TO THE EDITOR...

Letters should be marked clearly 'Letter for publication in *The Psychologist*' and addressed to the editor at the Society office in Leicester. Please send by e-mail if possible: psychologist@bps.org.uk (include a postal address). Letters over 500 words are less likely to be published. The editor reserves the right to edit, shorten or publish extracts from letters. If major editing is necessary, this will be indicated. Space does not permit the publication of every letter received. Letters to the editor are not normally acknowledged.

Prescription rights – Are we ready for change?

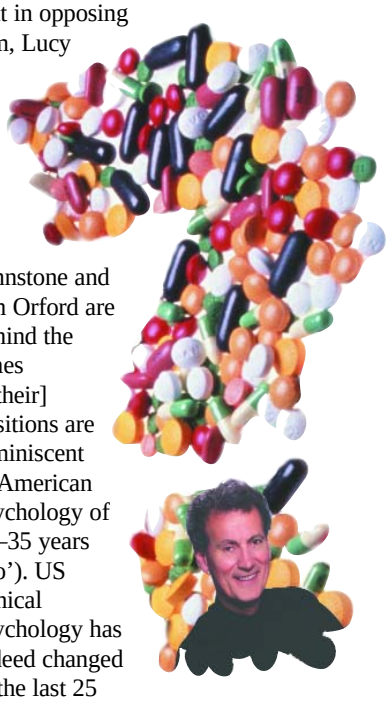
IT is ironic that in trying to make a case for prescribing rights for psychologists ('To prescribe or not to prescribe – Is that the question?', April 2003), Robert Resnick should rely so heavily on a rhetoric of progress and looking to the future. His arguments are, in fact, remarkably similar to those used by 19th century doctors trying to persuade the public that they were best placed to administer medical and psychological (moral) treatments to 'mad' people. Like the 19th century doctors before him, Resnick argues that a combination of treatments is obviously preferable to either alone; that a combination approach is justified by the interaction of mind and body; that the superior knowledge and training of their profession justifies their control of both forms of treatment; that combining the two in one profession is more efficient; and, of course, that it would be to the benefit of patients.

The arguments lacked substance then and they lack substance now. They obscure the lack of evidence for the validity of psychiatric diagnostic systems and the lack of any coherent biological theory of psychological distress or 'abnormal' behaviour. And although Resnick is not keen to make the point explicit, the credibility of prescribing rights depends on such evidence, or at least a belief in its existence, and not on the obvious fact that brain, emotion and behaviour interact.

Certainly, drug companies are acutely aware of this. In advertising psychotropic drugs directly to the US public via television and magazines, they strongly emphasise the 'official' DSM 'disorders' which their drugs 'treat'; they even provide diagrams of chemically imbalanced synapses which their drugs may correct (and drawings, too, of balanced synapses). Of course, they carefully avoid saying which chemicals are unbalanced, or suggesting that anyone sets their doctor the hopeless task of demonstrating the imbalance before the drug is prescribed and the balance afterwards.

As Lucy Johnstone points out, psychotropic drugs sedate, tranquillise and stimulate in non-specific ways, and those who advocate prescribing rights could at least be open about this rather than depicting drugs as 'proven treatments for proven disorders' or as treatments for 'symptoms' of diagnosable disorders.

Resnick is also mistaken in his (rather arrogant) assumption that in opposing him, Lucy Johnstone and Jim Orford are behind the times ('[their] positions are reminiscent of American psychology of 25–35 years ago'). US clinical psychology has indeed changed in the last 25 years, in the direction of greater medicalisation and dependence on the DSM, but those changes owe little to scientific progress and a great deal to medical insurers' insistence on the use of DSM categories as a basis for reimbursement to professionals. In other words, many US psychologists' livelihoods depend on their using DSM diagnoses.



UK psychologists, free of such restrictions, have been far better placed to develop critiques of diagnostic approaches and alternatives to them; they have done both with vigour and creativity. It is this growing conceptual gulf which Resnick seems unaware of; indeed, as Orford points out, he

BLACK AND WHITE – A GREY AREA

Jim Wood (Letters, April 2003) wrote suggesting that the words *black* and *white* should be avoided in *The Psychologist* in phrases where the connotations are respectively negative and positive. We asked what other readers thought. The letters we received were evenly divided between those for and against the suggestion. Here are extracts from some of the letters.

Richard Velleman (Avon & Wiltshire Mental Health Partnership NHS Trust and University of Bath): The language we use should not equate 'white' with 'positive', or 'black' with 'negative'. Hence it is inappropriate to write of illegal markets as 'black markets', or of the illicit economy as the 'black economy', or as Jim Woods points out, to use 'white' for 'pure, or to use 'black' for 'pessimism'. On the other hand, it is completely appropriate to ask for one's coffee to be black.

Peter Storr (London W1): To say that phrases such as 'whiter than white' or 'the future looks black' are referring to anything to do with race is at best unhelpful, and at worst diluting the importance of outlawing genuinely offensive statements.

Suvarna Sansom (Open University): I think that Jim Wood makes an insightful observation here and I would like to see the Society's style guide and that of Commission for Racial Equality reviewed to take into account that language 'does things', that language does not simply reflect society as it is in terms of concrete structures.

Helen Ross (University of Stirling): A colleague who works on a language project in Kenya assures me that the indigenous people have no qualms about using *black* and *white* as evaluative expressions. He points out that the metaphorical use probably stems from basic terms like *night/day* or *dark/light* rather than skin colour. English is rich in metaphors, and contains some reverse meanings for *black* and *white*. In financial matters it is good to be 'in the black'; and we all deplore a cover-up or 'whitewash'. Psychologists should concentrate on practical issues, and stop attempting to ruin our language.

seems unaware of the assumptions which inform his arguments.

By all means let us have a debate about prescribing rights, but let's not obscure it with talk of progress, quality care and UK psychologists 'evolving' to meet their US counterparts. Let us instead be open about the conceptual assumptions which inform the debate and about the actual rather than claimed actions of psychotropic drugs. Above all, let us ask an informed public how they see the 'unmet mental health needs' which Resnick refers to. I very much doubt that these will include a need for more drug prescribers.

Mary Boyle
Department of Psychology
University of East London

THE debate about prescription rights insufficiently addresses the issue of professional influence and power. For example, if clinical psychologists have prescription rights within the NHS should they be paid the same as psychiatrists?

I am a psychiatrist, who has been called more of a psychologist because I take a biopsychological approach to psychiatric practice. I am also a member of the Critical Psychiatry Network. Such a stance can lead to conflict, for example when working with more biomedically minded GPs, who continue to treat patients in primary care referred to specialists like myself in secondary care.

Under the New Mexico legislation, the prescribing psychologist still has to maintain an ongoing collaborative relationship with the healthcare practitioner who oversees the patient's general medical care. There also has to be malpractice insurance in place that will cover the practitioner as a prescribing psychologist.

Prescribing psychologists are subject to current 'best practice' guidelines, and in the NHS this would include those produced by the National Institute for Clinical Excellence. I am not necessarily discouraging clinical psychologists from obtaining prescribing rights, but these issues of regulation do need to be addressed.

In psychiatric practice the other powerful force for medical control, besides medication, is through the Mental Health Act. The current reform of the Mental Health Act has proposed that the clinical supervisor is normally a consultant psychiatrist, but may also include a consultant psychologist. I wonder how Lucy Johnstone and Jim Orford view this potential extension of clinical psychologists' professional influence.

Personally I am keen to facilitate the increasing role of clinical psychologists in the mental health field, because they tend to identify with my biopsychological approach. If they do take on the responsibilities of psychiatrists, they should also be eligible for the same professional prestige and authority, including salary.

Duncan Double
Norfolk Mental Health Care NHS Trust

PETER WASON (1924–2003)

PETER Wason's research and writings from the late 1950s until his retirement in the early 1980s challenged the orthodox rationalist views of his time, presented the first major studies of cognitive biases in the UK, and effectively founded the modern study of thinking and reasoning. He was exceptionally creative and developed a series of reasoning problems that are still in use today, most notably the 2-4-6 and THOG problems, and of course the four-card selection task that features in more published papers than any other method in the psychology of reasoning.

For those who knew him personally, the phrase 'officer and gentleman' might well spring to mind. On discharge from the army in 1945 he read first a degree in English at Oxford, before making a new start with a degree in psychology at University College London. He arrived at UCL in 1950 and stayed there until his retirement, for the most part as Reader in the Department of Linguistics. He told me he left the Psychology Department because 'he refused to teach' and indeed somehow managed to avoid undergraduate teaching and administration his entire career. As a PhD supervisor, however, he was inspirational and fiercely loyal to his own students. He taught creativity in research and clarity in writing, although it was impossible to match him in either regard.

Wason ran most of his experiments personally and always one-to-one. He disliked group testing and was bewildered by the introduction of computer-delivered tests by other reasoning researchers towards the end of his career. Although he performed statistical tests for the benefit of journal editors, he loathed them, and his papers are full of clinical observations about his subjects, as they were then called. Paradoxically, while Wason hated mathematics to the point of phobia, he was a brilliant chess player, a game he would play only by correspondence as he regarded over-the-board play as too stressful. He even wrote a book (with William Hartson) on the psychology of chess, unwisely denouncing the 'artificial stupidity' of chess-playing computer programs, which by now have beaten the world champion.

On his retirement in 1982 Peter Wason told me that he 'had made his contribution' and intended to play no further part in the field, concentrating instead on chess. While he largely stuck to this resolve for the past 20 years of his life, his death was a very sad event for all of us who knew him well and owed him so much. He was a great psychologist, and a great man.

Jonathan St B.T. Evans
University of Plymouth

...but one change at a time, please

I WAS very interested to read your series of articles on the possibility of psychologists having prescribing privileges. As your readers will realise, this issue is itself contentious. Your readers will also probably know that the British Psychological Society is currently working closely with the Department of Health with respect to the proposed reforms to the Mental Health Act. These reforms include the equally contentious proposal that psychologists could become 'clinical supervisors'.

These proposals look almost certain to become law. It has caused some debate and concern that psychologists could have such statutory powers – legal responsibility for the care plans of people receiving mental health care. I have no particular point of view on the question of psychologists' prescription privileges, but I am slightly concerned that we are debating the pros and cons of running

before we have learned to walk. The reforms of the Mental Health Act with the new statutory responsibilities of psychologists, have not yet occurred, and we are many years from knowing fully how those changes will affect our profession and our clients. We can predict substantial changes. It is usually unwise to change two things at once. I wonder whether we should, as a profession, take stock of one set of changes before discussing another.

Peter Kinderman
University of Liverpool

QUESTION TIME

How does Derren Brown of Channel 4's *Derren Brown: Mind Control* programme do his psychological tricks and illusions?

DERREN Brown does not claim to be using psychic ability, but what he does claim appears to be almost as amazing. Can he really be achieving all of those mind-boggling effects by the application of psychological science alone – or is he perhaps sometimes exploiting the standard techniques of the conjuror?

In a sense, of course, conjuring is a form of applied psychology, especially that branch of conjuring known as mentalism, specialising in the illusion of mind-reading and prediction. It may be of some relevance that Brown, like Uri Geller, already had a pretty successful career as a conjuror before he started claiming that he was producing his effects in a different way.

I have a professional interest in the psychology of deception. Are there ways that someone could appear to have psychic ability when in fact they do not? Indeed there are. The technique of 'cold reading' allows you to convince complete strangers that you know all about them (Hyman, 1989). A full description of this technique is beyond the scope of this reply but the technique does make use of some non-verbal cues – but only to a limited extent. As far as I am aware, no one could successfully use such cues alone to reliably obtain information that is as specific as that typically identified by Brown. If any readers (including Brown himself) could point me to scientific studies showing that I am mistaken, I would be most grateful.

I think it is pretty unlikely that the 'mind-reading' effects are produced simply by using an actor or by selective editing of film. It seems far more likely that much of the relevant advance preparation for the effect was simply never filmed at all.

If Brown really has successfully developed techniques to discern the contents of people's minds in the way that he claims, he has single-handedly achieved in a few years more than the collective attempts of psychologists over many decades. Maybe he has – but I won't really be convinced until I see him do it under properly controlled conditions.

Christopher French
Goldsmiths College

Reference

Hyman, R. (1989). *The elusive quarry: A scientific appraisal of psychical research.* Buffalo, NY: Prometheus.

ANSWERS, PLEASE...

I'M sitting on a train, lost in my own thoughts, my eyes resting on but not looking at a person who is engrossed in reading a book. Suddenly the person stops reading and looks at me directly, almost aggressively. It seems that he has become aware that I am looking at him, even though I'm not trying to attract his attention or even study him. How does that person know that I'm looking at him?

Dorothy Rowe
40 Highbury Grove
London N5

ECT, etc.

LUCY Johnstone's excellent critique ('A shocking treatment', May 2003) cites some research I was involved in (Rogers *et al.*, 1993), in which over a third of respondents (37.1 per cent) reported ECT to be distressing. On the other hand, 18.6 per cent said that it was 'very helpful', with some attributing it with almost magical curative properties. We found that it provoked the most polarised user-appraisal, across treatments.

If service quality is not reduced simply to professionally defined clinical effectiveness, such as the Royal College of Psychiatrists' position on ECT, then contradictions ensue. Some interventions may be experienced as being acceptable and appropriate, but they may not always be effective. For example, generally, talking treatments are anxiously sought and gratefully received. However, not all of their practitioners are benign and efficient, the efficacy of some types remains unproven, and deterioration effects occur in all forms of therapy for some patients.

INFORMATION

■ THE Standing Committee for the Promotion of Equal Opportunities is exploring the issue of **psychologists who work via interpreters** and what the associated training needs may be for members. We would invite comments, practice experience and research from any individual or organisation. We would welcome comments covering work that is both verbal and non-verbal in nature. Please send your comments to Felicity Hector (felhec@bps.org.uk) at the Leicester office.

Richard Beckett
SCPEO

■ I AM a second-year undergraduate studying psychology at the University of Plymouth. I am **seeking work experience** for the summer 2003 in the Plymouth area. Any opportunities would be gratefully received.

Suzanne Czerwinski
15 Gifford Place
Plymouth PL3 4JA
Tel: 01752 662013; e-mail: suzanne.czerwinski@students.plymouth.ac.uk

■ I AM the manager of a Forensic Day Centre in Clacton-on-Sea. We offer a service to offenders, ex-offenders, those at risk of offending and families of offenders. We have opportunities for people to join our staff team (on a voluntary basis). The centre provides valuable **experiences for students/graduates pursuing careers in forensic psychology**. Volunteers need to be available for six hours per week. Travel expenses will be reimbursed.

Sarah Tomlinson
85–87 Pier Avenue
Clacton-on-Sea CO15 1QE
Tel: 01255 423466; e-mail: office@clockwis.u-net.com

■ I AM currently compiling a book on the **placement experiences of counsellors/counselling psychologists** in training. I am seeking a half dozen counselling psychologists in training who are progressing either through the independent route or through a BPS-accredited programme to contribute material for several chapters. The aim is that you would be able to provide a chapter approximating 4000 words on

Inconvenient as it is for our professional interests, we cannot always claim that 'biological = bad, and psychological = good'.

All interventions for mental health problems need to be appraised honestly and *any* form of service contact considered sceptically by its users, especially when coercion is a constant backdrop to professional action (Rogers & Pilgrim, 2003). Arguably, the most damaging psychiatric treatment has been the 'old antipsychotics' (major tranquillisers), given the sheer scale of their iatrogenic toll. High prescription prevalence, polypharmacy and megadosing have created a global pandemic of movement disorders, with millions of patients left disabled or dead by them in the last 40 years (Fisher & Greenberg, 1997). ECT needs to be taken to task, but so do all forms of therapy.

David Pilgrim
Blackburn with Darwen PCT

Fisher, S. & Greenberg, R.P. (Eds) (1997). *From placebo to panacea: Putting psychiatric drugs to the test.* New York: Wiley.

Rogers, A., Pilgrim, D. & Lacey, R. (1993). *Experiencing psychiatry: Users' views of services.* Basingstoke: Macmillan/MIND.

Rogers, A. & Pilgrim, D. (2003). *Mental health and inequality*. Basingstoke: Palgrave Macmillan.

DEADLINE

Deadline for letters for possible publication in the August issue is **4 July**

STRAIGHT TO THE POINT...

■ *Sue Paulson (Cambridge) on our interview with Phil Salmon (April 2003):* What a delightful interview. It is refreshing to hear of a supervisor so concerned about her research students' welfare and ultimate success. Her present work with victims of torture shows her deep concern for others, even during her retirement. It must be a privilege to work with her.

■ *Michael Shayer (Cambridge) on the results of our poll to find your top 10 psychologists (April 2003):* Who can supply me with an answer to this paradox? Despite the vote putting Piaget at the top, and despite the justifiable reasons offered by Elliot Turiel, citing Piaget as part of one's theory base guarantees that the referees of any American journal will reject the paper (one of my reasons for deciding to publish only on this side of the Atlantic).

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 submit a 'Counterpoint' article of up to 1500 words – but we need to receive it within a month of the publication of the original article. We hope this format will build on the role of *The Psychologist* as a forum for discussion and debate.

one specific placement you experienced.
Paul Mason
E-mail: pauljonmason1@yahoo.com

■ I AM a second-year clinical psychology trainee who would be interested to hear from any undergraduate, assistant, trainee or qualified psychologist from an ethnic minority for my third-year research submission. I would like to interview you (face-to-face or on the phone) about issues to do with **ethnic diversity** amongst the profession. Your help would be greatly appreciated.
Lisa Rajan
Flat 3 The Azure
Bath Buildings
Montpelier
Bristol BS6 5PT
Tel: 0117 923 2253; 07961 154366;
e-mail: lisarajan@onetel.net.uk

■ THE **Human Factors group at Quintec** will be celebrating its 50th year in September 2004.

It is our intention to hold a celebration, possibly in west London, for all of our current and past members, together with some distinguished guests from the Ergonomics Society, the MoD and other relevant organisations. If you have ever been employed within this group, we would be delighted to hear from you. Call Laura Edgar on 01252 737377 or e-mail her at laura.edgar@quintec.com.
Sylvia Horner
Quintec Associates Ltd
Farnham
Surrey

■ I AM a graduate of psychology and am seeking **voluntary work experience in clinical psychology** either within a healthcare setting or in a research capacity, hopefully in South Yorkshire. I have experience of working with young adults with learning disabilities and with research into areas of child psychology. Please contact me
Helen Ball
240 Lancing Road
Sheffield S2 4EX
E-mail: helen_ball1@hotmail.com

■ I AM a second-year student of psychology at Bristol University and am keen to gain a **work experience placement** in clinical psychology any time during the period of August to October 2003 summer vacation in the Cardiff area.
Joanne Western
86 St David's Way
Watford Farm
Caerphilly CF83 1EZ
Tel: 029 2085 1060

■ I AM a second-year undergraduate student studying psychology and anthropology at Oxford Brookes University. I am looking for any **volunteer opportunities** that would give me experience in the psychology field during the summer of 2003 in the Bristol or Somerset area.
Lindsay Young
1 Starrs Close
Axbridge
Somerset BS26 2BZ
E-mail: wizzleawozzle@hotmail.com

■ I AM a psychology graduate (2:1) seeking **voluntary clinical work experience** in the Berkshire area. I have worked within the criminal justice system and with substance misuse and would like to widen the scope of my experience.
Hazel Dunbar
Tel: 0118 939 4893; e-mail: Hazel.Dunbar@Thames-Valley.probation.gsx.gov.uk

■ WE are working at the Psychology Service at Ashworth Hospital. We are interested in finding a **screening tool for adults with autistic spectrum disorders/Asperger's syndrome** (published or otherwise).

If anyone has any information on such a tool, please contact us: Beth Otyehel (0151 471 2611) or Helena Ramos (0151 472 4551).
Helena Silveira Ramos
Ashworth Hospital
Parkbourne
Maghull L31 1HW

■ I AM a second-year undergraduate psychology student at the University of Leeds and am looking for **voluntary work experience** over summer 2003 (June–September) in forensic psychology or a related discipline, preferably in West Yorkshire.
Bryony Crisp
E-mail: psc1bvc@leeds.ac.uk

■ MY PhD is funded by the National Probation Service in London and aims to help **improve services for victims of crime**. Following a pilot survey, I have developed a questionnaire which I intend to distribute to over 500 victims of crime. The data collected will inform an assessment tool that will aim to help criminal justice agencies assess and support victims. If you would like to take part in this research, please get in touch.
Rania Marandos
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London Probation Area
Tel: 020 7960 1123
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