prepared to develop National Occupational Standards (NOS). The NOS standards will become the benchmark for a new workforce trained in specific treatments, which can be manualised or limited, such as prescribing rights for nurses, or clinical nurse-specialists in CBT.

If there is no obvious scope for competition between differing branches of the professions then the government already has a history of creating a new body to carry out the task, such as the PMETB formed to oversee medical training. The responsibilities and powers of professionally qualified people with personal experience of working with patients are being replaced by quango-like bodies of professionally unrelated individuals.

Rational arguments about what works for patients are unlikely to move any government. We have to ask what kind of *political* activity will prevent this rush into market-driven madness and allow the professions to continue to practise in ways that serve their patients best.

**R. Goldstein**

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the increase in the IQs of two-year-olds, and whether an increase of approximately 27 IQ points over the period from 1917 to the present can be considered small.

I suggest that improvements in nutrition remain the plausible explanation for the increase in the IQs of two-year-olds as well as of older children. These improvements have been responsible for increases in brain size of about the same magnitude, and brain size is associated with intelligence at a correlation of about 0.4. Numerous further arguments

for the nutrition theory have been set out in Lynn (1990).

**Richard Lynn**  
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## Employability of graduates

**J**ONATHAN Hume (Letters, May 2007) argues that a first step toward addressing the employment difficulties faced by some psychology graduates would be for the psychological

community to 'act to inform employers of the benefits of employing psychologically informed personnel – such as better management, enhanced productivity, numeracy and

critical thinking'. Jonathan should therefore be pleased to know that in October 2004 the Higher Education Academy and the Council for Industry and Higher Education (CIHE) produced a student employability profile for psychology. This publication identifies the various skills that students can develop through the study of psychology, based on the Quality Assurance Agency for Higher Education subject benchmark statements, and maps these skills against input from CIHE employer membership regarding the employability skills, competencies and attributes valued by employers when recruiting. Copies of the profile are available for free from [www.heacademy.ac.uk/resources](http://www.heacademy.ac.uk/resources).

The Higher Education Academy Psychology Network has produced a couple of

publications that Jonathan (and other readers) may also be interested in. In March 2007 we published the final report from a project entitled 'Employability: How to maximise the employability of psychology graduates', which examined the views of the main employers and non-employers of University of Leeds psychology graduates. And in November 2004 we produced a report and information pack entitled *Enhancing the Employability of Psychology Graduates*, which discusses and analyses various ways in which psychology students and their lecturers can improve students' employability. Copies of these publications are available at no charge via [www.psychology.heacademy.ac.uk](http://www.psychology.heacademy.ac.uk).

Readers may also like to know that the Psychology Network is currently developing an employability

## PITTU LAUNGANI (1936–2007)

**O**N 28 February 2007 Dr Pittu Laungani, aged 70, died 18 years later than predicted by his hospital consultants. After contracting an undiagnosed virus in 1989, he subsequently developed polymyositis, which after complications led to pulmonary fibrosis.

Pittu considered he was 'bicultural' as he came from an orthodox Hindu background, yet attended a Jesuit school in Mumbai. He went to the University of Bombay and obtained his BA (1960) and MA (1962). In 1966 he left India on what he called 'my passage to England', and at London University under Dr Hans Eysenck undertook doctoral research into experimental cross-cultural psychology on personality and conformity, obtaining his PhD in 1982. From 1971 he lectured at South Bank University taking early retirement in 2001. He was then appointed Honorary Senior Research Fellow at Manchester University, a post he appreciated.

His areas of expertise often reflected his life experiences and included writing about recovering from life-threatening diseases, cross-cultural diversity and counselling, stress across cultures, death and bereavement. He published over 100 articles and chapters and 15 books. He often questioned whether counselling models had universal applicability as he believed that Asians would prefer a more hierarchical and directive approach to counselling. With Dr John Morgan he co-edited four volumes of *Death and Bereavement Around the World* (2002–2005), an important contribution to the field of thanatology. Pittu was still working on

a final volume, which will now be completed by a colleague.

He received the Lifetime Achievement Award in Cross-Cultural Counselling and Multicultural Psychology from the University of Toronto in 2005. A conference was held in his honour and a book is currently being edited celebrating his work.

He was President of the Institute of Health Promotion & Education (IHPE) from 2001 to 2003 and became Honorary Vice President from 2004 onwards. He was also Associate Editor of the Institute's International Journal of Health Promotion & Education. In 2005 he was made an Honorary Fellow of the IHPE in recognition of his contribution to health education and the Institute. After his death the Institute announced that they would rename the international journal's annual award to The Pittu Laungani Award for the Best Paper.

His last published book was possibly one of his best, bringing together his life's work, *Understanding Cross-Cultural Psychology: Eastern and Western Perspectives* (2007). In the final word in the book he wrote: 'Death does not discriminate... We fail to realise that death is but a breath away... Wisdom lies in learning to accept its visit, which will come when it comes – often announced, but sometimes unannounced. The secret is to be prepared... Harbour no regrets for the morrow, which if death strikes today, you shall never see.'

**Stephen Palmer**  
*Coaching Psychology Unit*  
*City University*

guide for psychology students based upon the collective input of psychology academics, career advisers, students and alumni. Further information can again be found on the website.

Evidence-based, subject-specific information developed by the psychology community

that could be used by students and employers to help address the employment difficulties faced by some psychology graduates therefore already exists – and there is more to come.

**Tom Simpson**  
*Higher Education Academy  
Psychology Network*

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## From clinical to forensic

**I** MUST correct Simon Hamilton (Letters, June 2007), who bemoaned the lack of opportunity for clinical psychologists wishing to gain forensic chartership other than via an MSc training course.

In fact, there is a clearly defined pathway via the Diploma in Forensic Psychology, which does not require enrolment in a formal

MSc course. The course handbook, available via the BPS website, clearly sets out the core competencies and provides up-to-date reading lists. It is comparable, in terms of costs and commitment, to the statement of equivalence in clinical psychology.

**Phil Willmot**  
*Nottinghamshire Healthcare  
Trust*

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## Research, ethics and the internet

**I**N defending the practice of some internet researchers of ‘lurking’ on discussion forums – effectively conducting research on people without any attempt to obtain their informed consent – David Giles (‘The internet, information seeking and identity’, July 2007) suggests that posting a message on a health-related discussion forum on the internet is equivalent to writing a letter to a conventional newspaper. However, there is evidence that the ‘lurking’ of researchers on websites and discussion forums can cause not only distress to individual users but also damage to the integrity and viability of the sites, many of which now specifically state that their presence is not welcome.

King (1996) illustrates this point with the final message of a member of one health website, who stopped using it after realising that it had been

monitored by a researcher: ‘When I joined this, I thought it would be a support group, not a fishbowl for a bunch of guinea pigs. I certainly don’t feel at this point that it is a safe environment, as a support group is supposed to be, and I will not open myself to be dissected by students or scientists.’

It is hard to imagine that anyone would consider it ethical for researchers to secretly record the discussions of an ‘in-person’ support group, just because the group happened to meet in a ‘public’ place. Why then is it acceptable to do the equivalent online?

It is possible to gain informed consent from the users of this type of website. However, it is time-consuming and there is always the risk that someone will decline, thereby denying the researcher a potentially interesting study. I suspect that this has more to do with why some choose to overlook this process than the issue of whether or not these forums are in the ‘public’ domain. A number of ethical guidelines have been proposed for conducting research on the Internet (e.g. Eysenbach & Till, 2001; King, 1996). However, to date, no consensus appears to have been reached and researchers seem to be free to take up whatever position suits them. Perhaps it is time for the Society to take a lead on this matter and produce some specific ethical guidance for online research?

Finally, in relation to the internet, I would argue that it is a mistake to think of it merely as the latest addition to the media, since it is so much more

than simply a method of expressing and communicating information, like TV, radio and newspapers. The internet is an environment, within which all kinds of human interaction take place. The nature of this environment allows people to interact in new and innovative ways, many of which provide interesting topics for research. However, it is important not to forget that, regardless of how they choose to present themselves online, the people that are behind the interactions are no less real than if you had bumped into them in the street and, as such, they deserve the same ethical treatment as everyone else.

**Darren Baker**  
*East London & City Mental  
Health Trust*

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