

Can we have a Happy Christmas?

Why do people get excited at Christmas when much research tells us that Christmas seems to bring out the worst in us?

For instance, despite the fact that our loved ones might try hard to select considerate Christmas gifts for us, we often receive gifts we really do not want. So how do we react on receiving such undesirable gifts? In one study, participants were made to believe that a new opposite-sex romantic partner had selected an undesirable gift for them. The results revealed that males as opposed to females reported less similarity to their new romantic partner after receiving an undesirable gift, suggesting that males are more likely to react unfavourably to receiving gifts they do not want (Dunn et al., 2008).

As if such ingratitude is not bad enough, shopping for these gifts at Christmas can sometimes be stressful, especially if we are battling through busy crowds. Therefore, is it possible that store owners attempt to manipulate the atmosphere in order to make us feel festive and keep shopping for longer? Research has found that shoppers' evaluations of stores tend to be highest at the time of year when Christmas music is being played, with this effect enhanced when the music played is paired with Christmas scent (Spangenberg et al., 2005), implying that our Christmas shopping endeavours are motivated more by artificial means than a willingness to please others.

As well as tradition, is there another reason we send cards at Christmas? Johnson (1971) revealed that most of us not only engage in the reciprocal sending and receiving of cards between friends and family, but we do this in an 'upwardly mobile' way

meaning that we tend to send more cards to the people we are trying to impress. A rather more shocking finding by Kunz (2000) has suggested that people were willing to exchange Christmas cards even with those they hardly knew.

Apart from sending cards to improve our social standing and increase the number of friends we have, can Christmas be used in other ways to achieve these things? One piece of research has suggested that people who have few friends can use exterior Christmas decorations as a signal to communicate accessibility and friendliness to their neighbours (Werner et al., 1989). This study also revealed that exterior decorations were a major cue to participant judges that householders were friendly, and even in houses that were judged to have an appearance of what they termed 'low sociability', exterior decorations had the effect of making these houses and the occupants appear more neighbourly.

Finally, in most Western cultures young children believe in



TIM SANDERS

Help for problem gamblers

I note in your news article in the October issue ('New gambling research centre') the comment from Dr Roberts that 'treatment facilities which primarily rehabilitate problem gamblers are very limited; in the UK the NHS does not provide treatment facilities, unless the individual has other disorders they might need treatment for'. Whilst this might be true of residential

rehabilitation facilities, it is not true of all treatment modalities.

The National Problem Gambling Clinic has been treating problem gamblers within Central and North West London NHS Foundation Trust since 2008. In that time we have received several thousand referrals and successfully treated many of these individuals using an evidence-based

cognitive behavioural therapy treatment delivered by clinical and counselling psychologists. However, despite greater numbers of gamblers developing problems in the UK – estimates currently stand at between 0.4 and 1.2 per cent of the adult male population (Health Survey for England, 2012) – we remain the only NHS service for problem gamblers in the

contribute

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Letters

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Robert Sternberg, Oklahoma State University

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fantasy figures such as the Easter Bunny and Santa Claus. Our knowledge of children's cognitive development would lead us to predict that the duration and strength of this belief should disappear at around the ages of five to six, when most children can distinguish pretend actions from real ones. However, one study has shown that children's belief in Santa does not decline until around age seven with about one third of nine-year-olds still believing in Santa (Tullos & Woolley, 2009).

Therefore, in view of the fact that half of us are ungrateful at receiving unwanted gifts, and those who buy them have to be artificially motivated to do so, and the fact that we use Christmas cards and decorations to make friends and really only pretend that Santa exists, can we actually have a happy Christmas?

Martin Graff

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United Kingdom. We also receive no funding from national or local public health resources, being supported partially by a grant from the Responsible Gambling Trust, a charity that collects a voluntary levy from the gambling industry for research, prevention and treatment of problem gambling.

We believe strongly that the NHS has a role to play in the treatment of problem gamblers, with or without comorbid difficulties, and are working hard to publicise the issue of problem gambling and to have it seen as a public health issue deserving of funding. Problem gamblers are a population of individuals from all walks of life who develop problems with a legally available and heavily taxed activity. We now have the knowledge and experience to deliver a successful psychological intervention, but without funding from public sources this intervention will remain at best peripheral and at worst nonexistent.

Dr Neil Smith

Consultant Clinical Psychologist

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National Problem Gambling Clinic

Autism – beyond the myths

I found it refreshing to read Christian Jarrett dispelling popular myths surrounding autism spectrum disorder in his article 'Autism – myth and reality' (October 2014). I have worked for several years with students who have autism and have found they face a constant struggle battling myths. In particular, the belief that people with autism are asocial and selfish has caused challenges for the young people with autism that I have worked with. They are often left out of normal social practices because people believe they are not interested in joining in; however, frequently they are interested in participating but just struggle to communicate this.

It is important to emphasise that in my years or working I have never encountered an individual with autism who I would deem to be asocial or selfish. I believe the distinction Jarrett makes between an autistic individual's struggle to complete theory of mind (ToM) tasks and their personality traits is fundamental to helping give people with autism support.

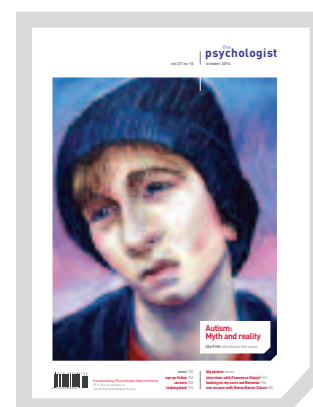
Autism causes difficulties in communication and understanding ToM; however, this does not halt an individual's desire to form

emotional bonds. Expressing affection can be challenging for individuals with autism, and this can be an even greater challenge when the public believes myths about autism causing asocial and selfish behaviours. Psychology has greatly improved our understanding of autism in recent years, and therefore it is now important to dispel myths such as this.

Increasing the levels of accurate knowledge surrounding the disorder can lead to the correct support being provided for people with autism. With the numerous challenges these individuals face, it is important to dispel myths that can hinder the progress people with autism make in overcoming their difficulties. I was pleased to read an article in *The Psychologist* clarifying the reality of the disorder, making the steps to eliminate myths and making life easier for people who have autism spectrum disorder.

Dulcie Gray

Lincoln



I was interested to read the special edition of *The Psychologist* 'Autism: Myth and reality'. Having worked as a clinical psychologist with people with intellectual disability for over 30 years, I have been interested and concerned about the growth of the use of the autism label and its impact on services for people with intellectual disabilities in particular.

The collection of articles all attempted to explain the key concepts of autism, whether it is a continuum or a category, whether there is a way of explaining cognitive differences between people with the label and those without, etc. I was

surprised that no author seemed to address a key issue. Surely an important reason to identify and categorise a subgroup of people is the hope that there may be key treatment implications for the members of that group? Yet no articles talked in depth about treatments or management for people with autism.

Yet in a way I am not surprised, because, when you look closely, there are no autism-specific treatment approaches. For example, the NICE Guideline 142 on recognition, referral, diagnosis and management of adults on the autism spectrum used 25 research papers that reached its criteria for acceptable evidence about treatment. Of these 25 papers, 15 were on people with intellectual disability, three were on people with intellectual disability and autistic spectrum disorder, while only seven were with people with autistic spectrum disorder alone. The approaches recommended do not differ from approaches that would be used for anyone with an intellectual disability. Many of the commonly used approaches in autism services such as TEACCH and PECS consist of sound behavioural, cognitive and communication principles that would apply to anyone with an intellectual disability.

Emerson and Baines (2010) estimated that between 20 and 33 per cent of adults known to local councils with social services responsibilities as people with learning disabilities also have autism. There is now a large autism specialist service sector of schools, residential services, day centres, peripatetic supports, etc., which is open to that significant minority of people with

intellectual disabilities. If these services really offer nothing substantially different to a good intellectual disability service, we should be questioning whether it is fair that extra help is available to those people with intellectual disabilities who have the autism diagnosis, when those without the diagnosis share similar needs.

The UK autism strategy for England asserts: 'Diagnosis alone is not enough: the fundamental change we want to see is that diagnosis leads to a person-centred assessment of need, in line with the NHS and Community Care Act 1990' Department of Health (2010, p.36).

A final thought: Why do we need the diagnosis in the first place for the person-centred response the guidance seeks?

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Dangers of 'colour-blind' perspectives

The article 'Child protection and the Rotherham abuse scandal' (October 2014) missed a key point observed by Professor Alexis Jay in her official inquiry into the scandal: 'By far the majority of perpetrators were described as "Asian" by victims, yet throughout the entire period, councillors did not engage directly with the Pakistani-heritage community to discuss how best they could jointly address the issue. Some councillors seemed to think it was a one-off problem,

which they hoped would go away. Several staff described their nervousness about identifying the ethnic origins of perpetrators for fear of being thought racist; others

remembered clear direction from their managers not to do so' (Jay, 2014, p.2).

Strategic colour-blindness (purposely

avoiding mention of a target's ethnicity to appear unprejudiced) potentially hinders eyewitness testimony (Egan et al., 2013). In the case of Rotherham, this phenomenon shamefully invalidated the experience of the marginalised and

socially excluded victims, enabling the offenders to continue to believe they were above the law and that the victim's complaints were irrelevant. Fieldworkers and practitioners who sought to whistleblow were likewise invalidated by the management executive despite practitioners seeking to protect the vulnerable. Independent academic research exposed the systematic nature of the offences in 2003 and 2006, but the work was blocked (and research files removed) due to the uncomfortable issues it raised for those whose priority was possibly less about child protection and more about playing politics. The case series investigated by Professor Jay therefore continued for another seven years. In the high-handed unfairness this scandal exposed, persons who believe themselves of a socially progressive outlook who tried to bury the offences may have ironically assisted in raising the appeal of right-wing political parties who will do little to improve local community cohesion.

A common discovery in any inquiry into official agencies failing to protect the public is their failure to communicate directly. Moreover, in helping people change, 'ownership of the problem' is crucial. Both are clearly in operation here. I point out that while colour-blind perspectives seek to minimise and ideally ignore racial group difference to reduce

racial bias (Apfelbaum et al., 2008), this does not respect and recognise the cultures and communities being homogenised, nor the basic reality that all communities have wrong-doers. As a practice point for readers worried that observing a client's heritage may somehow be prejudiced, note that when asked, persons of colour and minority prefer their personal identity, race and culture validated (Ryan et al., 2007).

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Councillors did not engage directly with the Pakistani-heritage community

Assisted dying – philosophical and religious perspectives

There may be many psychologists who disagree with the pro-assisted dying opinions voiced in the letter pages of the October 2014 issue of *The Psychologist*, though perhaps the majority of readers found themselves in agreement, or at least disinclined to actively resist a liberalisation of the legal framework.

It seems to me, however, that there is one overriding argument against such a change, namely that those people in society who are most vulnerable, either through their lived experience (including early experience and abuse) or because of societal structural inequalities (such as poverty, homelessness and old age), are much more likely to consider themselves as a burden on 'others', be it the state, their family or carers. This sense of being unvalued, which can be seen as arising from internalised relative powerlessness, would in turn inevitably act as a pressure to 'choose' assisted rather than natural deaths. As far as I can tell, assisted dying legislation attempts to deal with this through manifestly inadequate 'safeguards' involving the psychiatric diagnosis of depression or other limitations that have rapidly been challenged and diluted in

countries where legislative reform has been enacted (e.g. in Belgium the application of law on assisted dying is now extending to children and prisoners serving long-term sentences).

The point is that legislation to support individual freedom is rarely some kind of neutral act, which only promotes individual choice promoted by particular advocates: rather, because our lives and choices are socially and politically interconnected, such changes can disempower more vulnerable others. This moral argument is directly related to similar economic arguments about the iniquities of the free market, it is just much less visible in modern Western culture and certainly much less fashionable (MacIntyre, 2007)

Philosophical justifications in support of assisted dying grow out of the liberal-individualist position that permeates so much of modern Western life. And the discipline of psychology – its methods, concepts, conclusions and, at times, its application in clinical settings – is deeply permeated by this way of thinking (and interestingly was notably highlighted in the last page of the most famous and

important philosophical text of the last century (Wittgenstein, 1958).

Notable attempts have been made by people such as David Smail to challenge and make visible liberal-individualist assumptions in psychology practice; not surprisingly, given the scale the task, the success of such projects has been limited. It thus seems quite possible that the psychology profession may yet find itself advocating an opinion in favour of assisted dying that seems entirely just and rational without recognising 'whose justice or which rationality' is being given the dominant voice (MacIntyre, 1988) nor understanding the unintended consequences that follow for society's most vulnerable and powerless members.

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The article 'We should bring death back to life, into the open' (September 2014) generated some robust response to your journalist's comment 'Where are the supporters?' It is clear from both the original article and the responses that this is an emotive issue on which there are opposing views, even allowing for the quoted figure from Dignity in Dying that 80 per cent of the general public support assisted dying. What I did observe from the article and the responses was the minimal reference to religious considerations. Christine Kalus (October 2014) does recommend that the BPS should engage with interested parties including faith groups, and Carla Willig (November 2014) states that the Christian legacy of 'sanctity of life' includes the notion that suicide is a sin.

We are officially a Christian country, although in practice we are a multi-faith one. Unfortunately, professionals who dare to bring up the topic religion with their clients, or who even sport Christian symbols on their persons, risk sanctions from their professional bodies and even the law of the land. The reluctance to direct clients who are contemplating ending their own life toward pastoral counselling is, therefore, understandable even if regrettable, as this is a resource that can bring a fresh perspective to end-of-life issues.

Surprisingly, the Bible does not make a clear pronouncement on the rights or wrongs of taking one's own life. At least four suicides are reported in the Scriptures, and they are without any evaluative judgement: Saul (1 Samuel 31:4), Abimelech (Judges

9:54), Samson (Judges 16:30) and Judas (Matthew 27:5; Acts 1:18). Some add that Jesus' death was also suicide, as he said that he gives up his life of his own free will (John 10:18).

Inevitably, calling on the Scriptures can result in support of both views. In the red corner, against suicide, is the sixth commandment 'Thou shalt not kill' (Exodus 20:13), although this is usually interpreted to be just a prohibition against murder, as capital punishment and killing in warfare are permitted. There is also the belief that only God has control over life and death (Deuteronomy 32:39; 1 Samuel 2:6) and, in similar vein, the Lord gives and takes away (Job 1:21). In the green corner, tolerant of suicide, is the Beatitude 'happy are those who are merciful to others' (Matthew 5:7) and the commandment 'do for others what you want them to do for you' (Matthew 7:12) (all quotations from Good News Bible).

Obviously this publication is not the venue to conduct an exhaustive debate on the Scriptures, but it is clearly difficult to reach consensus on the ethics of suicide and euthanasia from either a religious or secular perspective. All opinions must be considered and respected, but it is prudent not to neglect the comfort and insight that can be gained from including a faith viewpoint in the debate on this crucial issue going through the parliamentary process at this time. Nor should practitioners in the caring professions shy away from it.

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Towards a comprehensive model of psychopathology

I have long ceased to take any unitary concept e.g. anxiety, ... seriously that is not founded on basic factor analytic research – exploratory or confirmatory. ... bivariate methods are as useless in finding wholes as is trying to eat soup with a fork...
(Raymond Cattell, *The Psychologist*, January 1993, p.22).

I'm moved to write in response to the letters by Sue Gerrard and Richard Hassel ('The end of autism', November 2014), but not to get into the debate about autism. Several contemporary issues, such as the debate on psychiatric diagnosis and DSM-5, whether autism is a category or a series of dimensions, and genetic contribution to chronic psychological distress, appear to be related to a lack of meaningful application of psychological theory. It seems to me that there is a requirement for a comprehensive model of psychopathology based on psychological research. While this would be difficult to achieve practically, it is surely the method by which to address these major debates.

I have often thought that the process is essentially straightforward:

1. Choose those phenomena that are considered in this culture at this time to be important because of outcomes we do not desire (e.g. 'depression' links

to suicide and unhappiness; anger links to aggression, injury and death; poor social understanding in children links to social isolation, etc.). The dimensions to be included could be exhaustively agreed among the community of psychologists in the field.

2. Develop measures for each dimension that achieve satisfactory reliability and validity, aiming to achieve high sensitivity and specificity.
3. On achievement of acceptable valid measurement on all psychological dimensions that are considered currently important, use data-reduction techniques to identify the underlying factor structure of our working psychological constructs, and importantly, discard the invalid.
4. Research those risk factors (not necessarily first causes) that load onto the negative outcomes on each underlying factor (e.g. attachment insecurity, socialisation of boys into aggression, lack of structured education for those with poor social cognition, etc.), seeking to address each through health and social care services.
5. Feed back to policy makers, the public and other professions about the new

basis of psychopathology in the above. Specify the relative power of known risk factors (allowing for unmeasured and unknown variance) that load onto outcomes, and what might be done to change these most efficiently.

A comprehensive model of psychopathology that is ambitious in scope but practical in usage does not emphasise debate about diagnosis or genetic causation. Current 'comprehensive' measures, such as the Millon Multi-axial Clinical Inventory, continue to have a basis in diagnostic systems that we now consider to lack sufficient validity.

Psychologists may then have to face up to an empirical model where current theoretical distinctions are debunked (e.g. merging of anxiety and depression into 'distress'). It is entirely possible that we achieve something like the DSM axes, but these will be based in sound bottom-up research. Health and social care policy may then have a basis in something like a scientific consensus.

Dr Allan Skelly CPsychol AFBPS

*Secretary, Faculty for People with Intellectual Disabilities
BPS Division of Clinical Psychology*

obituary

Robert Taylor (1956–2014)

Robert Taylor died on 7 September after a short but devastating illness. He was a dear friend, a valued colleague of all and someone who enjoyed life to the full.

After a spell as an assistant psychologist to John Teasedale in Oxford, researching mood and memory, Robert studied clinical psychology at Edinburgh University from 1979 to 1981 under the tutelage of the late and great Ralph McGuire. He obtained his PhD in 1984 and worked as a clinical neuropsychologist at Leeds and Wakefield before returning to the job at the Department of Clinical Neurosciences in Edinburgh in 1991, the job he had always wanted. He worked as a single-handed practitioner from then until his retirement in 2013.

In younger years, he was a skillful woodworker and musician, and enjoyed cycling and rowing. My husband (also an oarsman in his youth) and I met up with him every few months, laughed ourselves silly, listened to James Taylor and Carole King endlessly, played Trivial Pursuit, argued, discussed the NHS (also endlessly) and generally tried to put the world to rights.

His greatest happiness and pride was his two children, Stuart and Fiona. It is absolutely typical of Robert that he would not have boasted about his children's prowess any more than he would have talked about his own. In fact, having known him for 35 years and talked to patients and staff who worked with him, I heard much about his kindness and support for colleagues. He



worked very hard, had great compassion for the people whom he saw: often young people with catastrophic brain injuries, trauma and tumours. He occasionally joked about the fact that, had he let a long waiting list develop at DCN, he might have persuaded the NHS to employ

a few more neuropsychologists, rather than consultant neurologists. Instead, he did not take holidays, worked as hard as he could for his patients and quietly got on with the job at hand.

Robert was concerned about what he would do in retirement, but told me that he was enjoying himself immensely. He was intending to continue his medico-legal practice and had a vast amount of research material which he was intending to work on and publish. He was not happy about having developed illness so soon after retiring, because he was just settling into it.

In his last few weeks, even as he lurched from one medical crisis to another, he was more concerned for the well-being of his family and friends than he was for himself. He did not want to be a bother to anyone and never was. He is survived by his son and daughter, his brother Keith and his mother. And his friends: I am proud to have been one of them.

Alison Richardson
Edinburgh

Hallucinogens – don't choose ignorance

In response to Dr Lowenstein's letter (November 2014), I would like to speak up in support of the special issue of *The Psychologist* (September 2014) that focused on hallucinogens. I thought that the articles in this edition gave a well-balanced selection of views, highlighting both the potential research benefits of hallucinogenic drugs ('A brave new world for psychology?' by David Nutt) as well as the dangers and potential harm they can cause ('When the trip doesn't end' by Henry David Abraham). In addition, I found the excellent articles on the cultural context and history of hallucinogens ('Cultures of chemically induced hallucinations' by Vaughan Bell) and on how these drugs actually work on the brain ('How do hallucinogens work on the brain?' by Robin Carhart-Harris, Mendel Kaelen and David Nutt) extremely interesting. I'll admit that this is not my field of professional work or academic interest (as an educational psychology PhD candidate and education professional), but despite the lack of direct relevance to my work, I found these articles to be engaging. The world of hallucinogens is not one that the majority of people will ever have direct experience of, and it is absolutely right that the potential harms of these drugs are taken seriously, but it is still an interesting topic to read about and one that could well be useful to those undertaking psychological research in this field.

I do not believe that these articles were glorifying hallucinogenic drugs nor was



I was disappointed, but not surprised, to read Dr Lowenstein's comments on hallucinogenic drugs (Letters, November 2014). Before hallucinogenic drugs, such as LSD, were banned in the early 1970s they were used as an adjunct to psychotherapy. Much research was done and published, most of which is lost in the mists of time (for those who are interested the complete archive of the *Psychodelic Review*, 1963 to 1973, is available at www.maps.org/psychodelicreview). Whilst many of the papers are dated, reflecting the counter-culture of the 1960s, there are a lot of potentially useful research findings, most of which will not have been replicated. For details of

modern research there is the Multidisciplinary Association for Psychedelic Studies, (MAPS) website (www.maps.org), which is well worth a visit.

As an example of current research in the UK and Italy, the work by Petri et al. (2014) on psilocybin, the psychoactive ingredient of magic mushrooms demonstrates that 'the homological structure of the brain's functional patterns undergoes a dramatic change post-psilocybin, characterized by the appearance of many transient structures of low stability and of a small number of persistent ones that are not

there any suggestion that these drugs would be suitable for use in all psychological treatment or research. I'm sure there will be many psychologists who agree with Dr Lowenstein's opinion that 'there are much better ways to achieve contentment and to make one's life worth living'. I agree with this myself. However this doesn't mean that the other side of the debate shouldn't be heard or that potential benefits for psychological treatment and research shouldn't at least be discussed. I did not get the impression that, as stated in Dr Lowenstein's letter, this issue of *The Psychologist* was advocating hallucinogenic drugs. The articles were airing various views within the debate and these views should be free to be expressed. It is important that we, as psychologists, make an effort to expand scientific understanding and don't choose ignorance for the sake of long-held presumptions.

I also find it puzzling that Dr Lowenstein makes a distinction between alcohol and substances that lead 'to some form of addiction'. Alcohol is an addictive substance and it is well known what damage this can cause to people's health and lives. I don't understand why it would be acceptable to distinguish alcohol from 'smoking and the use of substances that can only be considered drugs generally'.

I believe that *The Psychologist* is doing a fantastic job of broadening people's horizons and research interests by entering into the debate on controversial subjects, such as hallucinogenic drugs, and I hope that unnecessarily conservative views do not discourage future publications on other contested subjects. I for one have no objection to being tarred with the brush of seeking to expand my psychological knowledge and I hope the majority of psychologists will feel the same.

Laura Oxley
York

observed in the case of placebo'. Such new connections, in the therapeutic context, may lead to new insights and consequent psychological change and growth, thus there are important implications for psychological therapy and possibly for neuropsychological rehabilitation.

It is unfortunate that Dr Lowenstein uses the term 'tinkering', which belittles the research currently being carried out and does nothing to advance the frontiers of psychology or neuroscience.

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(2014). Homological scaffolds of brain functional networks. *Journal of the Royal Society Interface*, 11. doi:10.1098/rsif.2014.0873

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Gillian Martin
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