Psychological Perspectives on the Assessment of Dyslexia: Pitfalls & Advances

Symposium Convener:
Dr Rainer Hermann Kurz
Science & Practice Convenor of the BPS DOP

1. Psychological Perspectives on Assessment: Is coaching a reasonable adjustment for adults? (Nancy Doyle)
2. Multi-Sensory Therapy for Mind, Body and Soul (Christina Jubb)
3. Differential Ability Profiling - Key to Understanding Cognitive Functioning (Alastair Coomes)
4. ‘Twice Exceptional’ Individuals - Safeguarding against Re-victimisation (Dr Rainer Hermann Kurz)

This session is in part sponsored by the British Psychological Society's Division of Occupational Psychology
Psychological Perspectives on Assessment: Is coaching a reasonable adjustment for adults?

Nancy Doyle MSc C. Psychol. AfBPsS
Working Group on Neurodiversity and Employment:

Nancy Doyle
Sarah Cleaver
Tessa Hollingsworth
Dr David McLoughlin
Dr Rachel Owens
Chris Rossiter
Dr Jo Roberts
Gurleen Manku
Kae Prendergast
Samantha Allen
Best Practice Guidelines for Cognitive Assessments of adults

CPD open to all psychologists on cognitive assessments for adults

Presentations at Occ Health & HR conferences to raise awareness

Written articles for psychology periodicals to share best practice

Conducted surveys to explore diagnostic experience, stress & health links

Contributed to the Access to Work consultation and DWP employability consultations
“The diagnosis brought about some sort of identity crisis I guess I am now still unsure where my personality ends and the dyslexia begins... What I believe are characteristics of my personality are not actually my own, but coping mechanisms (e.g. Keeping lists, the need for tidiness) – it feels like I am not sure who I am anymore.”

• Quote from McLoughlin and Leather, 2013
Signs of Dyslexia

- Delayed Speech
- B ?d ?
- Saw was
- Poor Spelling

Abundant Life Blog
Cognitive Skills:
• Working Memory
• Processing speed
• Time & Planning
• Attention and Concentration

Should we be recommending coaching? What evidence do we have that it works?
<table>
<thead>
<tr>
<th>Working Memory rating Scales: Adapted, adult-focused items (from Alloway et al., 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need help to stay on track with activities that have lots of steps</td>
</tr>
<tr>
<td>I find group discussions difficult and can interrupt too much, or I stay quiet because I don’t know when to speak</td>
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<tr>
<td>I find it hard to remember instructions</td>
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<td>I abandon activities or get distracted before I finish</td>
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<td>I find it hard to find the ‘right’ word when asked direct questions, particularly during interviews or in busy environments.</td>
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<tr>
<td>My ideas jump around from one thought to another</td>
</tr>
<tr>
<td>I have difficulty concentrating in busy environments – I prefer quiet space and smaller offices for talking and working</td>
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</tbody>
</table>
Do we have any evidence on how to improve cognitive skills?
Henri Tajfel and John C. Turner

“Social Identity Theory”

Albert Bandura

“Social Cognitive Learning Theory”
Knowledge transfer
• Self Awareness

“Social modelling”
• Vicarious Learning
• Role models

“Verbal persuasion”

“Self-efficacy”
• Mastery experiences

Can this apply to developing cognitive skills?
Is coaching the best delivery mechanism?
"Coaching: this is a partnership and more androgogical approach, in which the learner ultimately takes control of their own learning and progression. The aim is to help and increase the individuals' awareness of what they need to do to improve their performance or develop a particular skill."

(McLoughlin & Leather, 2013)
Scoping study of the literature

*A sample of 100 papers revealed 61% neuro based

Of the 41 work-related papers, 18 were education based, 1 mgmt, 1 HR, 1 OH, the rest from unrelated fields such as Social Work.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Grouping</th>
<th>Sample size</th>
<th>WM deficit?</th>
<th>SCLT Score</th>
<th>MC Y or N</th>
<th>Teaching methods used</th>
<th>P value</th>
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</thead>
<tbody>
<tr>
<td>Zeidan et al.</td>
<td>2010</td>
<td>working age</td>
<td>63</td>
<td>None</td>
<td>3</td>
<td>Y</td>
<td>facilitated meditation workshops</td>
<td>p=.27</td>
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<tr>
<td>Craik et al.</td>
<td>2007</td>
<td>older</td>
<td>49</td>
<td>Age related WM deficit</td>
<td>4</td>
<td>N</td>
<td>group training knowledge transfer with practice and de-briefing</td>
<td>NS</td>
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<tr>
<td>Jha et al.</td>
<td>2010</td>
<td>working age</td>
<td>60</td>
<td>Stress</td>
<td>3</td>
<td>Y</td>
<td>mindfulness workshops plus coaching</td>
<td>p&lt;.01</td>
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<tr>
<td>Moro et al.</td>
<td>2015</td>
<td>older</td>
<td>30</td>
<td>Age related MCI</td>
<td>4</td>
<td>Y</td>
<td>cognitive training with personalised follow up to coach strategies</td>
<td>p=.027</td>
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<tr>
<td>Chambers et al.</td>
<td>2007</td>
<td>working age</td>
<td>20</td>
<td>None</td>
<td>3</td>
<td>Y</td>
<td>mindfulness workshops</td>
<td>p&lt;.01</td>
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<tr>
<td>Moro et al.</td>
<td>2012</td>
<td>older</td>
<td>30</td>
<td>Age related MCI</td>
<td>4</td>
<td>Y</td>
<td>cognitive training with personalised follow up to coach strategies</td>
<td>p=.04</td>
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<tr>
<td>Alloway &amp; Warner</td>
<td>2008</td>
<td>children</td>
<td>20</td>
<td>100% DCD</td>
<td>4</td>
<td>n/k</td>
<td>physical coaching to perform fine and gross motor tasks</td>
<td>p=.02</td>
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<tr>
<td>Ariës et al.</td>
<td>2015</td>
<td>young adults</td>
<td>92</td>
<td>none</td>
<td>4</td>
<td>Y</td>
<td>computerised n-back and IMPROVE w/ group peer coaching to learn MC</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Ariës et al.</td>
<td>2015</td>
<td>young adults</td>
<td>63</td>
<td>none</td>
<td>4</td>
<td>Y</td>
<td>computerised n-back and IMPROVE w/ group peer coaching to learn MC</td>
<td>p&lt;.001</td>
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</table>
This dovetails with Carol Leather’s work on metacognition.
BUT! So far the evidence is based on groups, not 1:1.
Field study comparing groups & 1:1 to a control

ANCOVA at T3 controlling for Baseline differences

\[ F(2,39) = 5.275, \ p = .027 \]

Partial \( \eta^2 = .12 \)

**Group is significantly different from control at T3**

\[ t(27) = -2.152, \ p = .041 \]

**1:1 is not significantly different from control at T3**
Consider the evidence base for your recommendations

- Remember how intensely pivotal this might be for your assesseee, what happens next has a huge impact on well-being

Consider the social as well as the cognitive factors for recommendations

- Practise between sessions
- Role models
- Group work
- Involvement of line manager

Consider the type of coaching you are recommending

- Cognitive skills
- Metacognition
- Pedagogy
Multi-Sensory Therapy for Mind, Body and Soul

Christina Jubb
(Dyslexia / Schema Therapist)

The Case for Treating People as ‘Wholes’

www.access-education.com
Specific Developmental Dyslexia

A copy of the report of the Conference on Specific Developmental Dyslexia, held on April 12th, 1962 at St. Bartholomew's Hospital Medical School, is being despatched to every Education Authority. We should be grateful for a contribution of 5/0d towards the cost of preparing it.

I should be very glad if you would draw the attention of the School Medical Officer to this Report, further copies of which are available if required.

G.D. RATTENBURY
General Secretary
History in Brief 1877 – 1979
(Focus on UK development)

First recorded case of ‘word blindness’ and word deafness was noted by Adolf Kussmul 1877, a German Physician. Ten years later, Rudolph Berlin a German Ophthalmologist terms the word ‘dyslexia’.

Here in the UK it was Dr Pringle Morgan a GP who wrote about a patient in the British Medical Journal 1896. Cases were subsequently reported by James Kent, Medical Officer of Health in Bradford.

By 1917, James Hinshelwood warned that ‘word blindness’ was not being recognised, was greatly under diagnosed and that ‘children were suffering due to this neglect’.

1938 – Dr Eric Strauss was appointed Head of Dept of Psychological Medicine at Barts. On diagnosing a 12yr old who had been under threat of being locked away in an asylum, he appointed Maisie Holt to set up a treatment programme.

From 1949 both McDonald Critchley (primarily a Neurologist) and Tim Miles worked tirelessly in London and Bangor in the field. Tim and Beve were founder members of the BDA in 1972.

1972 – Beve Hornsby took over the Dyslexia Clinic. This was upgraded to a Department shortly before closure.

1979 – The International Year of the Child Symposium was held at Barts. Though Beve was the key speaker, Tim took part because by then, Bangor was the Centre of Excellence for the academic study of dyslexia. In the same way as Barts was for assessment and remediation.

By 1981, Beve had been forced out of Barts and founded the Hornsby International Dyslexia Centre in 1984. By then she had attended Bangor and gained her MEd. She was awarded her PhD when she was 70. It was from a medical faculty, despite her thesis being the remediation of dyslexia.
A Retrograde Step

In 2005, 30 years after Beve Hornsby set up the Diploma for Dyslexia Therapy – Dyslexia Therapists were excluded from the SpLD Working Group.

Furthermore, the qualification of Dyslexia Therapist was not recognised as being of a suitable standard to be included in its own right. Neither too was the combination of a Dip Ed in the Assessment & Remediation of Dyslexia and a Masters in Dyslexia from Bangor.

In my opinion this, together with the closure of the Hornsby International Dyslexia Centre, has led to dyslexia going backwards, not forwards.

In 2010, I was contacted by the Head of ‘Disability Learning Support’ of a Uni not far from Barts. Despite all the staff holding specialist qualifications, as approved by the Steering Committee, none of them understood the term ‘Specific Developmental Dyslexia’. McDonald Critchley, Beve Hornsby and Tim Miles will be turning in their respective graves.
Excerpts from a letter to a medical journal – 1979 - Beve

The case for Dyslexia Therapy as written by Beve Hornsby Head of St Barts Dyslexia Clinic

The closed shop, restrictive practices and the power hungry, prehensile acquisitiveness of unions is, sadly, by no means confined to industry. It exists in the NHS.

Patients are being compartmentalised as buildings where a carpenter cannot replace a light bulb. They are shuttled from one ‘expert’ to another through an endless referral system with exasperating loss of time and money.

People are ‘wholes’ and need treating as ‘wholes’. ‘Learning difficulties’ can be due to multifarious causes with a multitude of aspects which need assessment and treatment.

Treating patients as isolated parts means no-one will have seen the patient’s reactions and behaviour during each of the separate assessments.

Far more valuable is an interdiscipliary person trained in a variety of areas (psychology, teaching, speech therapy, occupational therapy and phonetics) who can carry out a complete assessment and arrive at a total picture of the patient’s difficulties.

If the team is comprised of only one profession (e.g. teachers), only the knowledge of one training is available. The same is true if confined to educational psychologists.

An idyllic situation exists in our Clinic. My elite band of Dyslexia Therapists are a combination of experts rolled into one, who deal with assessment and all aspects of remediation under one roof.

We need more funding to train and retain specialist staff. They are not ‘Jacks of all trades’, but Masters, and this should be recognised. Currently, they are graded as ‘psychological technicians’ – an arbitrary rank for highly qualified, dedicated personnel. We need more funding not less.
Hyperlexic with Asperger's and Dysgraphia

Writing is that of an exceptionally intelligent young man – who was a Cambridge undergraduate. He had reading and spelling levels in the high 90 percentile. This was in 2004, when it was easier to argue an atypical case. Plus, my reports were accepted in a category of their own by the bodies dealing with Disabled Students Allowance.

These days, this deserving student would not be classed as dyslexic. In fact he was ‘hyperlexic’. I did not label him as such because I did not think it would help his case. Instead, in his report, I argued that he had difficulties on the autistic spectrum including dysgraphia. Nowadays, I fear that he would slip through the net. I could still assess him, but my reports are invalid since the steering committee excluded Dyslexia Therapists.
Multiple Professionals

Monitoring

1. There should be careful monitoring and recording of [progress], which can be used in turn to inform future stages of her education e.g. individual education plan, provision map etc. It is to be expected that this systematic record-keeping will provide the principal means of reporting back in due course to Parents about her progress at subsequent Annual Reviews of this Statement.

2. The school should nominate a teacher specifically to co-ordinate [learning activities], review these with her regularly, and ensure that all staff are aware of her needs and the programmes to be followed. Such support and supervision should extend to offering [opportunities to seek personal guidance and reassurance as necessary.

3. Close and effective liaison should be maintained between [school and other agencies involved and home, in terms of a regular exchange of information about her work, progress, and general welfare. This information will be used to inform Annual Reviews of this statement.

4. Within 2 months of the Final Statement the SENCO, in conjunction with [parents and the appropriate professionals, will establish short-term educational targets and the strategies to meet them. These will be set out in an Individual Education Plan (IEP) or a provision map. These targets should be based on the objectives in Part 3.

5. 3 times per year the targets should be reviewed and consideration given to any modifications of the National Curriculum. [Should be actively involved in setting the targets and monitoring them if she is able to do so.

6. A full Annual Review must be held within 12 months of the issue of this statement, and then every subsequent 12 months. Should there be any serious concerns about [progress, or any suggestion that her needs have considerably altered, an Annual Review may be convened before the 12 month cycle has been completed.

PART 4: PLACEMENT

PART 5: NON-EDUCATIONAL NEEDS

[is prescribed medication for her ADHD, which is managed by the Child and Adolescent Mental Health Service (CAMHS).]
Misdiagnosis

Sometime a highly intelligent dyslexic slips through the net. This young lady had. Just as bad as not understanding her problem were the 'excellent strategies' she was provided with.

Telling a patient of 6½ to develop her literacy skills and visuo-spatial ability is not a strategy. The young lady was helped, however, by a correct diagnosis and Dyslexia Therapy. Her poor self-esteem rose, along with her confidence.

Conclusion

Verbal skills scored at the top of the average range, and her written arithmetic and reading comprehension correlated with this estimate. Her perceptual organisation attained the lower half of the average range and her reading accuracy and spelling correlated with her perceptual organisation. She has been provided with excellent strategies to overcome any underlying weaknesses and she is making very good progress. The pattern of her strengths and weaknesses together with the discrepancy between her reading and spelling accuracy and the level that would have been expected from her estimated intelligence (which is not wide enough to be statistically significantly) indicates that she has very few dyslexic signs, and with continued support for her remaining time in Key-Stage 1, she should be able to attain the appropriate level for her intelligence by the time (or shortly after) she transfers to the Junior part of the school.

Needs

Current educational needs would seem to be:
- To continue to develop her literacy skills.
- To continue to develop her visuo-perceptual skills.
- To maintain her self-confidence and self-esteem as an independent learner.
Equine Studies

Warwickshire College

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CV35 9BL
T: 01926 318000
F: 01926 318300
enquiries@warkscol.ac.uk
www.warkscol.ac.uk
Principal: Joan Morgan CBE

Academic
c/o Tina Jubb
Access Education
1 Whitby Road
Milford on Sea
Lymington
Hampshire
SO14 0NE

01 October 2009

Dear Abi,

Please find enclosed your marked piece of coursework. Well done with your excellent mark!

If you have any queries regarding your assignment marks or the course in general please feel free to contact us on 01926 318398 or email at equistudy@warkscol.ac.uk

We look forward to receiving your next piece of coursework when it is ready.

Yours sincerely

Cheryl Wilson
Equi Study DL Course Manager

T: 01926 318346
F: 01926 318300
E: equistudy@warkscol.ac.uk
A Medical Student

Dear Christina,

I am writing to let you know that I passed my qualifiers! After handing the report to the Exams Registrar I was awarded the much needed extra time in the exam. I found I had enough time to read the questions, understand them and answer them as well!

I wish I had come to you earlier! Thankyou! You have made me understand my strengths and weaknesses – now I know the best way to approach my studies.

I know for a certainty that I would have struggled now and in the future without your help. After the huge effort I had to put into my first degree and spending more time than anyone else I knew preparing for exams - I still attained marks lower than my set target.

But this time round, with the extra time I was allotted and revising with your advice in mind on how to use different methods I had a very different experience during my exam.

And in the short span of a few weeks I was more prepared than ever before! I passed my exam and even the ongoing lectures seem a lot clearer to me than before.

Even though I was not a classic dyslexic my efforts have always been impeded by my short term memory and poor reading and writing skills. These became more pronounced during my exams as graduate medicine is an intense course with a very high pass mark. I would encourage anyone with such issues to come to you for an assessment.

Best of luck in the future Christina.
Thank you card from George’s parents.

George came to us, aged 7 - a scared, aggressive lad who'd turned into a bully because he felt so helpless. He'd been seen by the County EP who'd failed to recognise that inside George was a very bright boy who was reaching out. Her answer to his ticks and lashing out at classmates, was to suggest he sat at the back of the class playing with Blu-tac to ‘keep him busy’. When he got home, he'd lash out!

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Dear Tina and Mike,

We can't thank you enough for all you have done for George. He has transformed into a different boy since he has been coming to you. In place of the frustrated, angry and aggressive son we have a happy, fun and loving son. Thank you for making such a difference.

To Tina and Mike

Thank you for teaching me. I had so much fun with you.

Love from George
Some factors that should have rung bells to the professionals within medicine and education who had consistently failed to identify his needs. Aside from specialist learner support staff within schools and his GP, K had been referred to more than one of the following disciplines on numerous occasions:
- Speech Therapy
- Occupational Therapy
- Educational Psychology

As far as I can ascertain, he only saw one Paediatrician. Her assessment consisted of throwing a ball at K six times and because he caught it three times, he was declared ‘AOK’. When the parents sought a second opinion, they were told they’d already had the benefit of a ‘thorough assessment’ by said doctor.

- Born by emergency ‘C’ section at 32 weeks
- Despite a CPAP machine (continuous, positive, airway pressure), K stopped breathing several times during his first 5 weeks.
- Milestones delayed
- Very delayed, unclear speech
- Nystagmus present
- Convergence insufficiency (neither eye dominant)
- Awkward gait
- K’s literacy levels were 1% and single word vocabulary 1%
- K was unable to produce any ‘free-writing’
- Basically – he was a non-starter

Despite very low scores on WISC with County EP, ‘K’ managed average scores on ‘Similarities’ and ‘Comprehension’ during our Assessment.
Court Referral - J

J was referred by a barrister on the orders of a Judge. Undergoing Schema Therapy was a condition he’d imposed along with sobriety, before J was released to a safe house under the care of a Guardian. If J stuck to the rules the Judge would look again at her custody case. At the time, her very young baby was under threat of adoption and her two elder boys were in the care of the local authority. J had been seen by multiple mental health professionals and social workers. The consensus was that J had Borderline Personality Disorder.

History was extremely traumatic. Due to a severe, life changing injury inflicted on her mother by her father (an incident witnessed by J) she became a carer aged 5. Dad was also a sex offender. J’s school attendance had been patchy and J stopped going altogether aged 14 to care for mum and younger brother. She was drawn to highly unsuitable partners and the father of her first two children was in prison. The baby’s father was a paranoid schizophrenic. With little education, J was trapped and turned to alcohol for comfort.

Whilst at my practice J underwent multi-sensory therapy as a day patient. This included Schema Focus to address the multiple traumas. There was a degree of dyslexia and this too was addressed. Poor eye convergence was present. This is a common factor we often find in patients who are depressed and or dyslexic.

By the time J was discharged, 9 months later, she was a sober, straight eyed, confident, avid reader. Aside from psychotherapy, the focus had been on the skills J needed – reading, writing, spelling, nutrition/cooking. The outcome was that J found a house to rent and redecorated it herself. She applied to a law firm to be a clerk, with the aim of becoming a solicitor ‘to speak out for women like me’. At the final hearing her barrister had failed to show. J was offered a Court solicitor, but spoke for herself. She got her boys back.
Somewhere over a Rainbow
Multi-sensory Therapy
Everything Flowers from Within

Children who are emotionally abused and neglected face similar mental health problems as children who are physically or sexually abused.

Sadly, children in England are still suffering insults and ‘overwhelming’ demands – just because they are dyslexic. And where do they turn? The following paragraph is taken from a letter written by Tim Miles on 6th Jan 1978 to ‘The Friend’, a Quaker magazine. A specialist ‘remedial’ teacher had stated there was no need to distinguish between ‘backward’ readers and ‘so-called dyslexics’. It was, she said, a ‘middle class’ invention. Tim assured her there were not many middle class folks in Bangor, nor I might add, in the East End of London where I was working.

Tim explained that dyslexia was a ‘pattern of difficulties’, or as Margaret Newton would advise at Aston ‘look for peaks and troughs’. In his letter, Tim invites the disbeliever to visit the Dyslexia Unit. And he ends with the fact that as a Quaker, he’d have hoped she’d understand the need for compassion. The failure to recognise dyslexics is, I quote: ‘downright cruelty, for it is tantamount to saying, I have not understood your problem’.

My most recent case was a 12yr old who’d presented with a facial tick, a stammer and a severe case of dyscalculia. Mum reported that he was also bed wetting. His maths teacher’s response when the boy asked for help was to shout ‘For God’s sake, how stupid can you be?’ And he gave him another detention. The problem is still being misunderstood. Yet it took us only 15mins after our assessment of him to explain fractions in a multi-sensory way – using an apple!

“Sometimes it is necessary to reteach a thing its loveliness” (St Francis & the Sow; Kinnell, G.)

At the Retreat we had a woman with depression and addiction, which had its roots in loss of self-worth due to undiagnosed dyslexia. She’s attempted suicide. Four years later, she is free from medication – and she has a degree in Creative Writing.
Yeo’s Colour Weaving Prayer
Differential Ability Profiling: Key to Understanding Cognitive Functioning

Alastair Coomes

Specialist Teacher
AMBDA APC- PATOSS

12th March 2016
BDA 10. International Conference, Oxford
Personal Introduction

Teacher since 1995 (over 20 years)
Specialist Dyslexia assessor and teacher since 2003/4
PATOSS APC & AMBDA
Work across age ranges early years to adult
Opposed to silo working, blinkers and hammers
MBPsS – Counseling Psychology Goal
This case questioned 3 key areas of practice:

• Environment – how true to life is our assessment to real life or experience that client will be facing day to day?

• Real life value of assessment – making assessment *real life* – how does it help practically and emotionally?

• Parsimony – does everyone understand what the assessment is saying – what is the truth for them?
## Profile of case

<table>
<thead>
<tr>
<th>Underlying Abilities</th>
<th>Performance</th>
<th>Cognitive* skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well Below or Very Low</strong></td>
<td><strong>Low Average</strong></td>
<td><strong>Phono-memory &amp; Working Memory</strong></td>
</tr>
<tr>
<td><strong>Below Average</strong></td>
<td><strong>Mid Average</strong></td>
<td><strong>Rapid Naming</strong></td>
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<tr>
<td><strong>Below Average</strong></td>
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<td><strong>Phono Awareness</strong></td>
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<td><strong>Low Average</strong></td>
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<td><strong>Mid Average</strong></td>
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<td><strong>High Average</strong></td>
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<td><strong>Above Average</strong></td>
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<td><strong>Very High</strong></td>
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**Tests Used:** WRIT, WRAT, CTOPP*, WRAMAL 2, DASH
Findings

• Fairley well compensated, intelligent dyslexic learner.

• However history of having major struggle with finishing higher education.

• Why? Poor at understanding or remembering what was being said by tutors.

• In court and with police (with heightened anxiety) even more so.
Addendum

- Am I testing just her compensated skills and ignoring the reality and issues that she has?
- Am I being lead by the test rather than thinking about how poor cognitive skills affect her?
- Am I just completing the same old assessment every one else has?
Dusting off an old friend

• Spadafore Reading Test –
Why it has gathered dust –

• American (but most tests are)
• Old (yes but we do still read stuff don’t we?)
• No standardised scoring (So no average..?)
**Listening Comprehension**

- Very poor listening comprehension

**Silent Reading Comprehension**

- Reading performance at expected independent level

**Grade Level**

- Chart indicating expected grade level for reading performance

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**SDRT SPADAFORE DIAGNOSTIC READING TEST**

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>Word Recognition</th>
<th>Oral Reading</th>
<th>Oral Reading</th>
<th>Silent Reading</th>
<th>Listening</th>
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<td>10th</td>
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<td>11th</td>
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<td>12th</td>
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</table>
# Profile of case

<table>
<thead>
<tr>
<th>Underlying Abilities</th>
<th>Well Below or Very Low</th>
<th>Below Average</th>
<th>Low Average</th>
<th>Mid Average</th>
<th>High Average</th>
<th>Above Average</th>
<th>Very High</th>
<th>Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-verbal – WRIT Matrices</td>
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<table>
<thead>
<tr>
<th>Performance</th>
<th>Spadafore</th>
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<tbody>
<tr>
<td>Listening Comprehension</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Cognitive* skills</th>
<th>Phonomemory &amp; Working Memory</th>
<th>Rapid Naming</th>
<th>Phono Awareness</th>
</tr>
</thead>
</table>

Tests Used: WRIT, WRAT, CTOPP*, WRAMAL 2, DASH
Implications

• ‘Her literacy levels although average are not commensurate with her ability. Further tests suggest that she has a core deficit in phonological processing in particular her auditory memory and working memory commensurate with a diagnosis of specific learning difficulty commonly referred to as dyslexia.’

• ‘When information... is relayed to her purely in an auditory manner, there is a high probability that she will neither be able to remember nor understand the full implications of what is being said...The nature and mode of communication can be viewed as the limiting factor to her level of understanding not her underlying intelligence or reading ability.’
Reasonable Adjustments & Legal Proceedings

• ‘The results of this assessment indicate that the severity of her educational special need would qualify her for a level of protection under the Equalities act of 2010. Developmental Disabilities such as dyslexia are listed under the Equalities act. Furthermore the effect of her very poor working memory needs to be considered as to its effect on her ability to process important verbally presented information.’

• Could the way that vital information was relayed have changed the outcome of this case?

• How do we enable our clients get the right access arrangements without embarrassment or fear of judgment.

• Can aspects of dyslexia (i.e. poor working memory) be attributed to other psychological symptoms?
Test don’t diagnose people, people do.

• Don’t renege responsibility or impact of difficulties to test but go further in trying to fully understand the context of an individual.

• Be open to changing paradigm – *I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.* – Maslow (1966).
‘Twice Exceptional’ Individuals - Safeguarding against Re-victimisation

Dr Rainer Hermann Kurz, Chartered Psychologist
ichinendaimoku@gmail.com
Science & Practice Convener of the BPS DOP
Member of the BPS Committee on Test Standards

This session is kindly sponsored by the British Psychological Society’s
Division of Occupational Psychology
Occupational Psychology (US: ‘Industrial/Organizational Psychology’) is the applied science of people at work.

The Division of Occupational Psychology (DOP) is part of the British Psychological Society (BPS).

We aim to develop and promote occupational psychology for the public good, and we represent the interests of occupational psychologists in the UK.

Occupational psychologists are regulated by the Health and Care Professions Council (HCPC), and the title of Chartered Psychologist is the gold standard in our profession.

For more information or to find an occupational psychologist, visit www.bps.org.uk.
Introduction
Personal Statement for Science & Practice Convener Role

In my 25 years as an Occupational Psychologist I always sat comfortably between the Science and Practitioner chairs. Synergising my R&D roles in Occupational Testing consultancies like SHL, Manpower’s Career Harmony, Saville Consulting and Cubiks with my academic interests lead me to present more than 70 contributions at conferences around the world. I also co-authored some journal articles and book chapters. I embraced technology at the outset of my career spearheading research into onscreen testing, expert systems and validation methodology. The tools, models and competency frameworks I developed are well regarded in practitioner user, test review and academic settings.

I served on the BPS DOP conference committee and am currently a member of the BPS Committee on Test Standards (CTS).

Based on my practice of Nichiren Buddhism (SGI) I strive to approach every day, every person and every situation with compassion, courage and wisdom. I welcome mindfulness and Positive Psychology approaches that lead towards self-realisation, transformation and healing.

As an I/O Psychologist with a conscience I am concerned about the INDUSTRIAL scale of child abuse and permissive ORGANIZATIONAL structures and processes. I am immersed in Pro Bono activities challenging instances of psychological misdiagnosis in family court settings (see www.forced-adoption.com) and unveiling the chilling truth about extreme abuse (see www.paracelsustrust.co.uk). I publicly shared my concerns about shortcomings in mental health diagnosis at the ABP conference: https://www.youtube.com/watch?v=y0rTRvJO1e0

As a Science and Practitioner convener I would like to encourage dialogue between academics and practitioners but also between divisions in the BPS – overcoming the ‘silo’ mentality. I wish to support the Psychometric Testing centre in its roll out of the Forensic Testing Standards and would like to establish a cross-divisional working group on Abuse, Trauma and Dissociation. Dependability, integrity, performance and potential take on new dimensions given the duplicity displayed by abusers.
Subject: please help this young adult

hi there i hope you can read this email and reply.

i have **been told after an iq test that i am a gifted crossover person** and should try to research this. i am not living in the area i took the test in so am not able to get all the help i wanted from the people in the know. cant find this phrase anywhere but i am certainly diagnosed with a learning dissability perhaps similar to an attention defecit **child too** so can you help me find the information i can read at my leasure please! it is **aural delay** i experience, **by months and years. i go totally deaf you see**! even if its about gifts in the verbal (very very high) and perception parts of the iq lot. dont speak the lingo very well you see.

i have moved to __________________________ now so i hope this is not too far. any information would be helpfull you know. can get a copy of the letter written to my doctor soon and this may give me a little more info.

ok, thanks from <__________>, 25 years old.

Dear <__________>,

Thank you for getting in touch with us. The term we use for ‘crossover’ is **twice exceptional** and you will probably find lots of information about this if you google the term. I am sending you some of our factsheets that you may find useful, however, most of them relate to children.

All the best, <Advisor>, Education Consultant

National Association for Gifted Children
Tel: 0845 450 0295
Fax: 0870 770 3219
www.nagcbritain.org.uk
Introduction
Dissociative disorders

- DSM-III (1980): Posttraumatic Stress Disorder (PTSD) & Multiple Personality Disorder (MPD)
- Putnam, F. (1989). Diagnosis and Treatment of Multiple Personality Disorder (Foundations of Modern Psychiatry)
- Herman, J. (1993). Trauma and Recovery. (C-PTSD)
- Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden (1996) SDQ20 Somatoform Dissociation Questionnaire:
  - Q12: ‘I cannot hear for a while (as if I am deaf)'
  - Q11: ‘I cannot see for a while (as if I am blind)'

Usually caused through abuse and neglect by primary carers in first 5 years of child’s life
Subject: please read calmly as soon as poss

To <Family Member>.

I hope very much you may be able to take this email on board. I would rather have continued my silence as its more enjoyable for me, however I fear you may pull something if I don’t allow you to force me to write and put a stop to your “worry”.

I am a healthy, **normally pregnant young woman** and other than my dna made brain there is nothing to worry about. I thought id told you that when we met recently. Whoever taught you to worry is good when there is nothing wrong, or a healthy relationship is one filled with worry and harrassment is abusive.

You are a member of my family but I think you know nothing about me, little about pregnant women and will forget this email as soon as you’ve read it. Its not your fault. Which is what I’ve learnt about you, you are extremely unreliable, inconsistant, insensitive or unthinking, worst a bully and a hypocrite. Which could be worse we all have horror parts to ourselves. But I simply can not welcome anyone with this combination of problems into my life now. I will not worry about you until I need to either. Not for a long time you see _You are aware I am not talking to my folks_. your _opinion based on the shallowest and scariest of society’s manipulations_ has been contrary to mine since I contacted you first-since xmas and is the same today. Which makes easy and safe freindship impossible. I refuse to wait for change. _You have no right to ignore my assurances that I am well, my friends who you wound up and fooled told you also I was fine_. I do not respect anyone who bothers me only to suggest there is a problem when there is not, and that’s not the sum of how I feel. So I think its best if you try to _never give my address to any family member, nor my phone number. And to not use them yourself_. Please do not feel obliged to tell people I was carrying a child or tell me who he should know. And leave the blooming post office out of it!

You could have easily emailed me instead of exposing me at such a bad time. Accidently ye have made secrets in our family where there were none, there was only imagination, speculation and privacy before. Ye made my privacy practically impossible and left me insecure, annoyed and _worried for myself and my child_ as my wishes and hopes for my future I’ve had to change by 360degree in an instant at a possibly hard time for me. Like I say, I wanted friendship, trust, understanding, calm and gentle communication by email where I was respected and in control of comings and goings, _not a chase_ based on delayed acceptance of an invitation and _deliberate hysteria_, your _failure to take friendly re-assurance and an enemies view on necessary action_. Sorry but that’s the truth.

I’m giving you an email as you deserve that much as far as I can see because we have never really had to communicate like this about anything before, or its not been possible. So there is hope we can come to the same conclusion and not waste precious energy in the future. I need none but my friends, services and the government’s help now. Thank you for the opportunity to enjoy my family ties, but it won’t work with us!

Peace, goodbye for now

yours sincerely
Subject: ill start again with more time please

‘hello again. sorry about the rushed mail earlier, ive been locked out of my mailbox for ages.’

i witnessed him abuse <child> after he came up behind me in the street where id gone to see my freind after appearing in my street and the town of his own accord and after finding out my friends address from my __________ many months earlier who said he wanted to post me something. that never arrived but an old man turned up asking my friends seven year old where i was..and it started.’

i decided not to go the police immediately with my child who would be evidence as the met policeman in <family home town> told me when i was thrown out of __________ house and asked for their aid, that my __________ was dangerous and even if something serious happened to either of us in the future it would be unwise without much more protection to go up in court against him. The problem arose when i reported him later a month after the assault, but instead of being beleived and supported they took us to the hospital for his checks then removed him claiming i was delusional, suicidal, neglectful (he had some bruises) and unable to be a parent while insisting if i didnt sign a voluntary section 20 they would call the men in white coats.

there is not way the universe will allow <child> to endure the years i did
Child neglect (at end of case 100% cleared)

Mental Health Issues (‘Delusional’):

– Schizophrenic
– Schizoid
– Paranoid
Informal testing for guidance & development:
  Work personality questionnaire
  Abstract reasoning test

Witnessing of interview with Clinical Psychologist

Recovery of IQ reports at age 7, 23 & 25

Commissioning of assessments (5 specialists)

Professional concerns about misdiagnosis
‘She has a wide reading vocabulary which I suspect is visually based on the recognition and recall of letter patterns. She is not so strong at phonically decoding i.e. sounding out unfamiliar words.’

‘She has a rather weak auditory memory which meaning that she finds it rather difficult to retain and recall sequences of sounds, this being essential to phonological processing and analysis in reading and spelling’.

‘There is some evidence of slight sequencing and ordering difficulties.’
Series of life-threatening attacks at 20

The WAIS results show a massive drop on Perceptual Organisation to the 32%ile, on Working Memory down to the 14%ile (‘this indicates a limited auditory memory capacity and the ability to sequence material held in that memory’) and Processing Speed at the 5%ile (‘some weakness in the way she processes visual information and in particular short-term visual memory’).

The pattern explained the learning difficulties the client was experiencing in her course and allowances were made (computer, exam time limit increase).
Results

IQ testing at age 25

<table>
<thead>
<tr>
<th>IQ/INDEX SCORES</th>
<th>VIQ</th>
<th>PIQ</th>
<th>FSIQ</th>
<th>VCI</th>
<th>POI</th>
<th>WMI</th>
<th>PSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sums of Scaled Scores</td>
<td>64</td>
<td>59</td>
<td>123</td>
<td>36</td>
<td>39</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>IQ/Index Scores</td>
<td>103</td>
<td>111</td>
<td>107</td>
<td>110</td>
<td>118</td>
<td>90</td>
<td>103</td>
</tr>
<tr>
<td>Percentiles</td>
<td>58</td>
<td>78</td>
<td>68</td>
<td>75</td>
<td>88</td>
<td>25</td>
<td>58</td>
</tr>
</tbody>
</table>

- After travels abroad volunteering on organic farms the client settled in a rural area and visited a Psychologist to seek a better understanding of her abuse history and occasional ‘processing delays’.

- WAIS III results show complete recovery on the Perceptual Organisation and Processing Speed to the levels attested at age 7 while Working Memory remained poor.

- This Psychologist attributed the ‘processing delays’ to a ‘bad egg’ (i.e. a pre-birth deficit) and encouraged the client to stop worrying about it and enjoy life – which the client did socialising with friends and raising a boy as a single mum.
### Results
#### Type Dynamics Indicator (Team Focus)

<table>
<thead>
<tr>
<th>Inspector ISTJ</th>
<th>Protector ISFJ</th>
<th>Guide INFJ</th>
<th>Investigator INTJ</th>
<th>Surveyor ISTP</th>
<th>Supporter ISFP</th>
<th>Idealist INFP</th>
<th>Architect INTP</th>
<th>Trouble-Shooter ESTP (2)</th>
<th>Energiser ESFP (1)</th>
<th>Improviser ENFP (3)</th>
<th>Catalyst ENTP (4)</th>
<th>Co-ordinator ESTJ</th>
<th>Harmoniser ESFJ</th>
<th>Adviser ENFJ</th>
<th>Executive ENTJ</th>
</tr>
</thead>
</table>

**ENERGISERS (ESFP):**
Energisers are drawn towards others, living their life by engaging, interacting and bringing optimism, hope, warmth and fun to the situations they encounter. They seek people and action, are always ready to join in themselves and usually create a buzz which encourages others to get involved.

### Type Dynamics Indicator (TDI) Scale Results:

E=Extraverted (people oriented rather than introverted)
S=Sensing (facts rather than intuition/ideas oriented) – Corridor score
F=Feeling (values rather than thinking/outcome oriented) – Corridor score
P=Perceiving (spontaneous rather than judging/rigid)
Managing pressure and stress

Your responses to the questionnaire suggest that you can sometimes react to situations a little emotionally, but not to a level that would make you very different from many other people. There may be times when you might feel a little troubled by situations and may find that your mood can vary depending on what is going on and what might have happened. Though again, you are not very different from many people in this regard.

Consistent with this is that you seem to have at least a reasonably positive self-image, at least as much as many people do. Although sometimes you may doubt yourself and worry about things that have happened, you will not let yourself get too preoccupied by such things and will try to put events in the past and move on. On the whole, you will expect that others will see you in a reasonably positive light and you probably also manage to retain a fairly positive view of yourself most of the time. Overall therefore, you appear to be a reasonably steady and balanced person in terms of your emotions and in this respect are fairly typical of many people.

More generally, it seems that you appear to find it as easy to wind down and relax at the end of the day as most people do. Being able to relax can be very useful in helping you to turn off from stress and recharge your batteries for the next day.
Results
EQi (MHS)

- Emotional Intelligence is Above Average.
- Particularly high on Self-Perception Composite – very sensitive and insightful.
- Very high on Emotional Expression and fairly high on Assertiveness – coupled with 95%ile Verbal IQ (Top 5%).
- High on Interpersonal
- Average on Decision-Making Composite.
- High on Reality Testing.
- Average on Stress Management Composite.
- Average on Optimism
Results

IQ testing at age 7

Most healthy adults appear ‘Narcissistic’.


MCMI-III

- Base Rate cut-offs:
  - 60 Median
  - 75 Significance
  - 85 Prominence

- ‘General Factor of Demoralisation’ (MMPI2) low as indicated by the orange vertical line

- Low scores on Schizoid, Depressive, Histrionic, Borderline, Anxiety, Somatoform, Thought Disorder

- Abuse Survivor

- Stalking

- Crime Report

- Misdiagnosis
‘Ms _______ account of herself and her symptoms and history in interview was fluent, but rather jumbled and **appeared somewhat perseverative** in her presentation.’

James T. Webb (2004) writes in his highly acclaimed book ‘Misdiagnosis and dual diagnosis of gifted adults: ADHD, bipolar, OCD, Asperger’s, depression and other disorders’ (p. 50) that ‘In people who are both intellectually gifted and suffer a learning disability, the state of hyperfocus and flow can be confounded with perseverance.’ The ‘advance praise’ first page of the Google e-book features some extraordinary quotes that are highly salient to this case:

‘This book makes a powerful statement that many behaviours associated with **giftedness may be misconstrued as behaviors associated with disorders**. I highly recommend this book to parents and teachers’. Nicholas Coangelo, Prof for Gifted Education and Director, Belin-Blank Centre, University of Iowa.

‘Misdiagnosis and dual diagnosis of gifted adults offers family members and educators a thorough and compassionate guide to **behaviors of gifted children and adults that are sometimes mistaken as psychiatric**, and to the psychological trauma that can result for these extra-ordinary intelligent youngsters and adults.’ Randy Hutter Epstein, M.D. New York. author and adjunct professor at The Graduate School of Journalism, Columbia University.

Webb et al (2005) remarked: ‘Some characteristics of **giftedness can look very much like those of a learning disability or disorder** and, as a result, gifted children are sometimes **incorrectly diagnosed with disorders**.’
### Discussion

**Dyslexia / ‘Twice Exceptional’ Diagnosis**

- Consistent evidence for Special Learning Disability ‘Dyslexia’
- ‘Twice exceptional’ profile ‘baffling’

#### Typical characteristics of twice-exceptional children[^10]

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Deficits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior vocabulary</td>
<td>Poor social skills</td>
</tr>
<tr>
<td>Advanced ideas and opinions</td>
<td>High sensitivity to criticism</td>
</tr>
<tr>
<td>High levels of creativity and problem-solving ability</td>
<td>Lack of organizational and study skills</td>
</tr>
<tr>
<td>Extremely curious, imaginative, and inquisitive</td>
<td>Discrepant verbal and performance skills</td>
</tr>
<tr>
<td>Wide range of interests not related to school</td>
<td>Poor performance in one or more academic areas</td>
</tr>
<tr>
<td>Penetrating insight into complex issues</td>
<td>Difficulty with written expression</td>
</tr>
<tr>
<td>Specific talent or consuming interest area</td>
<td>Stubborn, opinionated demeanor</td>
</tr>
<tr>
<td>Sophisticated sense of humor</td>
<td>High impulsivity</td>
</tr>
</tbody>
</table>

[^10]: Source of data and further details can be found in various academic studies and resources.


‘The most judicious course of action is to consider the Millon et al. (1997) study to be fatally flawed. It is noteworthy that none of the three alternatives justifies the use of the MCMI-III in forensic cases. In closing, we reaffirm the conclusions of Rogers et al. (1999): “The MCMI-III does not appear to reach Daubert’s threshold for scientific validity with respect to criterion-related or construct validity” (p. 438). Despite Dyer and McCann’s (2000) spirited defense, fundamental issues regarding validation (construct, criterion-related, and content), forensic applications, and unacceptable error rate argue against the use of its Axis II interpretations as scientific evidence.’

**CAPSULE SUMMARY**

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports.
Discussion
Poor Quality of Psychological Assessments in Family Courts

Evaluating Expert Witness Psychological Reports: Exploring Quality

‘Dubious 'experts' are paid to tear families apart
A new report condemns the shoddy standards of psychologists' reports in our family courts. ‘

A study by Professor Jane Ireland, a forensic psychologist, for the Family Justice Council examined 126 psychological reports trawled at random from family court documents. It found that two thirds of them were “poor” or “very poor” in quality

‘Another woman was found by a psychologist to be “a competent mother” – so the social workers went to a second witness, who found the same. They then commissioned a third, who at last came up with what they wanted: that the mother had, again, “a borderline personality disorder”. On that basis, her three children were sent for adoption.’

McDowall (2015): Bad Apples, Bad Barrels, Bad Cases
• General personality questionnaires suggest ‘normal’ personality

• MCMI-III issues raised with the BPS Committee on Test Standards (CTS) e.g. the tool does not meet the Daubert standard for validity assessment

• HCPC ‘Fitness to practice’ concern raised against Clinical Psychologist – rebuffed as did not meet ‘Standards of Acceptance’ for which ‘permission of the court’ has to be obtained before reports can be released (£1000’s and unlikely to be granted as ‘not party to the proceedings’ and ‘tame’ experts commissioned in the first place by vested interests)

• Criminal allegations (46 pages) submitted against 1st Court Appointed Expert (Consultant Psychiatrist) in the same Family Court process
Separate assessment by a Dissociation Expert attested that dissociative symptoms were shown in her early 20’s but were not present at age 30. The information processing issues seem to arise from the traumatic development trajectory and represent an ability deficit rather than being in any way indicative of a personality disorder.

Family Court processes are extremely secretive – parents accused of ‘neglect’ are not allowed to discuss case with anyone apart from their solicitor (who usually has little incentive to give proper support)

Mountains of documents – persecutory strategies/bias/ideologies:

What ‘reasonable adjustments’ were due?

What impact would concealment of IQ results at age 7, 23 and 25 have?
Dr Rainer Hermann Kurz, Chartered Psychologist
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Science & Practice Convener of the BPS DOP
Member of the BPS Committee on Test Standards
https://uk.linkedin.com/pub/rainer-kurz/0/b14/4a0
https://www.researchgate.net/profile/Rainer_Kurz2