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ACKNOWLEDGEMENT

We would like to thank the excellent reviewers who have contributed their time and expertise to making this publication possible. Their voluntary efforts enable us to bring you quality articles in a timely manner.

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Autism spectrum disorder in high secure psychiatric care: Current issues and considerations

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This article explores the current issues and considerations relating to patients with autism spectrum disorders (ASD) within high secure psychiatric care. ASD are neurodevelopmental disorders which are characterised by impairments in social reciprocal interactions and communication and restricted, repetitive pattern of interests and behaviour (American Psychiatric Association, 2013). Around one in a hundred individuals in the general population have ASD (Baird et al., 2006). Males are more likely to receive a diagnosis of ASD (Brugha et al., 2011; Loomes et al., 2017). However, it is increasingly recognised that the prevalence rate among women is underestimated significantly (Beggiato et al., 2016). There are some recent reviews of the literature which have explored possible explanations for why ASD in women is being underestimated (see recent reviews Allely, 2019a, 2019b).

Keywords: autism; autism spectrum disorder; neurodiversity; psychiatric care; special needs
It is now well-established that most individuals with an ASD are law abiding. There is no evidence which supports the notion that individuals with an ASD are more likely to engage in offending behaviours (Brewer et al., 2017; Im, 2016; King & Murphy, 2014). Where an individual with ASD becomes involved with the criminal justice system it is also typically found that offending is the result of a combination of environmental circumstances and the specific difficulties (ASD symptomology) related to ASD (de la Cuesta, 2010). There is a growing number of studies which have highlighted that ASD symptomology can, at least in some cases, contribute to certain types of offending behaviour including arson or fire-setting (e.g., Radley & Shahebano, 2011; Allely, 2019); sexual offending (e.g., Allely & Creaby-Attwood, 2016; Creaby-Attwood & Allely, 2017; Sevlever et al., 2013;) and child pornography (e.g., Allely & Dubin, 2018; Allely, Kennedy, & Warren, 2019).

**ASD in secure psychiatric care**

A recently carried out a literature review of studies (Allely, 2018) explored ASD in low, medium and high secure psychiatric care. There are three high secure psychiatric care (HSPC) hospitals within England, namely, Broadmoor, Rampton and Ashworth hospitals. All three hospitals represent the highest level of secure psychiatric care. All three are managed by different NHS trusts but they are follow similar security protocols and standards of care (NHS Commissioning Board, 2013).

**Awareness and views of ASD held by staff working within a secure psychiatric hospital**

There have only been two studies, to date, carried out which have examined the views of staff working in HSPC concerning individuals with an ASD – both conducted in the UK. In one of these studies, Misra and colleagues (2013) carried out an audit using a questionnaire sent to 100 nursing staff of one HSPC hospital assessing their knowledge of ASD and knowledge of best practice. Findings indicated that although the majority of staff reported some awareness of autism, most were unaware of the Autism Act (2009) – which outlines the ‘standard approach of care’ for individuals with ASD – and were uncertain of how to most effectively work with patients who had a diagnosis of ASD. The majority of the staff were willing to train and work within a specialist ASD team.

In the other study, Murphy and McMorrow (2015) used a 15-item questionnaire in order to explore the views and experiences of a wider range of staff working in one HSPC hospital who had direct patient contact. The staff group comprised of psychologists, psychiatrists, nursing staff, occupational therapists and medical centre staff. The questionnaire explored the staffs’ views (on vulnerability, benefits from therapy and any adjustments that they made to their practice), knowledge and training needs of staff in relation to ASD. In total, 206 questionnaires were returned to the researchers across this range of staff (about 60% of those distributed). The majority of staff reported that they knew someone with a diagnosis of ASD outside of the work environment (family member, friend, etc.). Most staff also had worked directly with a patient who they knew had a diagnosis of ASD. Regarding everyday management, just over 50 per cent of staff reported making some form of adjustment to their clinical practice in order to accommodate the needs of the patient with an ASD – in addition to adjusting their interactions and expectations of patients with an ASD. Just over half of the staff also had the view that, compared to other patients, individuals with an ASD may benefit from being managed in a different way. Surprisingly, only 22.3% of the staff group thought that the difficulties of patients who had a diagnosis of ASD were considered in their care in the hospital. Crucially, 64% of staff who took part in the survey thought that patients with ASD were more vulnerable to bullying or intimidation when compared to other patients. Only 27% of staff believed they had adequate skills and knowledge to work with patients with ASD. Nearly all staff (92%) wanted more training on ASD and 76% felt that autism awareness training should be mandatory. A number of the staff also reported the need for a specialist ASD ward within HSPC. With the exception of psychiatrists, most staff reported being unaware of the Autism Act (Murphy & McMorrow, 2015).
Experience and quality of life of patients within HSPC

Only one study to date has explored the experiences and quality of life of a small sample of seven individuals with an ASD in HSPC (Murphy & Mullens, 2017). In their study, they found a broad range of backgrounds, offending behaviours, personal experiences, as well as relative vulnerabilities and objective measures of functioning (such as participation in occupational and therapeutic activities, number of problem incidents, periods in seclusion and views from staff). Individuals expressed the view that there were too many rules and restrictions with HSPC which prevented them from pursuing their personal interests. For example, not being allowed to have a pair of binoculars to watch aircraft or not being allowed a computer. The regular security searches (involving physical rub downs) and room searches were also described as stressful by many individuals with ASD where their personal possessions were frequently not placed back in the same place during the search. Many individuals reported frequently having difficulties with sharing their immediate environments with other patients perceived as being ‘difficult, unpredictable and disinhibited’. Some of the patients expressed the view that they did not feel that their difficulties relating to their ASD were understood by staff. The majority of patients only received a diagnosis of ASD when they were admitted to HSPC. In sum, based on the individuals in this study, even within specialist ASD units there can be negative experiences. Interestingly, many patients with an ASD in this study reported having a preference for wards where there is mixture of individuals (not just wards which are specifically for patients with ASD. This may be because such mixed wards would be more representative of everyday life and that other patients without ASD can sometimes offer assistance or advice (Murphy & Mullens, 2017).

Evaluation of an optional autism awareness training provided to staff working in a HSPC hospital

This year, Murphy and Broyd (2019) carried out an evaluation of autism awareness training which was provided to staff working in a HSPC hospital in England. During the training staff are provided with information on ASD, the associated difficulties and how to work with an individual’s difficulties in a way that is positive. Murphy and Broyd also introduced staff to the SPELL guidelines (National Autistic Society, 2013) during the training day. The SPELL guidelines provide useful information on ways to work positively with individual strengths and weaknesses in individuals with ASD. An online survey of staff views who had completed an autism awareness training day. Most staff reported that the autism awareness training was most useful in understanding the difficulties associated with ASD (89.74%) and improving interpersonal communication (79.49%). Nearly 65% of staff reported that the training had been useful in helping them avoid potential problems and encouraged them to think about more ways to work with individual strengths. Nearly 30% of the staff felt that there was no unhelpful aspect of the training, 16 (41.03%) had the view that a one-day training course was not long enough and 30.77 per cent felt that more case discussion would be helpful to them. Nearly all members of staff (97.44%) reported that a refresher course would be useful and expressed the view that autism awareness training should be mandatory for all staff (Murphy & Broyd, 2019). Murphy and Broyd highlighted in their paper that the course was voluntary and a relatively small number of staff tool part. They suggest the need for further investigation into ways to increase staffs’ motivation to attend autism awareness training. Research investigating how the knowledge from the training is used by staff during everyday work with patients with ASD would also be useful.

Conclusion

To date, the relatively little research that has been carried out investigating ASD and HSPC indicates that individuals with an ASD in HSPC present with difficulties and needs which are different when compared to other patient groups. Moreover, the research shows that staff view patients with ASD as particularly vulnerable and would benefit from being managed in a different way compared to other
patients. Although the majority of individuals with an ASD reported positive hospital experiences, there is a very real need for improvements within HSPC, specifically, in creating an environment which is more autism friendly by making reasonable adjustments in ward design and how individuals are managed by staff (Murphy & McMorrow, 2015; Murphy & Mullens, 2017). Murphy and Broyd (2019) also point out that such adaptations are also useful when formally interviewing individuals with an ASD in forensic settings (see Murphy, 2018). As found in the study by Murphy and McMorrow (2015), the majority of clinical staff expressed the view that autism awareness training should be mandatory and many believed that they did not have enough skills in working with patients with an ASD. Lastly, as recently highlighted by Markham (2019) there is a lack of research investigating the experience of female adult patients with ASD (in terms of assessment and treatment, for instance) in secure hospitals (Markham, 2019).

References


Anxious childhood attachment predicts childlessness in later life

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The objective of this study was to test the hypothesis that childhood attachment predicts whether a person has children in later life. Although being a parent is considered a typical part of the human life cycle in most parts of the world, childlessness has increased substantially in recent decades in developed parts of the world. It is possible that insecure childhood attachment has contributed to this phenomenon, but this hypothesis has been relatively little explored. This study is a cross-sectional survey of 394 men and women aged over 50 years old, stratified by geographical UK region from a research panel, and analysed using hierarchical logistic regression. Validated measures of childhood attachment and other psychological and demographic factors were used. The main finding was that, independent of the impact of other variables (age, sex, education level, marital status, life stress, health-related quality of life, mental positivity, and avoidant attachment style), people who were childless were significantly more likely to have developed an anxious attachment to their primary caregiver in childhood. This study is the first to demonstrate the significance of anxious childhood attachment as a predictor of producing children in one’s lifetime.

Keywords: ambivalence; childlessness; family structure; social change; social trends
The global trend of increased longevity and declining fertility rates has resulted in a population that is both increasingly ageing and increasingly without children (Kreyenfield & Konietzka, 2017; Organisation for Economic Co-operation and Development, 2015). Most societies have expectations of their citizens involving transitions across the life course with attendant roles and meanings surrounding each specific phase (Becker, 1999; Goldberg, 2014). In most cultures, parenthood is a typical and expected part of the life cycle (Neugarten, 1969) and the majority of people intend to become parents (Archetti, 2019; Riskind & Patterson, 2010; Sylvest et al., 2018; Thompson & Lee, 2011). In the Netherlands, Keizer (2010) found that childless cohort was formed of three distinct sections: the childless of circumstance accounted for 80%; with rest equally divided by the chosen-childless (10%); and the infertile (10%).

Involuntary childlessness is typically associated with distress (Boivin, Bunting, Collins, & Nygren, 2007; Letherby, 2016; Luk & Loke, 2018). A diagnosis of potential or actual infertility can have a significant impact on mental and physical health on a par with serious medical conditions (Cousineau & Domar, 2007; Fisher & Hammarberg, 2017; Saleh, Ranga, Raina, Nelson, & Agarwal, 2003).

Factors that impact the fertility outcomes of men and women include childhood experience (Allen, 2019; Hadley, 2008; Hadley & Hanley, 2011), education level, relationship breakdown, ethnicity, and religion (Fisher & Hammarberg, 2017; Sobotka, 2017).

Psychological issues can play a role in childlessness too. Caspi, Elder, and Bem (1987) examined the continuities and consequences of childhood shyness. They found that men, but not women, who were shy as children were subsequently more likely to delay entry into marriage, parenthood, and stable careers than were their contemporaries. Social withdrawal may impede the formation of romantic relationships (Nelson et al., 2008) and shyness can have a negative effect on relationships through creating lower quality romantic relationships. For example, through reduced intimacy (Wenzel, 2002); greater instability for men (Caspi, Elder, & Bem, 1988); higher level of problems, distress, and lower satisfaction in marriages (Baker & McNulty, 2010; Filsinger & Wilson, 1983).

There are three main weaknesses of previous research into the causes of childlessness. Firstly, there is a paucity of research exploring the effect of psychological factors in childlessness. The majority of studies have focused on the impact of infertility – both medically and socioculturally. Secondly, most research in this area examines how infertility and involuntary childlessness cause stress. Thirdly, the majority of studies on infertility and childlessness focus on the psychological consequences for women rather than for men (Hadley, 2019).

Unfortunately, in research literature, the term ‘childlessness’ has frequently been used indiscriminately. Research has often reported childlessness simply as a binary of either ‘voluntary’ or ‘involuntary’ (Allen & Wiles, 2013; Pesando, 2018). Likewise, terms such as ‘infertility’, ‘childless’, ‘childlessness’, ‘childfree’, ‘childless-by-choice’, ‘involuntary childless’, and ‘childless-by-circumstance’ have been used inconsistently and without definition (Hadley, 2018a; Letherby, 2016). However, the terms ‘childfree’, ‘childless-by-choice’, ‘involuntary childless’ and ‘childless-by-circumstance’ have recently become widely used in academia and the wider media. The first two terms refer to those who have decided not to become parents. The third term has been ascribed a clinical status related to people whose infertility treatment has been unsuccessful and/or have withdrawn from infertility treatment. The fourth term relates to ‘childless’ people who have not accessed medical services regarding their fertility and/or circumstances have prevented their wish for parenthood. Contemporary research acknowledges the subjectivity and fluidity inherent in people’s reproductive circumstances. The ‘childless’ are now viewed as a heterogeneous group that form a ‘continuum of childlessness’ with distinct groups at either end (Monarch, 1993). As personal circumstances change over the life course people position themselves at different points (Letherby, 2010). For the purposes of this paper, ‘childlessness’ refers to an absence of ‘biological’ or ‘social’ children (i.e., those who are adopted, fostered, or stepchildren).
Demographic explanations

There is a complex relationship between demographic considerations and the social factors described in the introduction. In their review of childlessness in Europe, Tanturri et al. (2015) examined the historical context, current trends, definitions, concepts, and theoretical explanations for childlessness. The interaction between two determinants (e.g., cultural factors) and micro determinants (e.g., personality factors) of childlessness, and the consequence of childlessness were scrutinised. The main determinants were family changes (e.g., divorce), women's education (influencing postponement of first birth in some parts of Europe), social acceptance of childlessness in North and West Europe, and change in family size ideals. There is a possible influence of family-friendly policies, but this is under-researchers in the UK. Studies have also considered attitudes and values (Hakim, 2005), occupation vs education (Neyer & Hoem, 2008), household income, personality, gender equity and early life predictors.

The few studies that have focused on men show macro determinants that are largely country dependent, such as anti-traditionalism, secularisation, and celibacy. Micro determinants include relationship formation and early life predictors but again, no studies focus specifically on men. Testa (2012) analysed aspirations to family size (ideal, intended and actual family size), and found that men have a smaller ideal family size than women do. Testa also found that although there was a positive correlation between women's mean ideal family size and their share of life satisfaction, men associated childlessness with an increase life satisfaction.

Medical explanations

Medical conditions are widely associated with childlessness. One in seven couple in the UK seek medical advice concerning conception (Human Fertilisation and Embryology Authority, 2014). Factors affecting fertility are relatively common. For example, the endocrine condition polycystic ovary syndrome (PCOS) is of the most common causes of subfertility in women, affecting 10% of women or more (A.A. Barry, Smith, Deutsch, & Perry-Jenkins, 2011). It is known that fertility problems are a cause of distress for both men and women (Earle & Letherby, 2003; Petrou, 2018). However, the majority of research literature focuses on women (Culley, Hudson, & Lohan, 2013; Letherby, 2016; Throsby & Gill, 2004). This gender difference might be due to the greater social pressure on women to have children (Benyamini, Gozlan, & Kokia, 2009; Russo, 1976; Seager, Sullivan, & Barry, 2014), and the stressful treatment procedures that women may go through (Cousineau & Domar, 2007; Everywoman, 2013). For example, the invasive procedures involved in vitro fertilisation (IVF) including general anaesthetic for laparoscopic egg retrieval (Littleton & Bewley, 2019). In addition, as noted by the Royal College of Obstetrics and Gynaecology (RCOG): ‘the negative psychological impact of early pregnancy loss can be both severe and protracted and affects women and their families’ (Graziosi, Mol, Ankum, & Bruinse, 2004, p.10).

In the UK, men’s fertility history is not routinely recorded; therefore it is not possible to assess the number of childless men in the UK (Hadley, 2018b). However, despite the widely held belief that men are fertile from puberty until death, the reality is that sperm efficacy lessens with age (Bray, Gunnell, & Smith, 2006) and many fertility clinics will not accept donations from men aged over 40. Men are said to experience existential stress over involuntary childlessness more than women do. Yalom (2008, p.9) suggests that there is a ‘longing to project oneself into the future... biologically through children transmitting our genes.’ This existential aspect can make engaging in infertility issues with men difficult because men are often socially validated by their virility in biological, social, and economic arenas. Moreover, an international review of anthropological studies reported infertile men may be deemed ‘weak and ineffective’ (Dudgeon & Inhorn, 2003, p.45).
A number of studies have focused on the impact of infertility on Health-Related Quality of Life (HRQoL). Women in these studies typically report lower Quality of Life (QoL) than men do, though men's QoL is also reduced by a diagnosis of infertility (Chachamovich et al., 2010; Fisher & Hammarberg, 2017).

**Psychological explanations**

Psychological factors may be associated with childlessness. For example, psychological stress can affect physical and psychological well-being. This is a complex process but, broadly speaking, mostly occurs through two mechanisms. First, the impact on the behaviour of the individual includes anxiety and social withdrawal, depressive behaviour, and maladaptive coping strategies such as substance abuse. Second is the impact on health through psychoneuroimmunological pathways (McEwen, 2008) i.e., a direct impact of stress hormones on the immune and reproductive systems.

An example of the impact of stress on childlessness is the meta-analytic finding that distress is associated with miscarriage (Qu et al., 2017). The mechanism for this effect is likely to be the activation of the hypothalamic pituitary adrenal axis (HPA) increasing stress hormones such as corticotrophin-releasing hormone and adrenal cortisol (Parker & Douglas, 2010).

**Attachment**

The qualities of our relationships in adult life are based on the quality of our relationships in early life (Bretherton & Munholland, 1999). The emotional bond, or attachment, created with our primary caregiver(s) in infancy and childhood influences all future bonds, especially romantic partnerships (Hazan & Shaver, 1987). Childhood attachment can influence the quality of our relationships throughout life, and consequently whether people have children or not.

There is a large body of work, dating back to Hampton (1927), demonstrating the impact of personality on relationships (Arroyo & Harwood, 2011; Kerr, Lambert & Bem, 1996; Nelson et al., 2008; Tackett, Nelson & Busby, 2013; Zhao, Kong, & Wang, 2013). For example, Caspi, Elder, and Bem (1988) found that men with childhood histories of shyness married later than other men, had children later, and were more likely to experience marital instability. Women with similar childhood shyness characteristics did not appear to be affected in the same manner.

Hazan and Zeifman (1999) emphasised that Bowlby’s (1979, p.129) attachment theory operated over the life course ‘from the cradle to the grave’. Parenthood and childlessness affected well-being in a variety of ways at different times across the life course; for example, by generational norms (Umberson, Pudrovaska, & Reczek, 2010). In addition, substantial life events influence intimate relationships and affect attachment styles and behaviours (Cheng, Zhang, Sun, Jia, & Ta, 2015; Ding, Zhang, & Cheng, 2016; Umberson, et al., 2010). Stress experienced in infancy and childhood, especially persistent stressors which are perceived as uncomfortable, may be damaging to physical and mental health, and shape the individual's subsequent physiological response to stress (Gerdhart, 2006). Likewise, separation and loss in adult pair bonds impacts on physical, psychological, health and social well-being (Hazan & Zeifman, 1999).

Barry, Seager and Brown’s (2015) survey of 217 adults found that worse childhood attachment problems, especially avoidant attachment, predicted a reduction in adulthood relationship satisfaction. Similarly, Hadley and Hanley (2011) found that involuntary childless men reported difficulties in forming of relationships due to poor parenting in childhood. Interviews with undergraduate psychology students in the US (155 male and 224 female) found that avoidant and anxious/ambivalent views of close adult relationships predict more negative views of parenthood and parent-child relationships (Rholes,
Simpson, Blakely, Lanigan, & Allen, 1997). Carnelley and Jaffe (1994) found that the romantic and marital relationships of people high in avoidant or anxious/ambivalence were less close, trusting, intimate, and less satisfying.

Hypothesis

This study tests the hypothesis that demographic and psychological factors will predict whether someone in their 50s has children or not.

METHODS

Design

This study is a cross-sectional survey analysed using hierarchical binary logistic regression. Logistic regression is used when the dependent variable is binary. The dependent variable in the present study was parent status, divided into three binary outcomes: (1) parent or childless; (2) parent or child-free; and, (3) parent or other. The predictor variables were four demographic variables (age, sex, education level, and marital status), and four psychological factors (health-related quality of life, mental positivity, attachment style [anxious or avoidant]). Background variables that were controlled for were sexuality, ethnicity, and life stress. Apart from categorical outcomes, most items were scored on a six-point Likert Scale from ‘very much agree’ to ‘very much disagree’, with an additional option of ‘choose not to answer’, for questions of a sensitive nature.

The survey used Qualtrics survey software and data were analysed using SPSS statistical software version 22.

Participants

Participants were men and women over the age of 50. This age limit was selected for two reasons. First, to cover the ‘baby boom’ increase in live births in the UK between World War II and the early 1960s (Goldstein, 2009). Second, at the time of the study (2017), 50 was the earliest age a person was eligible for retirement (Phillipson, 2013). Lightspeed, a digital collection company, and certified by the British Healthcare Business Intelligence Association, recruited participants from a panel of thousands of people across the UK. A quota sample of men and women, stratified by UK region, was collected.

A pilot study by the authors found a relatively low uptake rate for men. Consequently, for the purpose of statistical power, we purposefully asked Lightspeed to approach more men than women in order that we had an adequately large group of men.

The exclusion criteria were: (1) not giving key information (gender, parental status, etc.); being under 50 years old; and, (3) not completing the consent form.

Dependent variable

Parent status was assessed by self-reported answers to the questions: ‘Do you have children?’ (Yes or No); ‘For you, how much is having children (or not) a matter of your personal choice?’; ‘If you don’t have children, how much have each of the following contributed to you being childless: fertility problems, age, medical problems and other issues e.g., employment status, shyness, etc.’
From the reported answers, participants were grouped as: (1) parents; (2) a non-parent by not finding the right partner (‘childless’); (3) a non-parent by choice (‘child-free’); and, (4) a non-parent due to other reasons.

Predictor variables (demographics)

Age was measured in years by self-report. Gender was self-reported from a choice of male, female, male-female, or female-male transgender. Level of education by the response to the question: ‘What is your highest level of educational qualification?’ [O Level General Certificate of Secondary Education (GCSE), A Level, GCSE, Degree (or above), Skill (National Vocational Qualification (NVQ), City and Guilds, etc., Other (please specify)]. Marital status was defined by self-report of any of the following being single, married, in a civil partnership, divorced, in a relationship, widowed or other.

Predictor variables (psychological)

Health-Related Quality of Life (HRQoL) – The MOS 36-item Short Form Health Survey (SF-36; McHorney, Ware, Lu, & Sherbourne, 1994) is a 36-item health questionnaire which addresses HRQoL for eight dimensions of health whereby lower scores indicate worse health. The median Cronbach’s alpha for this scale was 0.85.

Mental positivity – Positive Mindset Index (PMI; J.A. Barry, Folkard, & Ayliffe, 2014) was used. This brief scale consists of six items (happiness, confidence, being in control, emotional stability, motivation, and optimism) on a five-point Like scale (from, for example, ‘very happy’ to ‘very unhappy’). This scale shows how good internal reliability (Cronbach’s alpha = 0.926) and correlates well with the psychological subscale of the SF-36 whereby higher scores indicate more mental positivity.

Attachment – The Relationship Structures (ECR-RS) questionnaire (Fraley, Niedenthal, Marks, Brumbaugh, & Vicary, 2006) is a nine-item measure based on Hazan and Shaver’s (1987) classic study. A review of the ECR-RS concluded that it provides ‘one of, if not the, most appropriate self-report measure of adult romantic attachment currently available’ (Sibley, Fischer, & Liu, 2005, p. 1534). In the ECR-RS, anxious attachment (which corresponds to Hazan and Shaver’s description of anxious/ambivalent attachment) is described by three items: (1) ‘I often worry that this person doesn’t really care for me’; (2) ‘I’m afraid that this person may abandon me’; and, (3) ‘I worry that this person won’t care about me as much as I care about him or her’. Avoidant attachment is described by six items: (1) ‘It helps to turn to this person in times of need’; (2) ‘I usually discuss my problems and concerns with this person’; (3) ‘I talk things over this person’; (4) ‘I find it easy to depend on this person’; (5) ‘I don’t feel comfortable opening up to this person’ (reversed); and, (6) ‘I prefer not to show this person how I feel deep down’. Cronbach’s alpha coefficients are between 0.75 and 0.91 for anxious attachment and between 0.87 and 0.92 for avoidant attachment (Fraley, Hefferman, Vicary, & Brumbaugh, 2011; Moreira, Martins, Gouveia, & Canavarro, 2015) whereby higher scores indicate more problems with attachment.

Control variables

Ethnicity and sexuality – Ethnicity was assessed by the response to the question: ‘Please state your ethnic group: White, Mixed, Asian or Asian British, Black or Black British, Chinese, Other (please specify)’. Sexual orientation was assessed by the response to the question: ‘How would you describe your sexual orientation: Bisexual, Gay, Heterosexual, Lesbian Woman, Choose not to answer, Other (please specify)’.
**Stressful life events** – Stressful life events were measured in order to control for any impact of recent events on any of the other psychological variables. To measure stress related to life events experienced in the past 12 months, participants completed a checklist of life events of various degrees of stressfulness (Miller & Rahe, 1997) whereby higher scores indicate more exposure to stressors.

**Setting**

The setting was online and recruitment was from the Lightspeed panel that consists of thousands of people across the UK.

**Sample size**

Based on the guidelines by Peduzzi, Concato, Kemper, Holford, and Feinstein (1996), the minimum sample size for logistic regression should be $10 \times k/p$, where $k$ is the number of predictor variables, and $p$ is the smallest of the proportions of negative positive cases. In the present study, $k = 9$ and $p = 0.24$ (24%), where the smallest proportions of cases was of parents ($n = 332$) to other reasons ($n = 79$). Thus, minimum sample size needed for statistical power was $10^*9/0.24 = 375$. This is smaller than our total sample size ($N = 394$) which meant that there was sufficient power to compare parents to non-parents study.

**Procedure**

During June 2017, potential participants were identified on the panel who met the inclusion criteria for this study. These people were contacted, and the study was run until our quota was reached. Recruitment was completed in five days.

**Ethics**

All participants gave their informed consent to participating in the study, and the guidelines of the Declaration of Helsinki were followed. Participants were paid a small fee for doing the survey, as is the norm when panel members complete a survey. Phrasing questions was done with sensitivity. At the end of the survey, contact details were given for those who might need further information or support from Samaritans (UK charity), and childless community support networks More to Life and Infertility Network UK. The study received ethical approval from the University College London’s Research Ethics Committee (REC Reference: 4075/010). Continuous data were presented as means ± SD, and categorical data were analysed using Pearson’s Chi-square ($X^2$) test; with Fishers Exact Test adjustment where appropriate (see Tables 1 & 2). Binary logistic regression models were employed to investigate the factors associated with parent status, and the results reported as odds ratios (ORs, called ‘Exp(B)’ in SPSS) with 95% confidence intervals (CIs). Missing data were deleted pairwise, so that where a participant gave some information but had given responses to all items; data for any responses they gave could be included in the analysis. The significance threshold was set at $p < .05$ and all significance values were two-tailed. All statistical analyses were carried out using SPSS statistical software for Windows, version 22 (IBM Corporation, 2013).

**RESULTS**

The median duration participants took to complete the survey was 610 seconds (minimum 193, maximum 62,783). ‘Speedsters’ (those who completed the survey in less than 40% of the median time) were excluded, as per the Lightspeed standard practice. Also excluded were data showing signs of response bias (e.g., giving the same response to every question). Twelve participants were omitted from analysis because they were aged less than 50. Only one of the non-heterosexual samples was childless,
meaning that there were too few non-heterosexual people in the sample for sufficient statistical power, thus non-heterosexual data had to be omitted from further analysis. Similarly, the ethnicity variable had to be omitted from the regression models because only 1% of the sample was non-White. Therefore, regression models in this study included predictor variables: age, sex, education level, marital status, life stress, health-related quality of life, mental positivity, attachment style (anxious, avoidant).

The final sample size was 394 (237 men and 157 women) aged >50. The mean ± SD age of men is (76.9 ± 7.5), for women is (76.8 ± 7.4). Of the men, there were 195 parents and 42 non-parents. Of the women, there were 125 parents and 32 non-parents.

Table 1 shows the background characteristics of the sample measured as categories. There was no significant difference between men and women in terms of ethnicity, marital status, or educational level.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>235 (99.6%)</td>
<td>154 (98.1%)</td>
<td>3.204 [ns]</td>
</tr>
<tr>
<td>Other</td>
<td>1 (0.4%)</td>
<td>3 (1.9%)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5 (2.1%)</td>
<td>4 (2.5%)</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCSE</td>
<td>64 (27%)</td>
<td>52 (33.1%)</td>
<td></td>
</tr>
<tr>
<td>A Level</td>
<td>90 (38%)</td>
<td>54 (34.4%)</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>57 (24.1%)</td>
<td>31 (19.7%)</td>
<td>2.580 [ns]</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>16 (6.8%)</td>
<td>12 (7.6%)</td>
<td></td>
</tr>
<tr>
<td>Doctoral</td>
<td>5 (2.1%)</td>
<td>4 (2.5%)</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/Civil partnership</td>
<td>151 (64.2%)</td>
<td>87 (55.8%)</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>33 (14%)</td>
<td>25 (16%)</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>12 (5.1%)</td>
<td>18 (11.5%)</td>
<td></td>
</tr>
<tr>
<td>In relationship</td>
<td>18 (7.7%)</td>
<td>10 (6.4%)</td>
<td>7.390 [ns]</td>
</tr>
<tr>
<td>Single</td>
<td>20 (8.5%)</td>
<td>15 (9.6%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 (0.4%)</td>
<td>1 (0.6%)</td>
<td></td>
</tr>
</tbody>
</table>

Note: X values are all with Fisher’s Exact Test adjustments; show that there was no statistically significant difference between men and women on ethnicity, relationship status or education.

Table 2 shows the background characteristics of the sample measured on a continuous scale (age, life stress, etc.) and the categorical outcome variables, grouped according to the sex and parent status of the participants.
Table 2
Mean ± SD Outcomes According to the Sex and Parent Status of the Participants

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Parent</td>
<td>Child-free</td>
</tr>
<tr>
<td></td>
<td>(n = 195)</td>
<td>(n = 22)</td>
</tr>
<tr>
<td>Age</td>
<td>77.62±7.69</td>
<td>73.14±6.33</td>
</tr>
<tr>
<td>Life stress</td>
<td>82.69±91.24</td>
<td>53.36±56.18</td>
</tr>
<tr>
<td>HRQoL</td>
<td>3.62±0.73</td>
<td>3.89±0.81</td>
</tr>
<tr>
<td>PMI</td>
<td>2.20±1.31</td>
<td>2.24±1.27</td>
</tr>
<tr>
<td>Anxious</td>
<td>2.26±1.00</td>
<td>2.47±1.30</td>
</tr>
</tbody>
</table>

HRQoL = Health-Related Quality of Life, measured with the SF-12
PMI = Positive Mindset Index
Binary logistic regression

Four binary logistic regressions were conducted, each comparing the odds of being a parent to the odds of being: (1) a non-parent for any reason; (2) a non-parent through not finding the right partner (childless); (3) a non-parent by choice (child-free); and, (4) a non-parent due to other reasons, including the health of self or partner. The term for item 2: ‘a non-parent through not finding the right partner’ was drawn from the work of several authors (e.g., Allen & Wiles, 2013; Cannold, 2005; Graham, Hill, Taket, & Shelley, 2013; Simpson, 2005). For the purpose of using marital status as a predictor in binary logistic regression, the various subgroups of the marital status variable were combined into one dichotomous variable: participants who were married or in a civil partnership, versus participants in all other categories.

Tables 3–6 show that marital status was by far the strongest predictor of whether someone was a parent or not.

Table 3 shows that being older increased the odds of being a parent rather being a non-parent (OR = 0.923 [0.89–0.96], p < .0002). More life stress in the past 12 months was associated with increased odds of being a parent (OR = 0.995 [1.00–0.99], p < .022). The strongest predictor of parent status was marital status: being married significantly increased the odds of being a parent (OR = 9.117 [4.9–16.72], p < .001).

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.923</td>
<td>0.89–0.96</td>
<td>.0002</td>
</tr>
<tr>
<td>Sex</td>
<td>1.179</td>
<td>0.65–2.14</td>
<td>.589</td>
</tr>
<tr>
<td>Education</td>
<td>.987</td>
<td>0.75–1.30</td>
<td>.926</td>
</tr>
<tr>
<td>Marital status</td>
<td>9.117</td>
<td>4.97–16.72</td>
<td>.001</td>
</tr>
<tr>
<td>Life stress</td>
<td>.995</td>
<td>1.00–0.99</td>
<td>.022</td>
</tr>
<tr>
<td>HRQoL</td>
<td>1.008</td>
<td>1.01–0.98</td>
<td>.627</td>
</tr>
<tr>
<td>Mental positivity</td>
<td>1.332</td>
<td>1.33–0.83</td>
<td>.231</td>
</tr>
<tr>
<td>Anxious attachment</td>
<td>1.223</td>
<td>0.92–1.64</td>
<td>.174</td>
</tr>
<tr>
<td>Avoidant attachment</td>
<td>.927</td>
<td>0.67–1.28</td>
<td>.648</td>
</tr>
</tbody>
</table>

Table 4 shows that being older increased the odds of being a parent rather than being childless (OR = 0.903 [0.84–0.97], p < .006). Showing more signs of an anxious attachment style was associated with increased odds of being childless (OR = 1.772 [1.09–16.28], p < .021). The strongest predictor of parent status was marital status: being married significantly increased the odds of being a parent (OR = 19.439 [6.23–60.61], p < .003).
Table 4
*Predictors of Being a Parent (n = 319) Compared to Being Childless (N = 23)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.904</td>
<td>0.84–0.97</td>
<td>.006</td>
</tr>
<tr>
<td>Sex</td>
<td>1.386</td>
<td>0.50–3.87</td>
<td>.533</td>
</tr>
<tr>
<td>Education</td>
<td>.808</td>
<td>0.51–1.28</td>
<td>.366</td>
</tr>
<tr>
<td>Marital status</td>
<td>19.439</td>
<td>6.23–60.61</td>
<td>.003</td>
</tr>
<tr>
<td>Life stress</td>
<td>.998</td>
<td>1.00–0.99</td>
<td>.593</td>
</tr>
<tr>
<td>HRQoL</td>
<td>1.042</td>
<td>0.98–1.10</td>
<td>.167</td>
</tr>
<tr>
<td>Mental positivity</td>
<td>1.195</td>
<td>0.54–2.67</td>
<td>.664</td>
</tr>
<tr>
<td>Anxious attachment</td>
<td>1.772</td>
<td>1.09–2.88</td>
<td>.021</td>
</tr>
<tr>
<td>Avoidant attachment</td>
<td>1.0553</td>
<td>0.59–1.88</td>
<td>.860</td>
</tr>
</tbody>
</table>

Table 5 shows that being older increased the odds of being a parent rather than being child-free (OR = 0.914 [0.87–0.97], p < .001). The strongest predictor of parent status was marital status: being married significantly increased the odds of being a parent (OR = 9.246 [4.18–20.45], p < .003).

Table 5
*Predictors of Being a Parent (n = 319) Compared to Being Childless (N = 36)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.914</td>
<td>0.87–0.97</td>
<td>.001</td>
</tr>
<tr>
<td>Sex</td>
<td>.983</td>
<td>0.44–2.19</td>
<td>.966</td>
</tr>
<tr>
<td>Education</td>
<td>.928</td>
<td>0.65–1.33</td>
<td>.685</td>
</tr>
<tr>
<td>Marital status</td>
<td>9.246</td>
<td>4.18–20.45</td>
<td>.003</td>
</tr>
<tr>
<td>Life stress</td>
<td>.996</td>
<td>0.99–1.00</td>
<td>.158</td>
</tr>
<tr>
<td>HRQoL</td>
<td>1.010</td>
<td>0.97–1.05</td>
<td>.644</td>
</tr>
<tr>
<td>Mental positivity</td>
<td>1.692</td>
<td>0.91–3.13</td>
<td>.094</td>
</tr>
<tr>
<td>Anxious attachment</td>
<td>1.061</td>
<td>0.72–1.56</td>
<td>.767</td>
</tr>
<tr>
<td>Avoidant attachment</td>
<td>1.085</td>
<td>0.71–1.65</td>
<td>.704</td>
</tr>
</tbody>
</table>

Table 6 show that more life stress in the past 12 months was associated with increased odds of being a parent (OR = .986 [0.98–1.00], p < .02). Being married significantly increased the odds of being a parent (OR = 3.494 [1.11–10.96], p < .032).
Table 6
Predictors of Being a Parent (n = 319) Compared to not Having Children for Medical or Other Reasons (n = 15)

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.979</td>
<td>0.91–1.05</td>
<td>.566</td>
</tr>
<tr>
<td>Sex</td>
<td>1.551</td>
<td>0.52–4.66</td>
<td>.434</td>
</tr>
<tr>
<td>Education</td>
<td>1.132</td>
<td>0.69–1.86</td>
<td>.627</td>
</tr>
<tr>
<td>Marital status</td>
<td>3.494</td>
<td>1.11–10.96</td>
<td>.032</td>
</tr>
<tr>
<td>Life stress</td>
<td>.986</td>
<td>0.98–1.00</td>
<td>.020</td>
</tr>
<tr>
<td>HRQoL</td>
<td>.992</td>
<td>0.94–1.04</td>
<td>.749</td>
</tr>
<tr>
<td>Mental positivity</td>
<td>.793</td>
<td>0.33–1.90</td>
<td>.603</td>
</tr>
<tr>
<td>Anxious attachment</td>
<td>.971</td>
<td>0.55–1.72</td>
<td>.920</td>
</tr>
<tr>
<td>Avoidant attachment</td>
<td>.699</td>
<td>0.36–1.37</td>
<td>.299</td>
</tr>
</tbody>
</table>

DISCUSSION

The aim of this study was to discover the predictors of being childless in later life. A total of 393 men and women participated (319 parents and 74 non-parents). The main finding of interest was that, controlling for other variables, participants who were childless showed significantly more signs than parents of having an anxious attachment style (p < .021).

Table 2 shows that HRQoL and PMI scores were around the norm for this age group. The life stress scores were below 150 in each group, indicating generally low levels of stress (i.e., not many life events). The anxious attachment scores are similar to those found by Fraley et al (2011) – about 2.1 compared to 2.5 – though the avoidant attachment scores are slightly lower (about 2.2 compared to 3.2), perhaps due to the much older age of the present sample compared to Fraley et al (mid 70s to early 20s).

The findings that parents were significantly older and experienced more life changes than the other groups is unlikely to be of theoretical interest. The finding of being older is probably due to chance. The finding regarding life events probably relates to the various formal and informal social interactions – schools, health, employment, relationships – involved with children across the life course. For example, the SHARE study (Dykstra & Fokkema, 2011) reported that family were significant positive factors in the health and well-being of older people. European later-life families were exemplified by having an adult child living close by and with frequent contact with at least one of their children. Moreover, there were strong family care obligations with regular parent-to-child 'help-in-kind' (Dykstra & Fokkema, 2011). However, the finding the childless people showed more sign of an anxious attachment style than parents did is of theoretical and practical significance. Because this study was able to control for other psychological variables, we can say that the relationship between anxious and childlessness is independent of other demographic and psychological variables. For example, it cannot be explained HRQoL, PMI, or the impact of recent life stress.

There is evidence that the quality of relationships in adult life echo the quality of our relationships in early life (Bretherton & Munholland, 1999). Stress in childhood impacts physical and mental health and shapes the subsequent physiological response to stress (Gerhardt, 2006). Childhood attachment problems, especially avoidant attachment, predict both adult relationship quality (Bretherton & Munholland, 1999) and adulthood relationship satisfaction (J.A. Barry et al., 2015; Caspi et al., 1988) argued that childhood experience produces a style of 'interactional continuity' that is active throughout life course. This links directly with the inner working model of attachment theory where the pattern for
relating to others is set by parental responses (Bretherton & Munholland, 1999). Therefore, there is an evidence base for the present finding that anxious attachment predicts childlessness in adulthood, though ours is the first study to find evidence for this link in older adults.

It is interesting that in the present study attachment anxiety, but not avoidance, should predict childlessness. In one sense, it might be predicted that avoidant people would be less likely to become parents given that they tend to have little hope of achieving intimacy (Crittenden & Ainsworth, 1989). In contrast, people high anxious/ambivalence would be predicted to be preoccupied with intimacy needs (Hazan & Shaver, 1987). The answer might be that a person’s fears (of abandonment, rejection, etc.) create emotional and behavioural barriers that prevent them from doing the things that create the circumstances of becoming parents, rather than simply having a general sense of lack of intimacy, as seen in the avoidant people. Our study did not find that other demographic variables, apart from age and marital status, predicted parenting status. In contrast, Tanturri et al (2015) found that some demographic factors increased childlessness, for example, women’s education caused postponement of first birth in some parts of Europe. However, the present study found no significant influence of educational level on being a parent or not. In addition, medical problems associated with fertility (of one’s self or partner) were not a significant predictor of childlessness.

Strengths of the present study

This study has several strengths. Firstly, while most research explored cultural or medical explanations for childlessness, the present study explored the relationship between psychological factors and childlessness. Many research have explored the impact of infertility and childlessness on psychological functioning, but the present study explored the impact in the opposite direction i.e., the relationship between psychological experiences in childhood and childlessness in later life. Furthermore, the majority of previous studies focus on the psychological consequences for women rather than men; this study examined the influence of sex as a predictor of parent status, though we found no significant influence of sex.

Another strength of the study is that we used a quota sample stratified by UK region, which means that potential regional differences were accounted for in the analysis.

Weaknesses of the present study

Although a novel aspect of this study is that it tested the hypothesis that psychological factors influence childlessness rather than vice versa, the fact is that with a cross-sectional design we cannot say with certainty what the direction of causality is. In order to know this with more certainty, a longitudinal study would be required, assessing the development of attachment in infancy, and following up the infants into later life. This design, although being much more costly in terms of time, effort, and finances, would – with appropriate control for other variables – be a landmark study in our understanding of the relationship between childhood attachment and parent status in later life.

Although the sample size was large and adequate to power the main test in this study (parents vs those with no children for any reason), the other three tests needed an average of 8% more participants for adequate power. Although this loss of statistical power is relatively small, we cannot be sure that our analysis overlooked a significant relationship in regards the predictors of being child-free, and not having children for other reasons. On the other hand, the statistical power was sufficient to detect several significant findings.

The participants were almost entirely White and heterosexual, thus the findings might not generalise well to more ethnically and sexually diverse population. This narrowness of the sexuality characteristics
probably reflects that the fact that the present study drew upon a sample of people who were raised in times of strong heteronormative and pronatalist norms. This means that the findings can be best generalised to Caucasian heterosexual people across the UK, but on the other hand this is a relatively large demographic.

Future studies

Ideally, research into the impact of childhood experiences on adult lifestyle should be done longitudinally. Likewise, there is a concomitant need to characterise stressors that may have impact on fertility. Consequently, future studies may require participants to identify any stressors that they experienced during their reproductive years.

CONCLUSION

To the knowledge of the authors, no other study to date has highlighted the significance of anxious childhood attachment as a predictive factor of childlessness in later life. These findings have implications for our understanding of lifespan development. For example, if confirmed by longitudinal research, they provide an interesting insight into one of the potential causes of social isolation and vulnerability in later life, and suggest interventions based on attachment theory that might be introduced at almost any point in the lifespan. The present findings also have implications for interventions in relationship counselling and other therapeutic settings. For example, where couples are in disagreement concerning whether or not to have children, the therapist might aim to address any unresolved childhood attachment issues in each partner before the question of having children is resumed. Moreover, the findings offer an insight into a profound aspect of the continuation of the human species.

References


and relationships during emerging Adulthood. *Journal of Youth and Adolescence, 37*(5), 605–615. [https://doi.org/10.1007/s10964-007-9203-5](https://doi.org/10.1007/s10964-007-9203-5)


Pesando, L. M. (2018). Childlessness and upward intergenerational support: Cross-national evidence from 11 European countries. *Ageing and Society, 39*(6), 1219–1254. [https://doi.org/10.1017/s0144686x17001519](https://doi.org/10.1017/s0144686x17001519)


Qu, F., Wu, Y., Zhu, Y.-H., Barry, J., Ding, T., Baio, G., . . . Hardiman, P. J. (2017). The association between psychological stress and miscarriage: A systematic review and meta-analysis. *Scientific Reports, 7*(1), [https://doi.org/10.1038/s41598-017-01792-3](https://doi.org/10.1038/s41598-017-01792-3)


Seager, M., Sullivan, L., & Barry, J. (2014). Gender-related schemas and suicidality:
Validation of the Male and Female Traditional Gender Scripts Questionnaires. *New male Studies, 3*(3), 34–54.


Simpson, R. (2005). "Living like the (Bridget) Jones’s?" Using the BHPS to research whether there is a delay or decline in partnership formation in Great Britain. Paper presented at the BHPS 2005 Conference, University of Essex.


Can time spent on social media affect thin-ideal internalisation, objectified body consciousness and exercise motivation in women?

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The primary aim of this study was to investigate the effect of exposure to social media on ideal body image, awareness of one’s body and motivation to exercise. Participants completed a measure of Facebook, Instagram and Pinterest use, after which they proceeded to complete measures of thin-ideal internalisation, exercise motivation and objectified body consciousness. One hundred female students at a UK university, aged between 18 and 52 years, completed the measures described, with age weight and height used as covariates. Multivariate analysis of covariance revealed that time spent on social media was related to levels of thin-ideal internalisation, objectified body consciousness and motivation to exercise. Exposure to social media has negative effects on female’s perceptions of their ideal beauty and their own body as well as on motivation to engage in exercise.

Keywords: body image; exercise; motivation; social media; thin-ideal internalisation
The media is one of the most influential sociocultural factors affecting ideal body type (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999), featuring exercise and dieting-related content and depicting idealised images of women (Luff & Gray, 2009). Research has also found that exposure to the mass media is related to body dissatisfaction and negative body image among women (Grabe, Ward, & Hyde, 2008; Groesz, Levine, & Murnen, 2002; Harrison & Cantor, 1997; Tiggemann, Verri, & Scaravaggi, 2005). Body image may be defined as feelings, thoughts and perceptions about one's own body (Grogan, 2008). Body dissatisfaction, on the other hand, occurs when an individual views their body negatively perceiving a discrepancy between their real and ideal body (Cash & Szymanski, 1995).

Social media

The use of social media such as Facebook, Instagram and Pinterest has become particularly popular in recent years, with such platforms allowing users to create and manage online profiles, interact with friends and share information and photos (Tiggeman & Zaccardo, 2015). Those most likely to use social media are 18–29 year-olds (Lenhart, Purcell, Smith, & Zickuhr, 2010) with 90% of 16–24 year olds in the UK reporting using social media and 90% of 18–29 year olds in the US using it (Pew Research, 2013). More importantly, females are more likely to engage in the use of this compared to males (Duggan & Brenner, 2013). Certain types of social media platforms allow various editing filters which may enhance a user's content, allowing them to impression manage their appearance (Levine & Chapman, 2011). Therefore the photos uploaded on social media profiles may portray idealised versions of users (Manago, Graham, Greenfield, & Salimkhan, 2008). Accordingly, those users viewing filtered images may upwardly compare themselves with unrealistic beauty ideals uploaded by other users, leading to feelings of inadequacy (Alperstein, 2015), and consequently extreme dieting and exercise (Lewallen & Behm-Morawitz, 2016). Furthermore, Blomfield-Neira and Barber (2014), point out that the use of social media differs from the use of traditional media in several ways. Firstly, self-promotion and self-presentation are facilitated via social media (Murray, 2015; Van Dijck, 2013). Secondly, social media content is personalised, and users tend to attribute 'higher perceived realism' to this, which may be more persuasive (Perloff, 2014). Similarly, users are likely to view friends' exercise post-workout photos, for example, as more realistic than photos portraying idealised body types of real athletes found in the traditional media. Thirdly, unlike traditional media, access to social media is unlimited, allowing users to receive and view information, such as photos and status updates shared by their peers at any time. Thus, people's exposure to an idealised body, depicted in edited photos of peers has increased (Andsager, 2014).

Social comparison

Social comparison occurs when individuals compare their own limitations and abilities to those of their peers, (Ruble, Boggiano, Feldman, & Loeb, 1980). Making task-related comparisons can be observed among children as young as seven (Ruble et al., 1980), with appearance-related comparisons usually occurring around the period of early adolescence (Chen & Jackson, 2009; Mueller, Pearson, Muller, Frank, & Turner, 2010). Upward social comparison has been linked with body image concerns and specifically with the drive for thinness and body dissatisfaction (Ho, Lee, & Liao, 2016; Strahan, Wilson, Cressman, & Buote, 2006; Want, 2009). In the context of traditional media, Bessenoff (2006) suggested that younger individuals who engaged in social comparison of images featuring thin females in commercials were more likely to report higher levels of body dissatisfaction and depression than individuals who were exposed to commercials that did not feature these. Furthermore, Tiggemann and McGill (2004) found that females, who compared themselves with others in their close environment, also had a tendency engage in social comparison with women depicted in magazines more frequently, especially when coming across depictions of thinness. Similarly, Chrisler and colleagues (2013) analysed 977 tweets sent by individuals watching a Victoria's Secret Fashion Show. They found that
90% of tweets about body image indicated that viewers engaged in a process of upward social comparison.

**Thin-ideal internalisation**

Thin-ideal internalisation is described as ‘the extent to which an individual “buys into” socially defined ideals of attractiveness and engages in behaviours designed to approximate these ideals’ (Thompson & Stice, 2001), and thin-ideal female beauty is prevalent in Western media, (Levine & Chapman, 2011). Meta-analyses (e.g., Grabe et al., 2008) and literature reviews of research (e.g., Scharrer, 2013) suggest that media depictions of the thin-ideal body have a significant impact on women's body image concerns. Furthermore, a link has also been found between thin-ideal internalisation and body dissatisfaction with the suggestion that thin-ideal internalisation may predict higher levels of body dissatisfaction (Keery, Van den Berg, & Thompson, 2004).

**Objectified body consciousness**

Objectified body consciousness, is defined as a preoccupation with how one’s body appears to others (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996). Objectification theory (Fredrickson & Roberts, 1997) states that women are socialised to view their bodies from an observer's point of view because they live in environments that pervasively and persistently objectify the female body (Manago, Ward, Lemm, Reed, & Seabrook, 2015). Objectified body consciousness consists of three main features: body surveillance, internalisation of beauty ideals that are culturally dominant and appearance based evaluation of the self (Manago et al., 2015). However, there is little research which has explored the effect of social media on objectified body consciousness.

**Exercise motivation**

Females with positive body image frequently quote regular exercise as being a tool to increase their well-being, a way to enjoy themselves, improve their health and relieve stress (Wood-Barcalow, Tylka, & Augustus-Horvath, 2010), rather than a way to lose weight. However, females who use Instagram may be affected in a negative way (Holland & Tiggemann, 2017), although only a small body of research has investigated the link between exposure to social media and exercise motivation (e.g., Tiggemann & Zaccardo, 2015). Holland and Tiggemann (2017) investigated compulsive exercise and disordered eating among females who engage in posting exercise routines on Instagram, with women who posted such images scoring higher on measures of compulsive exercise, drive for muscularity, disordered eating and drive for thinness than women in a control group who posted travel-related images.

**The present study**

Time spent on social media has been linked with low mood (Fardoully, Diedrichs, Vartanian, & Halliwell, 2015), body dissatisfaction (Stronge et al., 2015) and disordered eating (Mabe, Forney, & Keel, 2014). However, the evidence regarding the relationship between social media exposure and body image concerns is still limited. Therefore, the aim of the present study is to investigate the link between exposure to Facebook, Instagram and Pinterest with body image concerns and exercise motivation among females. It is hypothesised that more time spent on Facebook, Instagram and Pinterest will be associated with higher levels of thin-ideal internalisation, objectified body consciousness and exercise motivation.
Participants

Participants were 100 female students at a UK university and selected from various classes within the university. They were aged between 18 and 52 years, with a mean age of 22.04 years (SD = 6.16). Participants were also asked to report their weight which ranged from 48 to 108 kilograms (M = 65.77), and height which ranged from 150 to 180 centimetres (M = 166.76).

Measures

Ideal Body Stereotype Scale (Stice & Agras, 1998) – This measure assessed internalization of the thin-ideal requiring participants to indicate the extent to which they agreed with each of six statements, about what an attractive female looks like (e.g., ‘Women who are in shape are more attractive.’). This scale used a 5-point Likert scale, from ‘strongly disagree’ to ‘strongly agree’. This scale possesses concurrent, discriminant, predictive and convergent validity as well as acceptable internal consistency (Stice & Agras, 1998). Higher scores on the scale indicate higher levels of thin-ideal internalization.

Objectified Body Consciousness Scale (McKinley & Hyde, 1996) – This scale consisted of three subscales: (1) body surveillance, which measured whether an individual views their body from an observer’s point of view; (2) body shame, which measured the shame felt due to their body not meeting the cultural standards; and, (3) appearance control beliefs, which measured belief of control of their own appearance. This scale comprised of 24 items and a 7-point Likert scale from ‘strongly disagree’ to ‘strongly agree’. Higher scores on the scale indicated higher levels of objectified body consciousness.

Exercise Motivation Scale (Markland & Ingledew, 1997). This scale assessed motivation to participate in exercise, and comprised of 51 items, 20 of which were used in this study (e.g., ‘I exercise to help control my weight.’) on a 6-point Likert scale, from ‘not at all true for me’ to ‘very true for me’. Higher scores on the scale indicated higher levels of exercise motivation.

Procedures

Participants completed the measure of Facebook, Instagram and Pinterest use, after which they proceeded to complete the measures of thin-ideal internalisation, exercise motivation and objectified body consciousness. For the purpose of analysis, participants were assigned to one of the four groups, based on the self-reported time spent on Facebook, Instagram and Pinterest. Group 1 (N = 19) consisted of females who reported spending less than 0.5 hour on Facebook, Instagram and Pinterest per day. Females, reporting spending between 0.5 hour and 1 hour on Facebook, Instagram and Pinterest per day were assigned to Group 2 (N = 20). Group 3 (N = 25) was made up of females who reported spending between 1 hour and 1.5 hours on Facebook, Instagram and Pinterest daily, and finally, females who reported spending over 1.5 hour per day on Facebook, Instagram and Pinterest were assigned to Group 4 (N = 36). Age, weight and height were used as covariates in the analysis.

RESULTS

A multivariate analysis of covariance (MANCOVA) was conducted for the three dependent variables, with age, height and weight used as covariates. There was a significant effect for the time spent on Facebook, Instagram and Pinterest for thin-ideal internalisation, F(3, 93) = 5.21, p = .002, ηp2 = .144. Bonferroni’s post hoc test revealed significant differences between Group 1 (Facebook, Instagram and Pinterest for less than 0.5 hour per day; M = 15.73) and Group 4 (Facebook, Instagram and Pinterest for over 1.5 hour per day; M = 20.26). The covariate, weight, was significantly related to thin-ideal internalization, F(1, 93) = 8.61, p = .004. However, height and age were not significantly related to thin-ideal internalisation. MANCOVA analysis revealed that there was a significant difference between the
time spent on Facebook, Instagram, and Pinterest for objectified body consciousness, $F(3, 93) = 14.5, p < .001, \eta_p^2 = .319$. Bonferroni’s post hoc test revealed significant differences between Group 1 (Facebook, Instagram, and Pinterest for less than 0.5 hour per day; $M = 85.46$) and Group 3 (Facebook, Instagram, and Pinterest for a period of 1 hour to 1.5 hour per day; $M = 107.5$), as well as significant differences between Group 1 and Group 4 (Facebook, Instagram, and Pinterest for over 1.5 hour per day; $M = 106.48$). Bonferroni’s post hoc test also revealed significant differences between Group 2 (Facebook, Instagram, and Pinterest for a period of 0.5 to 1 hour per day; $M = 84.23$) and Group 3. Significant differences were also found between Group 2 and Group 4. The covariates weight, height, and age were not significantly related to objectified body consciousness. The MANCOVA further revealed that there was a significant difference between the time spent on Facebook, Instagram, and Pinterest for exercise motivation, $F(3, 93) = 4.47, p = .006, \eta_p^2 = .013$. Bonferroni’s post hoc test revealed significant differences between Group 1 (females using Facebook, Instagram, and Pinterest for less than 0.5 hour per day; $M = 38.1$) and Group 4 (females using Facebook, Instagram, and Pinterest for over 1.5 hour per day; $M = 51.66$). Bonferroni’s post hoc test also revealed significant differences between Group 2 (females using Facebook, Instagram, and Pinterest for a period of 0.5 to 1 hour per day; $M = 37.7$) and Group 4. The covariates weight, height, and age were not significantly related to exercise motivation.

Figures 1 to 3 show the thin idealisation, objectified body consciousness scores, and exercise motivation scores for number of hours per week spent on social media.

*Figure 1*: Thin idealisation scores for time spent on social media.
DISCUSSION

The aim of this study was to investigate the link between the time spent on Facebook, Instagram and Pinterest and levels of thin-ideal internalisation, objectified body consciousness and exercise motivation. As hypothesised, the results of this study revealed that time spent on Facebook, Instagram and Pinterest were linked to higher levels of thin-ideal internalisation, objectified body consciousness and exercise motivation, with participants who spent more time on social media scoring significantly higher on all three measures of body image concerns than participants who spent lower amounts of time on social media per day. Overall, these findings are in line with previous research on the effects of social media on body image concerns and exercise motivation (e.g., Meier & Gray, 2014; Tiggemann & Slater, 2013).
Thin-ideal internalisation

It is possible that women use Facebook, Instagram and Pinterest for inspiration and comparison, which gives them an opportunity for self-evaluation. Indeed according to Tiggemann, Polivy and Hargreaves (2009) comparisons made online can be inspirational at the beginning, however as time passes and women see no major effects of dieting and exercising, they may become frustrated which may consequently result in body dissatisfaction. Putting together existing knowledge on negative effects of media exposure with the present results, it is possible that even if the use of Facebook, Instagram and Pinterest is initially enjoyable and inspirational, it may result in social comparison and internalisation of the thin-ideal which is recognised as being a risk factor for body dissatisfaction and weight concern (Keel & Forney, 2013), both of which are precursors for eating disorders (Stice & Agras, 1998).

Interestingly, the literature regarding the effects of traditional media, suggests that girls with body image issues and girls exhibiting disordered eating report higher motivation to use media that depict thin-ideal beauty (Thomsen et al., 2002). As proposed in the previous literature, individuals who report high levels of thin-ideal internalisation are driven to use social media and engage in appearance-related activities more frequently which in turn reinforces existing body image concern (Meier & Gray, 2014). Future research should therefore focus on examining the nature of relationship between Social Media exposure and thin-ideal internalisation.

Objectified body consciousness

Objectified body consciousness measured in this study, had three main components, which were body surveillance, internalization of beauty ideals that are culturally dominant and appearance based evaluation of the self (Manago et al., 2015). Recently, researchers started to explore objectified body consciousness in the context of mass media and suggested that exposure to social media can increase levels of objectified body consciousness among females (e.g. Tiggemann & Miller, 2012). Therefore, it was hypothesised that engagement in social media would affect objectified body consciousness among participants. As predicted, participants who spent time on Facebook, Instagram and Pinterest reported significantly higher levels of objectified body consciousness. This finding supports objectification theory, which argues that self-objectification creates increased opportunities for body surveillance, body shame and perceived control over one's body (McKinley & Hyde, 1996). Online communication may explain high levels of objectified body consciousness among participants, who spent large amounts of time on Facebook, Instagram and Pinterest. Due to the fact that social media allows users to share their posts to large amounts of people, individuals often cautiously monitor and edit the content they upload (Levine & Chapman, 2011). This may be because users realise that their friends might see the content, which motivates them to be vigilant about how they will portray themselves. This study was the first one to extend the investigation of the effects of social media use on objectified body consciousness to the context of Pinterest and Instagram use with previous studies employing only time spent on Facebook or Facebook involvement. However, due to the fact that the present study requested participants to report the overall time spent on Facebook, Instagram or Pinterest it is not possible to investigate the specific nature of the relationship between Pinterest and Instagram and objectified body consciousness alone. It may only be speculated that exposure to Pinterest and Instagram have negative effects on objectified body consciousness among women. Therefore further research is needed to explore the links between Social Media and objectified body consciousness.

Exercise motivation

The results of the present study confirm that time spent on Facebook, Instagram and Pinterest significantly predicted levels of exercise motivation. This finding is consistent with prior research that has explored the effects of social media exposure on motivation to engage in physical activities (Boepple & Thompson, 2016; Holland & Tiggemann, 2017). A previous pioneering study conducted by Holland and
Tiggemann (2017), found that exposure to ‘fitspiration’ images leads to higher scores on measures of compulsive exercise and disordered eating among women. The results of the current study revealed that none of the covariates were significantly related to exercise motivation. The participants in this study were of similar age and weight; however, according to Strelan, Mehhafey, and Tiggemann (2003), young women may possibly be more motivated to exercise for appearance-related reasons than older women who tend to exercise in order to gain health benefits.

LIMITATIONS AND CONCLUSION

Research regarding the effects of media on body image concern, is often limited to Western populations, frequently from the US, UK, or Australia which favour the same thin-ideal figures. However, women across the world seem to find similar female figures to be physically attractive (Tiggemann, 2011) and similar results have been found for ethnic groups other than young, white females; for instance, Latinas and Asian adolescents, report levels of body dissatisfaction comparable to that of Western women (e.g., Schooler & Lowry, 2011; Ho, Lee, & Liao, 2016). Additionally, participants in the present study were of a similar young age. Future research should further explore the effects of Facebook, Instagram and Pinterest use on body image concern in males, older people and members of various ethnic/racial groups. Furthermore, the present study examined the effects of the overall time spent on Facebook, Instagram and Pinterest collectively on the body image concern, which makes it difficult to estimate accurately the effect of each platform separately. In conclusion, this study contributes to the existing knowledge regarding media effects on body image. Given the growing popularity of Social Media, particularly among young people, it has become increasingly important to develop an understanding of how the relationships between social networking and body image concerns work. This study focused on exploring the influences of Facebook, Instagram and Pinterest on body image concerns and exercise motivation. Findings from this study demonstrate that time spent on these platforms may influence thin-ideal internalisation, objectified body consciousness and exercise motivation among females, which lends strong support to the Sociocultural theory (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). Given that all measured variables in this study were linked with body dissatisfaction and disordered eating, it is essential to work towards minimising the negative effects of Social Media exposure, especially in times when the media has such a crucial function in society, it is essential to highlight the positive features of the Social Media while minimising the negative consequences.

References


Tiggemann, M., & Miller, J. (2010). The Internet and adolescent girls’ weight satisfaction and drive for thinness. *Sex Roles, 63*(1–2), 79–90. [https://doi.org/10.1007/s11199-010-9789-z](https://doi.org/10.1007/s11199-010-9789-z)


Recruitment, selection, and assessment: Are the CV and interview still worth using?

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Over the last decades, research on employee recruitment has increased dramatically. However, it remained that the two most popular instruments utilised in employee recruitment, selection, and assessment are the curriculum vitae (CV) and interview. Despite the unwavering popularity of these instruments, there has been much debate regarding their ability to reliably predict job performance. Two major trends in organisational psychology are to either ‘fit the man to the job’ (FMJ) or to ‘fit the job to the man’ (FJM), both aim to promote the recruitment of candidates who will give optimal performance in the organisations to which they apply to. This article seeks to analyse the literature in employee recruitment, selection, and assessment in order to assess whether the popular combination of unstructured interviews and CVs are a reliable combination in selecting employees in the labour market.

Keywords: employee selection; job interview; organisational psychology; recruitment policy; work performance
The two most popular instruments utilised in employee recruitment, selection, and assessment are the curriculum vitae (CV) and interview (Zibarras & Woods, 2010). CVs (one type of ‘biodata’) are often used by employers and recruiters to select or promote employees into new positions in an organisation. Despite their popularity with employers, CVs have little research evidence supporting their use in recruitment, selection, and assessment procedures. The most obvious advantage of the CV is that it gives an employer instant access to a candidate’s education level, qualifications, experiences, and overall skill set, which may be pertinent to the job being applied for (McEntire & Green-Shortridge, 2011). One study by Wolgast, Bäckstron, and Björklund (2017) reported that the recruitment of better candidates was influenced by the way in which CVs were assessed – participants who used structured sets of criteria when assessing CVs selected candidates that were better for an opening than participants not using similar criteria. However, even when adding structure to CV selection, the CV is still considered to be an unreliable instrument to recruit candidates. Estimates reveal that up to half of candidates exaggerate on their CVs (George & Marett, 2004), which in turn can result in financial implications for an organisation if a new employee is not performing as well as the employer would have expected.

Further to the general criticisms of the CV, discrimination is another conspicuous element that has been reported to have an impact on CV selection. There is a growing body of experimental and field evidence that supports the notion that minority groups (ethnicity, gender, sex, sexuality, religion, etc.) face ‘penalties’ when attempting to access the labour market when these protected characteristics are signalled on their CVs. In a study conducted in Sweden, Rooth (2010) has employers select from different CVs – the manipulation was if the candidate had a Swedish-sounding name of an Arab-Muslim-sounding name. Indeed, Rooth found that those individual employers with negative implicit attitudes towards Muslims (measured by using an Implicit Association Test; see Greenwald, Nosek, & Banaji, 2003) were significantly less likely to make an offer to the candidates with the Arab-Muslim-sounding names. This effect was still prominent even though all of the CVs were controlled for in terms of their quality (as is the case in most studies of this kind). Another lab-based study of this kind was conducted by Beattie, Cohen, and McGuire (2013) who found that participants were less likely to choose a CV belonging to a fictitious candidate with an Afro-Caribbean-sounding name than those with a Caucasian name if they had negative implicit attitudes towards those who are black as opposed to white. Other characteristics such as sex, sexuality, attractiveness, and so forth have also been reported face ‘penalties’ when accessing the labour market (see Neumark, 2016 for a comprehensive review). Studies of this kind are a problem for employers as changing attitudes (especially on an implicit level) can be difficult to do, therefore it can be challenging for employers to not allow their attitudes to influence the process of assessing and selecting CVs.

Unstructured interviews are subject to a range of different biases too (McDaniel, Whetzel, Schmidt, & Maurer, 1994, p.159). Such biases include: the sex of the applicant (Bernard, Paik, & Corell, 2007); their race (Huffcutt & Roth, 1998), attractiveness (Kutcher & Bragger, 2004), etc. (see Levashina, Hartwell, Morgeson, & Campion, 2013 for a review). Unstructured interviews are low in financial costs and are relatively simple to administer, as well as applicants reporting that they like them, thus maintaining their popularity (van der Zee, Bakker, & Bakker, 2002). Due to their issues, unstructured interviews are not an adequate technique to predict workplace performance – therefore their wide usage is not well-founded. Barrick, Shaffer, and DeGrass (2009) conducted a meta- analytical study in order to assess the impact of self-presentation tactics (such as appearance and attractiveness, self-enhancement, etc.) adopted by candidates on interview ratings as a means of examining how applicants falsely represent themselves in an interview. Their analysis concluded that appearance, verbal and non-verbal behaviour, and impression management behaviours had a positive relationship with interview ratings in an unstructured interview. The same paper reported that as CV structure increased, the significance of the aforementioned factors decreased. This evidence supports the contention that structured interviews may be more beneficial for employers to utilise (see Huffcutt & Arthur, 1994). A study by
Huffcutt, Conway, Roth, and Stone (2001) found that a structured interview has good criterion validity, thus giving way to predicting work performance.

Given this evidence, the most obvious alternative is for employers to adopt structured interviews during their recruitment, selection, and assessment processes (Relojo, 2012). Structured interviews are generally administered as either: (1) behavioural interviewing (Janz, 1989 as cited in Arnold et al., 2016, p.150) or, (2) situational interviewing (Maurer, Sue-Chan, & Latham, 1999). Behavioural interviewing – otherwise known as behavioural pattern description interviews (BPDIs) – involves applicants stating how they have acted in previous work situations and applying these experiences to the position that they have applied to. The rationale for this form of interview is based on a wealth of empirical evidence, which contends that previous behaviour is a predictor of future behaviour (Ouellette & Wood, 1998). It is the role of the interviewer to assess whether the applicant is able to replicate their previous occupational performances in the new position. BPDIs utilise behavioural anchored rating scales (BARS) – these are used in order to rate the responses given by the applicants against questions in the interview schedule. BARS aid interviewer objectivity by ensuring that interview questions (and how they are assessed) remain consistent between interviews as well as ensuring that the interview remains relevant to the vacancy (Reilly, Bocketti, Maser, & Wennet, 2006), this is possible because BARS are typically established around the job analysis for the position. Situational interviews, on the other hand, involve the candidate being presented with probable workplace scenarios whereby they must report how they would respond to such situations. The rationale for this format interview is based on research contends intention to behave predicts future behaviour (Ajzen, 1991). The responses required from the candidates are compared to the responses acquired by experts who have event information of what they would expect from good employees (as well as poor and average employees) in the vacant position. An obvious issue underlying situational interviews is that they fail to consider how much prior experience the candidate has in previous roles, which may well be relevant to role that they have applied for. The most obvious solution here is to combine it with a CV – a CV would allow for an overview of the candidate’s experience (although the limitations discussed earlier still apply to the CV, e.g., biases).

Given the fact that many jobs are complex, especially in the graduate labour market, it would be best practice to administer aptitude tests. Aptitude tests measure different facets of cognitive ability, and a wealth of evidence has supported the contention that they are the best predictor of occupational performance (e.g., Gottfredson, 2002, p. 331; Sackett, Borneman, & Connelly, 2008; Salgado, Anderson, Moscosco, Bertua, & Fruyt, 2003). One key study by Ones (2005) provided in meta-analysis of meta-analytical studies, this study supported the argument that aptitude testing has the best predictability for a job performance. However, attitude testing should not simply be considered to always be the best method for recruitment, selection, and assessment. Ones and Viswesvaran (2003) reported that when a job was more complex (.58) as opposed to less complex (.23), the predictive increased (validity coefficients provided in parentheses).

In conclusion, employers should be cautious when adopting the popular combination of an unstructured interview and a CV, both of which have major flaws especially in terms of bias (thus reducing their predictive validity). The most cost-effective solution here is to increase the structure of the interview and then combine this with a CV. However, aptitude testing is considered to encompass what are the best methods in recruitment, selection, and assessment. These methods are best utilised when recruiting for more complex job positions.
References


Challenges vs opportunities: A different perspective of resilience

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Resilience has been researched and debated for a while among both children and the adult population with great emphasis on how children (and adults) and their well-being has been fundamental to their development and growth physical, emotional and social. Educational settings have been put under pressure in ensuring that wellness, well-being, and resilience become core topics in the new proposed curriculum (Department for Education, 2019). Workplaces and employers are looking at programmes on well-being and wellness to reduce high levels of absenteeism and ill health. With great emphasis on mental and physical health and increased cases of experienced high level of anxiety (and stress) often leading, if not ill-managed, to maladaptive patterns of behaviours and poor mental health, resilience and the ability to cope – coping, tolerance and adaptive skills – have gained real weight in the understanding of positive short and long-term well-being. This paper endeavours to explore the subject by proposing an alternative perspective and understanding of what resilience could mean and how it could be differently nurtured, developed and indeed understood. By exploring alternative narrative around adversities and challenges which are part of the life course of any human being, it aims to propose a perspective that relies on strengths, interests and opportunities. These ought to be embraced as a fundamental way for life-long learning new adaptive skills or for consolidating naturally existing ones. It concludes by reflecting on the fundamental significance for individualised programmes that take into consideration multi-factors in the development of resilience skills.

Keywords: mental health; resilience; stress; wellness; well-being
What is stress and how can it be better conceptualised? How can stress and adversarial situations be of use to individuals? How is resilience developed and fostered? This article will aim at providing some explorative answers and reflections in these areas.

Stress and adversities: Challenges or opportunities

Sarafino (2012) defines stress as the experience when individuals perceive a discrepancy between the physical or psychological demands of a situation and the necessary resources of their biological, psychological or social systems. Stressful event (s) or adversities in a lifetime is nowadays taken for granted. Stress is part of life. The significant weight given to the word – though it is widely different definitions – has often led to an overemphasis of what stress actually is, how it is experienced and managed, almost to a point that exposure to it ‘needs to be avoided at all cost’.

While it is recognised that severe stress can potentially lead to symptomatologies and psychopathologies and subsequently poor physical and mental health, and long term exposure to unmanaged stress leads to overall serious health problems, I propose looking at stress from a different perspective which helps to promote instead the growth of resilience, coping and adaptive skills which are essential to long term human well-being and development.

Using Lazarus & Folkman (1984) transactional stress model it can be conceptualised more usefully as a transaction between an individual’s coping mechanisms and resources and one’s environment – rather than a state, event or unrelated experience. When stress/adversity is conceptualised in such a manner, the stressful event can be better reconstructed and re-thought as a challenge and opportunity to foster or even discover individual’s coping skills and mechanisms as the stressful event is not static. It is a continuous interaction between the individual, their resources and their environment. And even if it was static, more adaptive and acceptance skills can be taught and fostered.

It is not so much about avoiding criticism, adversity or conflict, but learning that these are fundamentally key elements in equipping children (and adults) in dealing with different situations that will harness a balanced, healthy and socially integrated individual. It is looking at providing a different weight, colour and emphasis to the experience of stress, and that, again, to function optimally is actually necessary. It is also not about diminishing its significance but altering the way stress is generally taught. Not as a negative, bad, ill-thought way of perceiving the world but as an opportunity to develop, foster and enhance necessary skills.

Resilience: Are we asking the right questions?

It is well known that resilience is not something we are born with, or a personality trait, though there are some predisposing factors which might facilitate and nurture the acquisition, fostering and/or enhancing of resilience skills (Southwick et al., 2014). In a recent article Davies (2019) discusses resilience in the context of prevention of violent extremism and suggests that foundational approaches around critical thinking and multiple perspectives are being taught in schools through PSHE (Personal, Social and Health Education), where learning to deal calmly, critically is a key component of resilience. Emotional resilience is also related to one's ability to successfully perform a specific task/activity – self-efficacy and self-esteem (Relojo-Howell, 2016) – as well as empathy which are recognised as key skills when having to cope and manage criticisms and aversive and conflict situations (Davies, 2019).

Southwick et al (2014) suggests that biological, psychological, social and cultural factors that interact with one another to determine how one responds to stressful experiences are the determinants of resilience – a definition which evolved from an APA (American Psychological Association, 2010) definition of resilience which states that it is: ‘the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress’. The APA definition which is helpful, tends to be guiding the narrative and the questioning on the actual adversity, trauma rather than looking at the successful process of coping and adapting well – in the face of these adversities.
While we need not to lose sight of the causes of distress, anxiety, and the nature of adversities asking different questions on what actually is working, what are the components naturally implemented in the face of adversity which makes some individuals more successful in their coping mechanisms, better understanding the natural strengths that individuals are capable and able to adopt in the face of challenges and crisis might provide a different way to support the learning and development of resilience more widely.

It is often the opportunity to guide and share light, with the right line of questioning what already resilience skills are being adopted naturally in the pursuit of strong interests, even hobbies and the ability to place a light on potential existing barriers and how these are actually naturally addressed by the individual which has been an alternative approach to the development of personal resilience models.

Working with elite performers among others has guided the support in directing the light onto what individuals already have adapted on a daily basis in an area of strong interest. Through simple scenarios and experiments, barriers can be place to support the individual in seeing and becoming aware of these existing skills. It will be over a number of sessions that further scenarios can be discussed in order to consolidate and strengthen their personal resilience skills. There is not one way of coping and each individual will be able to discover and develop their personal coping skills and mechanisms. Realistic and coproduced goal settings have been another key element for successfully clearly motivate individuals in the development of their personal resilience skills. Masten (2014) talks about a mastery motivation system which can be a very powerful driver of learning and resilience; this involves the innate enjoyment and satisfaction of engaging and interacting with the environment and set activities. The successful undertaking of these activities can also be a key internal motivator. Masten (2014) sustains again that mastery motivation is a powerful driver of resilience and one that we can observe across multiple species.

**Flexibility and 'learnable' adaptability**

Resilience can be learned, fostered, and even enhanced if we continue to challenge its definition, conceptualisation and operationalisation. Resilience might be better understood and therefore taught as a continuum. The way human beings cope or manage with a stressful, adversarial situation depends completely on the actual situation (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014), repertoire of resources available and the individual’s ability to apply corrective feedback.

Bonanno & Burton (2013) suggest through their work and research a ‘learnable flexibility’ and I would add adaptability as resilience skills are discovered, strengthened and further fostered according to the changing situation. Adapting to a changing situation, according to corrections and cognitive appraisals and re-appraisals of that situation can support individuals in harnessing both a sense of control and self-efficacy which bare great weight on motivational systems and the extent an individual is ready and able to move forward despite setbacks.

**CONCLUSION**

This article aimed at exploring and proposing an alternative understanding of the stress model in conjunction with how resilience can be better conceptualised as a continuum. Starting by revisiting and discussing the role of stress nowadays through the transactional stress model (Lazarus & Folkman, 1984) and looking at – rather than something to be avoided at all cost, proposing through reflections of author’s professional practice – how alternative definitions of stress could be more efficiently adopted. Challenges and opportunities, systems, goal settings and flexible learning, adaptability have been proposed as an alternative way to the understanding of stress, adversarial events and resilience skills.

Thinking of stress as an inevitable part of life learning, a process or continuum which sooner or later we will all be exposed to - of course with different degrees depending on context, situations, available resources at the time and inner (and outer) capacity to flexibly adapt and change by embracing the
challenge, might be a more useful and effective way to harness and strengthen natural existing resilience skills.

By accepting that there is no 'one fits all' way of best coping, but by engaging each individual in a journey of self-discovering of inner strengths (which we all to a certain extent hold already) in an open and honest way through understanding and accepting each situation and it's complex systems, we might be able to not only increase preventative measures but also increase likelihood of long term lasting positive outcomes.

References


https://doi.org/10.1177/1745691613504116


https://doi.org/10.3402/ejpt.v5.25338
Mental health within higher educations: Challenges and recommendations

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People in the throes of madness need to hold on to some form of peace, like an anchor, while discovering their innermost serenity. The state hospital centre offers no such peace. Even in someone’s most tormented nights, consumers armed with the right skills, resources, and support can identify a technique to self-manage their internal chaos and external dysfunction. This article is intended to arm readers with the tools necessary to self-manage their own frustration tolerance throttle. It will provide trauma- and peer-informed insights to practitioners to help patients regulate their thinking and feelings as they tune into their mental status and internal barometer for healthy living after discharge from the state hospital centre. Consumers should feel empowered to always live peacefully and independently, regardless of their chosen path to serenity and peace, even when the world becomes too chaotic to live without medical or psychiatric intervention.

Keywords: mental health; mental health diagnosis; positive psychology; serenity; well-being
As both a mental health professional and a person carrying a diagnosis, I find one term misused and overused; it is tantalising and laden with ableism. The expression is 'high-functioning'. Clinicians use it to categorise and label people whom they feel are doing well and have their diagnoses managed. Most people do not realise that there is no such thing as high-functioning. It is a myth, but one that, without question, is as misleading as it is dangerous to consumers labelled by it. Of course, some people carrying a mental health diagnosis are managing their lives just fine, but this is an entirely different phenomenon. People carrying a diagnosis who are not symptomatic are ‘in remission’. There is no high-functioning term thrown around in the DSM-5. Instead, the DSM uses the expression 'in remission', 'partial remission', ‘sustained remission', etc. to describe the status of people's active or inactive symptoms.

But somewhere along the road, clinicians and others began using the term high-functioning when talking about mentally ill people. The term, however, does not carry any stable meaning. From clinician to clinician, the term's inherently valueless status means its meaning will shift and inaccurately and ineffectively describe mentally ill person's situation. Clinicians use the term to talk about a person's capacity to work, perform ADLs (activities of daily living), and relate to others, as well as to generally talk about how 'well' a person is doing (Katz, 1983). However, 'well' is not a clinical term. So, why do people continue to use the term high-functioning? I suspect it is rooted in the application of the DSM-IV, which include a GAF (Global Assessment of Functioning) to evaluate how a person manages across different domains of living and how they 'function' in these areas. A low score gestured to a person struggling to perform basic life functions, while a high score signalled that the consumer was managing his illness well. The GAF was not only used to score and diagnose; government agencies and disability determinists use it to rate a person's general prognosis and even predict if they would need government assistance. A low score might award a person carrying diagnosis disability payments, whereas a high score would disqualify them from services.

This is where the myth began to emerge in the field of mental health. The GAF score and its application and implementation in clinical practice were as rife with inaccuracies and misuse at it was unhelpful in determining the real clinical picture of the person diagnoses. Inter-rater reliability between clinicians was low, and the scores were often irreproducible from the same clinician using the scale multiple times evaluating the same person's health at different times with the same health status and client reporting.

In fact, in my conversations years ago with a therapist who was still using the GAF to evaluate my own health in a treatment plan review, I would jokingly ask: 'What is my GAF this time?' Since I was also a clinician at the time, and I knew how ineffective and inaccurate the GAF score was truly was, I would question my therapist's score. If I was scored at a 70, I would say: 'You know, I think I am really 75,' and my therapist would clumsily go over the scale with me, and we would pick out a number that 'seemed' more representative of how I was doing. But in reality, this number was only a marker. Although it was an unreliable diagnostic tool, many government agencies continue to use it to award much needed services like case management and housing services for consumers (Kennedy, Madra, & Reddon, 1999).

The crux of the issue is that the term high-functioning carries with it an assumption that the person carrying the diagnosis is doing just fine. Clinicians, carers, family and friends often use this term to justify the untimely termination of assistance, the elimination of benefits, and the cessation of enrolment in programmes to maintain their progress. Without question, high-functioning patients are left to their own devices after they reach a point in their recovery when they can be independent. This is unfortunate, however, because the result is that many consumers fall back into the system and becomes symptomatic again because they are left to navigate their lives without the helpful programmes and disability assistance they have been accustomed to receive because of their condition.

In many cases, consumers cycle back into the system when they reach a certain point in their recovery and are no longer eligible for services. Chronic patients find their symptoms become active again, often
with greater severity. Without needed services, many patients are at risk of going into ‘free fall’, because they are not connected to treatment and are supposedly recovered. These patients often fall through the cracks of the system.

To improve the system, we need to fundamentally change the language and the very meaning of word used in clinical practice (‘Patients at the Center’, 2004). Once the language is stabilised and more accurately used to highlight a person’s clinical picture, we can begin to assimilate a new lexicon to talk and think about the way mental health treatment is handled by the experts, as well as by people with a vested interest in a loved one or family member.

Criminalising mental illness

Many online articles, newspapers, at those at mental health forums talk about increasing community violence as a result of inadequate mental health awareness, lack of access to treatment, and uninformed laws surrounding forced treatment. Even more abundant are writings about people with severe and persistent mental illness in the corrections system, often the result of a fundamental misunderstanding of mentally ill needs for rehabilitation. In some cases, mentally ill people are remanded to jail without committing an offence because of bed shortages in psychiatric hospitals. Whatever the reason, people with a mental illness intersect with the courts and/or corrections departments, and the manner in which law enforcement handles and interacts with mentally people must change. This includes the police, judges, lawyers, and people charged with processing mentally ill people suspected to have committed crimes and are therefore under the auspices of criminal justice system for rehabilitation.

One also finds an increase in the number of articles on US school shootings, violence in American university systems, and other incidents. These events are rooted in this fundamental lack of awareness about mental health issues associated with students in general and, more importantly, the developmental and systemic underlying factors that bring university students into crisis. Most students entering university between the ages of 17 and 19 have never been diagnosed with a mental illness. However, there is an important caveat to remember here: Many people suffering from depression, anxiety, and other serious mental health issues. As a result, they fail to get help when they need it since they have never been in crisis before. For most students, living away from home for the first time or even those attending university in their own communities, research suggests that the risk is high for experiencing an undiagnosed mental health disorder (Martin, 2010). For students with a previous diagnosis, secure your mental health services before matriculation into university. Many treatment centres, in rural areas especially, have long wait lists for services and treatment options may be far and few between.

In my case, as student at Binghamton University in upstate New York, I already had an existing diagnosis from high school. Suffering from anxiety and depressive symptoms, I was encouraged to find services in university. Ironically, the important lesson from my university experience was not that my existing illness went untreated. Instead, the problem was the emergence of a new diagnosable condition and disorder. I developed schizophrenia, the symptoms of which in most cases activate in early adulthood (Miller, Byrne, Hodges, Lawrie, & Johnstone, 2002). For most traditional university students, these are the years when people are truly at risk.

Thus, I was connected to treatment, was aware of my existing illness, and knew how to get help when I needed it. But, when my schizophrenia activated in 2008, I was not aware of symptoms and their impact on my behaviour and perception. At the time, I was an English major applying to graduate school. I was also a very eager to learn and connect with professors in the English department. No question, I stood out from other students, in part for the amount of time I spent on campus and in the department offices and in part for speaking with staff or walking around campus all day and into the
night. As my condition developed and I began to unravel, I became even more visible to the staff. Indeed, I was in the department offices so often and behaving so bizarrely that those department personnel connected the Dean and the University Ombudsman to enact a set of rules and establish boundaries for my ongoing presence in the office.

While some staff members suggested I had a mental health problem and, indeed, I was sent for an evaluation to determine if I was safe to continue as a student, I passed the evaluation and returned to the classroom the same day. I was more confused than ever and was also frustrated and angry with staff for suggesting there was an issue with my behaviour. In my eyes, I was simply trying to continue my education after being rejected for further study in graduate school. I thought I was in an uncharted territory. In some respects, I was, because students who are rejected from graduate school are not often already enrolled in the university's undergraduate programme. If they are, the undergraduate programme often signifies the completion of their schooling. I, however, kept going and applied for non-matriculated graduate courses and other classes so that I could stay connected to the University and figure out a path to acceptance into a graduate programme. Retrospectively, even after my recovery, my logic does not seem completely irrational; it was bizarre, and extremely distressing to the staff. I was already on their radar and still was not connected to the treatment I needed so desperately. Instead, I remember vividly that one day, when I entered the English Department office, looked up, and saw the secretary pick up the phone and say: ‘I am calling the police.’ Believing I was a victim, I did not think the police would do anything or respond to her call. I was wrong, again. Within minutes, I was approached by the university police, who handcuffed me in the department corridor, walked me out of the building, put me in a police car, and took me to the university barracks.

There, I was handcuffed to a pole, crying uncontrollably and very agitated. At the time, if my illness was misidentified and not taken seriously before my arrest, it certainly was not handled well afterward by the campus police I was charged with loitering. It summarises no real crime. Rather, it reveals the mishandling of my mental health. Condition and offers another missed opportunity for connecting me to a mental health service or intervention that could have identified my condition before it worsened. Instead, I was left to my own devices, feeling like a victim and totally petrified of the staff on campus. Even if I thought I had a problem after my arrest, I certainly was not going to the staff to address it. I was left isolated, agitated, and totally without treatment, help, or an intervention by the university that could have halted the progression of my schizophrenia before it developed into full blown psychosis that resulted in state hospitalisation.

On a more global level, however, what happens to students who are not on the campus radar? These are the students I talked about earlier, the undiagnosed high school students at risk of going without treatment in university. Are these students, too, left to their own devices if they are in crisis on campus? I fear for these students, for they are without a voice, without support, without insight into their own mental health, and without access to treatment. Anxiety disorders from stress, depression, and – in cases like mine – schizophrenia, are among a catalogue other conditions for which university students are at risk. They are prone to these conditions because of systemic issues with treatment on campus and developmental organic risk for brain disease and mental illness (Cannon et al., 1994). Although I had a therapist, my illness still went untreated and misidentified; I cannot imagine what might have happened if I did not have any help at all, or if people had not observed my communication with school staff and reported my behaviour at department meetings. While the manner in which the department handled my situation was abysmal, at least it was still handled on some level. Indeed, there was some level of oversight, however, clumsy, regarding the treatment of my condition by staff and my therapist in the community. If I had gone without assistance, as many university students do, this article's conclusion would have been different. But, until universities have adequate mental health services and approach individuals with a mental health diagnosis, or a suspected diagnosis, with dignity and
respect, students will continue to be the very first victims of the society’s criminalisation of mental illness.

When I returned to Binghamton University a year later as a graduate student in social work, I visited the English department. The staff spoke of another student who had a serious mental health crisis, but this time the student’s situation was handled more appropriately. The extreme nature of my crisis and its unfortunate outcome finally signalled that mental health crises require a different approach than was used with me. Indeed, we learn from our mistakes, at a macro level as a society and at a micro level as individuals. In the case presented here, mistakes were made by both the system at the university level and by individual staff involved with my situation in the department. There is no question that the events unfolding in Binghamton in 2008 and those that followed mirror a larger fundamental problem in our approach to mental health in the higher education system and as people who intersect the legal system as a result of their mental health diagnosis.

First episode psychosis

There are two additional caveats before we apply theory to practice. First, when dealing with the interpersonal world, no level of calmness and serenity can prepare you for what someone will throw at you when they are in crisis and mishandling a situation. In these cases, you may not have to dig deep into your psychological profile to unhinge your frustration. Instead, remind yourself that other people's problems are their own. Feeling or thinking for them will only make their jobs more complicated and difficult to manage independently in the future. The second: Sometimes you should be, or need to be, anxious. Our anxieties are signals that tell us we need to make changes in our lives. If you cannot locate the deep-seated issue, and you know something has to give, sometimes just going ahead without digging too deep into your subconscious or psychological wellspring might provide you with a fast and very much needed change to feel better in the next few moments. The most ornate and complex set and manifestations of symptoms exist in the schizophrenia and related psychosis family of mental health diagnoses (Guttman, 2018). Symptoms are labelled differently to address and explain the experience of the symptomatic person. To identify which is a negative and which is a positive symptom, that is, disorders akin to schizophrenia and related psychosis, practitioners and peers interested in learning about their recovery must distinguish their experiences between an added feature to his presentation and an internal sensation or belief at work in your thought processes. One example is though broadcasting. This is a positive symptom in which a person believes his personal thoughts are available to other people seemingly anywhere in the world (Durham Peters, 2010). It differs from telepathy in that these thoughts are not transmissions per se, but a vast web of shared knowledge among the people listening or accessing the information being broadcasted.

Paranoia

Paranoia is disabling because it limits us by cutting off our world and making us feel uncomfortable to explore and live our lives without fear (Westermann, Kesting, & Lincoln, 2012). Paranoia is fear, and fear stops us from celebrating every moment of our existence. No reason exists to live with paranoia. So, how do we stop it? Eliminate it? The most important place to being is with assessing what you are afraid of and categorising it into three domains of fear. The categories include: (1) letting our small critical thoughts snowball into major fear; (2) eclipsing hopes and limiting our future-oriented thinking; and, (3) combining our fears or apocalyptic projections.

We are critical because we care. We want to manage our lives effectively and precisely. But these small critical thoughts can snowball into major crippling fears that stop us from getting out of bed or being social and making new friends. Why let that happen? Check in with yourself. Self-monitor and find an internal balance with your thoughts. Ever look forward to something? Future-oriented thinking keeps us
motivated and happy about time elapsing or, in plain language, experiencing every moment of every day. Paranoia stops us from experiencing our days because we become so pained that we stop and detach; we do anything to stop the internal fear from strangling other aspects of our lives. The worst thing you can do to make paranoia worse is to combine fears. A hurricane is bad news, but flooding due to high winds and high water is even worse.

**Delusional systems**

Delusions put the crazy in madness and mental health disorders. This means, simply, that when we think he is ‘out there’ and ‘nuts’, we are referring to the delusional systems within a person's larger set of symptoms. Delusions carve out the imaginary and marry it with our orientation in various ways that complicate and distort our reality and sense of self (Jeannerod, 2009). When we say someone is delusional, clinically we mean someone's ideas and the beliefs they hold about their world are more than just unusual, they are a departure from reality. What is happening internally is not congruent with the external world. Usually, with most mental health disorders featuring psychosis, delusions are more abundant that one isolated, disordered thought. Delusional systems are either fixed or solvent. This means that no matter how a person's recovery progresses and how much external world changes, the delusion persists. This post targets how delusional systems are born and evolve in the person experiencing an altered reality and what the implications are for practice and treatment.

A delusional system is not complex when first born. In fact, it may be as simple and benign as a newly formed idea or routinely repeated habit executed internally by a person trying to complete their ADLs or go to school or work. For example, a person might be cleaning wax from their ears when a switch flips in the brain and slowly, seemingly organically, the thought transforms. Suddenly, and conversely over time, the person cleaning the ear is no longer purposefully removing wax, he is doing something different and likely more malignant in design than when the idea was first executed by the brain. In my own experience, when I first experienced the birth of a delusion it was my relationship status with a friend and, ultimately, marital status. At one moment I knew myself as single. Then over time, and yet suddenly, I knew of myself as married with a child on the way, depending on the health of my friend's womb and a piece of fruit on my windowsill that I connected to the health of her uterus. This is an example of how distorted thought can evolve into a complex system with both fixed and solvent features.

How a delusional system develops directly informs how clinicians should take it apart in treating the person with altered realities. Since delusional systems develop over time and are realised suddenly by the person experiencing the change in their external world, the clinician must identify where and when the ‘break’ or shift occurred and what that meant for the person experiencing the shift in reality. For example, if a person, over time, thinks a microchip is implanted in his brain, the clinician must identify when the break originally occurred for the person and what it means to experience the symptom. This means, similar to performing a maths equation, that charting the clinical picture's distance from the shift in reality in terms of each aspect of their mental status (e.g., time, place, judgement, insight, etc.) is the first step in unwinding the delusional system's content and breaking fixed-thought structures into less toxic and maladjusted patterns.

I experienced this symptom first-hand during my final days in the community before I was hospitalised for full onset of first episode psychosis. This symptom is not so much scary as it is confusing and disorienting. I was driving down a major interstate when I first heard my thoughts and believed they were being listened to by friends and family, who were actually hundreds of miles away. However, when experiencing the symptom first-hand, I felt as if my family could hear my thoughts immediately and without regard to space or time. I could even hear the beginning of their responses to my transmission if my imagination or subconscious really had a choice about things. In this sense, voices
and delusions collide together to make this feature of psychosis even more difficult to experience without breaking from reality. The break is not a sharp departure in orientation, but rather noise and interference of thoughts; the addition of these positive symptoms and the space needed to hold on to this overly complex delusional system takes time to process information effectively as it occurs. This is why very psychotic people speak slowly, and their reaction time is longer; there is so much more to process to maintain even basic life functions. So much is happening or not happening in the person's speech and language centers in the brain that the person experiencing the symptom must sort out the overabundance of stimuli to stay connected to the world without getting lost in internal preoccupation.

To broadcast thoughts, the person transmitting must be listening. Since thought broadcasting is a symptom and non-existent under normal circumstances, the person must acknowledge that it is happening as it happening. Thought patterns that are too involved and overly complex are even more diffused and difficult to decipher as either real or a symptom of illness. This is why, as this symptom progresses, people get increasingly lost in internal preoccupation and are unable to come out of their heads per se and spend their time just listening to or even responding to his internal thoughts externally or aloud. This is when you typically hear of people responding to attention or appear bizarre to others. Since this also occurs late in the progression of the diagnosis, people experiencing the symptom are usually already in the hospital. Without experiencing this symptom, it is hard to believe it can happen to a person. I solve the mysteries already at work from a growing delusional system. In my case, I was driving. You may be walking the dog. Just be safe in any event and remember safety is first and foremost the goal when you begin experiencing something so otherworldly and yet so personal that it breaks the very conventions of time, space, and communication between people subject to physics and human anatomy.

The final night I was hospitalised in the community hospital, I heard screaming all night long from my neighbour’s room. She was carrying on like a child. The screams resembled those of a baby’s cries. I kept pressing the button next to my bed to summon staff, but nobody arrived until the next morning. Given the sleep deprivation and my compromised mental status, I was delirious at this point. By the time the staff from the unit was in my room addressing the situation, I was feeling so nauseous from the noise all night that I leaned over and vomited on the social worker and lunged towards the psychiatrist for help. I was immediately placed in the quiet room to be monitored and assessed for safety every 15 minutes until I was stabilised. About an hour later, the doctor came into my room and advised me that I would be transferred to another hospital and that I would be staying there for a very long time. We all have limitations. Some of them are more visible to the naked eye; others are more covert and hidden from the public but still an internal struggle we battle every day. As a therapist, I have the opportunity to listen to other practitioners talk about their patients and their ideas on how to help them in their treatment.

**Mania**

Sometimes my head spins from the ideas circulating around the table; hopefully, now it will be clearer to practitioners what treatment fit means in the context of supporting people in their healing with functional impairments. Mania can seem like the best high in the world and must be undersold as an affective state impairment in functioning of all shapes, sizes, and forms. During a manic episode, you can transcend historical points of reference and religious symbolism/iconography prescribed by your belief system and finds yourself incorporated into it despite anachronistic markers, which should signal a problem with your perception. In this case, mania will, in fact create a new reality, if only for the moment, and shift your guidance into a space that will seem like anything is plausible when something is very wrong with your affective regulation. I have experienced first-hand manic episodes in which I have been awake for weeks at a time without sleeping or needing rest. I have witnessed other people so dysregulated from mania that they would do somersaults across the floors of the psychiatric ward just to find their bodies would later feel the shock of these poorly planned acrobatic theatrics. With certain
diagnoses, manic symptoms become more difficult to identify. People carrying diagnoses that include psychotic symptoms should pay even close attention to their moods because psychosis can worsen with extreme elevations of mood. This then further complicates a person's insight, as well as the judgement of their symptoms. For most generic mood disorders, extreme euphoria, decreased need for sleep, hypersexual arousal, and religious ideation are the usual suspects when manic symptoms are present. Should these symptoms activate in a subclinical or mostly unproblematic manner, in your life, you may be working with hypomania (Bowen & D'Arcy, 2003).

In terms of self-management and self-regulation, several options are available for reducing the harmfulness of a manic episode on your interpersonal life and your capacity to execute activities of daily living without incident. These strategies are dependent on the manner in which mania was activated and how severe your symptoms are. Stimulant- and drug-induced mania is just as dangerous as organically-driven manic episodes. Considering substance abuse treatment for cases like this will be an important step in managing your symptoms for the long haul (Burden, Pilao, & dela Rosa, 2018). Like most people, even minor stimulant use from caffeine can trigger an episode. Living a chemical-free lifestyle is not for everyone, but it can provide a baseline, at least temporarily, with which to gauge further consumption of foods and beverages that might trigger an episode. For non-chemically induced episodes, internal and external barometers are essential for knowing your affective state baseline. Listen to your friends and colleagues; maybe recent complaints have been made about your behaviour, or maybe your feel like it is challenging to maintain a balanced mood. You may also begin to create markers in your living environment.

Creating a plan for friends and family will greatly reduce the risk of potential harm from an episode. This means making friends and family aware of your symptoms and triggers so they can help you avoid the ups and downs of mood dysregulation and even help you make decisions if your judgement and insight are too impaired for rational decision making. I send emails to friends and family when I feel like my moods may be impaired or have impaired my decisions or, in the future, might harm others. Preparedness and attention to details are always essential when managing an illness. Surround yourself with supportive people and allies in your recovery. You should never feel embarrassed by your behaviour, but you always need to accept responsibility for it. That is how recovery works: acknowledging that change is necessary and moving forward in the process of adapting our behaviour until it serves our purposes.

Stilted language and word salad

Anyone who knows me personally or professionally is ware of my love of language. As a person diagnosed with schizophrenia and a lover of language, the road to recovery and symptom stabilisation has been difficult and frustrating. Schizophrenia impacts the speech centres and hemispheres of the brain. I passed through several phases of speech problems, some more observable than others. This article will focus on two common speech-related symptoms people with schizophrenia experience: (1) stilted language and (2) word salad. I will tie in my own lived experience with these symptoms and my experience treating the disorder as a clinician with experience in chronic disorders and serious and persistent mental illness.

Schizophrenia and psychosis-related symptoms worsen over time. When I first began experiencing each of these symptoms I was a university student studying English and rhetoric. Just to give a little background, I was always a bit pompous even before my schizophrenia symptoms became active. As a student studying English, I liked to use language that was extraordinary and heightened above the common colloquial of university students and most native English speakers. When my symptoms began to activate, I was preparing for my last year at university and my brother was getting married. As the best man at his wedding, I had the honour of writing the wedding toast. Given my love of language, an
already elevated vocabulary, and knowledge of rhetoric from years of study, I wrote then what I thought was a great wedding toast. But upon reflection, and the timing of the activation of my symptoms during my final year of university, I truly believe that my choice of wording and rhetoric was impacted by my symptoms.

The wedding toast is a great example of stilted language. The toast itself was written in the style of Jean-Paul Sartre. At that time, I was very much interested in literary theory and philosophy of language. I had also just finished reading *Being and Nothingness* and wanted to put theory into practice. The toast talked about my brother’s relationship with his new wife and its evolution. I thought that their history together would be perfect material for a toast. So, I talked about how their relationship evolved from nothing into something. The toast followed this theme and in one great crescendo, I launched into the metaphysics of all of it – their relationship and how this phenomenon yielded the very wedding I was toasting. I also remember reviewing multiple drafts of the toast with my parents before finalising the version I read at their wedding. To be quite honest, every memory I have of speaking and using language after the wedding until I was finally hospitalised for full blown psychosis was stilted and gradually more pompous, flowery, and excessive. Ultimately, it became unrecognisable and incoherent.

This is when the word salad emerged, and what was a catalogue of symptoms activated was. By the time I was in the hospital, I could not speak recognisably. Indeed, I suffered a major deficit in language and a loss of it altogether as my symptoms worsened. However, the language I was using to communicate was jumbled to say the least. The syntax, word order, and sentencing structure of my spoken word ‘choice’ were all over the place. In the hospital, I had a very hard time communicating with staff and even worse, my needs at the time due to these language issues. There were other speech issues too, as I experienced many of them because of the activating psychosis. Indeed, I was experiencing perseveration and echolalia, which is when a patient repeats the language of staff or people around him instead of communicating an original message (Cuesta & Peralta, 1999). The worst symptom was the word salad, mostly because nobody knew what I was talking about. Given I have all my clinical records from the unit; I have gone ahead over the years and reviewed the staff notes, as well as my own writing on the unit. I observed a trend and common degradation of language from the time I was first admitted to transfer to the state psychiatric centre for unresolved psychosis. As time passed and my length of stay increased, symptoms such as word salad and stilted language also became more intense and more visible in the records. Similarly, my situation on the unit, condition, and prognosis worsened.

Hindsight is 20/20, or so the expression goes. Sure, looking back today I am able to identify these symptoms, chart their frequency and intensity over time, and evaluate my overall condition. But back then, all of this was news, and I was working in the unknown. Many people who experience these psychosis symptoms do not realise they are even experiencing them. This can be the result of the gradual progression and onset, which is hard to self-identify in the moment and over time (McGlashan, 1999). Even as a clinician, I can make mistakes in early detection with my own patients and the activation of their psychosis symptoms. Certainly, in my case, these symptoms seemed normal until I became too detached from reality to understand how disconnected I was to the world around me. I was disconnected by language, above all, and then, ultimately, by perception, which only further complicated my capacity to relate to others in a meaningful way. To this day, my speech continues to heal, and I am being more vigilant these days about the quality and content of wording and status of my language.

Let us be completely honest about healing after discharge from the state hospital centre. Depending on the functional impairment or limitation in completing self-directed tasks to maintain a standard of living and quality of life after discharge, treatment plans to address interfering symptoms are only the beginning when it comes to complete recovery. Depending on the goals of the individual, the interfering symptoms should not be the focus of treatment. Instead, focus on strengthening the weak points in
functioning, regardless of the particular symptoms blocking the person's ability to maintain a desired quality of living. Interfering or unresolved symptoms can be treated, but they are certainly should not be the focus of treatment. Some people never experience relief from their symptoms because of extreme chronicity and untreatable impairments. Not every symptom is rooted in a diagnosis; sometimes, flaws in our personalities govern the expression of our limitations. We need to refocus treatment to target and identify the weak points in a person's functioning – whatever the symptoms are that block abilities and create impairments. I have seen first-hand clinicians and peers dwelling on unresolved and chronic symptoms as if strengthening a person's weakness in functioning would not help them move forward in their healing.

DISCUSSION

I have said there is no universal way to capture or express the experience of psychosis. I might be incorrect in this claim. This all depends on your definition of capture and experience. Therefore, to determine the validity of my original statement, I am going to suggest the following new three-part theory surrounding the study of psychosis and its application in practice: (1) the accumulation of psychotic symptoms and the worsening of psychosis symptoms is rooted in the changing of signs within a person's system of signification; (2) although the identification of psychosis symptoms does not mark or capture a sign, the worsening of corresponding, primary, residual, or inactive symptoms can be portrayed as a wholesale changing of a person's experience in reality; and, (3) this occurs through a fundamental restructuring of a person's won interpretation of their system of signs, in language, oral expression, and all brain functions that interact with the world through use and passage through his interpretive eyes.

The term universal definition means 'common effect' (e.g., noun) or 'applicable to all case' (e.g., adjective) if we analyse both the structure of sentencing in a linguistic breakdown universal of both meaning and usage. The point of departure for defining 'universal' also makes visible the multiplicity inherent in the world. In fact, this applies to all words, especially when they are analysed for both meaning and usage. No doubt, signalling the instability of a common signifier or even effect is both neutered and more rightly highly suspect. What I mean is that, as the number of common signifiers increases in any given system of signification, the likelihood, or odds, of a common effect being experienced by people in crisis and going through the throws of first episode psychosis becomes more and more unlikely. Given the projection of worsening psychosis symptoms and the uniqueness of each experience, the chances of any person seeing, hearing, feeling, or smelling something the same way as another person is totally implausible.

Psychosis symptoms can serve as the body's response to a life adjustment. In doing so, the mind creates a maladaptive coping mechanism. This is not to say the organic brain disease is a coping mechanism. Rather, the manner in which the body compensates and handles the change in brain function is in essence both a method of coping and adapting to something altogether harmful for the body. The change in brain function is what I am suggesting problematic. The body's response involves coping with the interpretation of their own system of signification is healthy to a point. Sometimes, the mind needs to deal with the dysfunction of its regulation by systematically changing its signs. I fully believe during initial psychotic symptoms, the early moments of a person's break are generally experienced as more systematic in terms of the composition of the changing sign itself. I am suggesting that before psychosis symptoms worsen, they will shift from more systematic sign changes to more disruptive, arbitrary, and altogether difficult-to-follow changes within a person's system of signification and own interpretation and connection to the world; this makes sense. As brain tissue becomes more damaged, neurons and their pathways will become more misaligned and signals to and from the brain more chaotic and dysfunctional. This is to say that before things get really out of hand, therapists can measure the rate of
change and introduce measures into the worsening of psychosis symptoms by charting and mapping out the rate of change within the person's system of signification.

The clinical significance of these claims has potential. If we assume my claims regarding the experience of psychosis can be measured, mapped out, and analysed for degradation between linkages of signifiers, the usefulness of this scheme becomes clear. Further analysis will have to research the correlation between sign linkage and the experience of the individual suffering from psychosis. Given all signs are going through changes, with the active disease process also assumed to move towards a higher degree of chaos instability, measuring distress tolerance to such changes will also be necessary to the research to add full meaning to understanding how everyone's unique experience shares commonalities.

Psychosis is experienced by people carrying its active constellation of corresponding and altogether unique symptoms differently. At different times, along a spectrum, psychosis symptoms exist in a dark harmony, sometimes feeding off one another and sometimes working in complete isolation. The spectrum intensifies in many cases over time upon initial activation. The spectrum of psychosis symptoms delineates how the symptoms are experienced individually, that is the timing, triggers, age, and developmental circumstances (Kuha, Keawkubthong, & Relojo, 2018) around the symptoms activation and life circumstance. The intensity of the corresponding symptoms, their subsequent manifestation into behaviour, and their possible impact on a person's mood are also all individuals. Almost every aspect of how psychosis is experienced is individual to that person. The only universals are how the symptom is clinically treated, how our society handles people actively experiencing the symptom, and our view and biases that go along with people in crisis as a result of unmanaged persistent psychosis symptoms. What is not talked about too often is the otherworldly nature of psychosis as its first activating. There is certain mystique to psychosis. Indeed, psychosis does distort how we perceive reality and plays around with our level of attachment to the world. But, without question, for people in extreme situations, unusual situations, experiencing a new or reoccurring crisis, and bizarre situations which complicate our existence as we know it, the introduction of a new angle or worldview can sometimes be very exciting and seemingly needed to pull ourselves out of a holding pattern. The symptoms impact on the individual may indeed seem welcome, timely, and necessary to experience a needed change.

CONCLUSION

My psychosis symptoms activated at the very moment I needed to experience a change and adjustment in my life, in now I interacted with the world and in how I understood it. Indeed, when a person needs to make an adjustment or life change, activating psychosis symptoms can paint the world in more palatable colours, and perhaps even shift perception enough to identify alternate and new solutions to existing problems which continue to persist because you have not been able to step outside your own perspective. Job loss or unemployment, relationship changes, and major life circumstance adjustments are very difficult to tolerate. Indeed the DSM-5 diagnosis of an adjustment disorder exists as primarily the pathway to greater more complex issues if we let our problems go unresolved for long periods of time. Given people experiencing and adjustment disorder are unhappy with how the change feels or how it impacts the thought process, our behaviours may ultimately be impacted by the distress involved from whatever trauma we are passing through in the moment. Thus, the brain goes ahead and activates psychosis symptoms so the body can more easily tolerate the change without feeling or thinking about the problem as intensely and as painlessly as possible. There is a reason why homeless people suffering from psychosis usually became psychotic after they lost their homes and need to adjust to life on the streets. People who go through major life adjustments can take solace and comfort in the initial stages of psychosis.

Psychosis and how the individual is ultimately impacted will be different for each person, but over time and in the presence of additional stressors, the symptoms worsen and become unmanageable. So, the
gradual and welcome shift in perception will seem and feel welcome for a while, but, if the same stressors continue to aggravate, agitate, and feel welcome for a while, but, if the same stressors continue to aggravate, agitate, worsen, or persist, expect the detachment to increase, and a sharp departure from reality will be in your cards in the near future. For the person adjusting to life on the streets or going through a tremendous loss, the mind will accommodate whatever the person needs to do to cope with their new reality. Sometimes, the mind does not work the way it should. In the case of psychosis activating, it may seem to work for a period of time, but ultimately, the symptoms are overwhelming and become so profound that life becomes too distant and unrecognisable to live without incident. I am suggesting that initially, some variance in our reality may seem appealing, but as the symptoms worsen and become more extreme, the interplay between our already stressed situations and our bodies’ response to the stress is overwhelming, disturbing, and scary to experience. There is no question that those of us prone to psychosis becoming active or reactive chronically understand this mystique about the way our bodies experience this response to whatever we want to escape from or sometimes forget because it is so traumatic or just worth forgetting.

References


Brain-based psychotherapy integration: Clinical biopsychology

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Copyright. 2019. Psychreg Journal of Psychology
ISSN: 2515-138X

There has been an increasing interest in psychotherapy integration over the past 30 years and that most therapists now tend to use the label ‘eclectic’ when asked about their orientation. More recently, there have been discussions of neuroscience in relation to psychological treatment, although most times this has involved simply naming brain structures (e.g., amygdala) or using vague statements (e.g., ‘experience transforms the brain’) related to concepts and treatments that have been in existence for decades. However, it is a reasonable conclusion that a brain-based approach is the only avenue that will allow true psychotherapy integration since the brain is responsible for all behaviours, whether those are functional or maladaptive.

Keywords: neuroscience; psychological treatment; psychotherapy
I was trained in Lurian approach in neuropsychological assessment. While I was teaching a graduate course on neuropsychology in 1984, I developed a theoretical explanation of Alexander Luria’s views of cortical processing based on the cortical column as the binary unit that operated in circuits—Simply think of a cortical column as a few thousand neurons operating in synchrony. However, there was not sufficient evidence at that time to support a publication on the model that was called ‘speculative’ and ‘untestable’ by peer reviewers. With technological advances leading to an explosion of neuroscience research since that time, there was sufficient support that allowed the first peer-reviewed article (Moss, 2006) on this theoretical view I called the ‘dimensional systems model’. Based on that theory, I published the first article on a psychotherapy approach referred to as the ‘clinical biopsychological model’ the following year (Moss, 2007).

The following is a brief description of the viewpoint of the clinical biopsychological model: There are a large number of interesting aspects ties to these new theories. I will briefly discuss two. These are: (1) providing an explanation for the ‘unconscious’; and (2) explaining the bases for ‘giver’ (Type G) and taker (Type T) interpersonal behaviour patterns. However, I want to first provide a brief overview of how the brain processes those three points.

The cerebral cortex is the outmost portion of the brain that controls our human cognitive abilities, such as language and problem solving. The right and left cortices are considered to be semi-independent functioning minds. Within the suggested parallel processing design, the side that can best respond to an ongoing situation is the one that assumes control of the ensuing response. Both hemispheres receive similar sensory input (e.g., vision and hearing). The posterior lobes (i.e., parietal, temporal and occipital) are involved with processing and memory storage tied to incoming sensory information, while the frontal lobes are involved with analysis, planning, and response initiation, as well as associated memories of such activities. The left cortex processes sensory information in detailed manner, resulting in its being slower than the right. The right cortex processes the information much faster, but in a global, less-detailed manner. There is exchange of information between the sides, although this exchange can be both excitatory and inhibitory. From a developmental perspective, there is initially only very limited information exchange between lobes with each side, and between the hemispheres. This allows each cortical area to develop fully its memories and associated processing prior to influence from other areas. Additionally, left hemisphere functions (e.g., receptive and expressive speech) will develop slower than those of the right hemisphere (e.g., non-verbal emotional analyses and responses) since there are a greater number of information units (i.e., cortical columns) and interconnections in the circuits associated with left hemisphere processing. A final point is that the right hemisphere’s global processing allows for faster responses if confronted with outside danger; thus, this side is best designed biologically (i.e., for survival) to respond and assume behavioural control while in a negative emotional state.

The left cortex primarily handles language functions since this is highly detailed. Thus, the left posterior cortex is involved in comprehending (including memory storage) both spoken and written language, while the frontal lobe controls spoken language, including the motor memories of language. In contrast, the right cortex is involved in many less detailed global functions, including non-verbal emotional analyses and responses. The right posterior areas are involved in comprehending (including memory storage) non-detailed emotional behaviours shown by others, as well as storage of external (e.g., sight and sound) and internal (e.g., visceral responses) sensory memories tied to emotions. The right frontal lobe is involved in emotional expressions involving prosody and body language, including the motor memories of such expressions.

Conscious vs unconscious

I originally referred to the left hemisphere being involved with all verbal thinking, including one’s internal verbal dialogue. Michael Gazzaniga (1989) similarly described the ‘interpreter’ of the left
hemisphere. I now use the term verbal interpreter to refer to the ventral lateral frontal region which includes ‘Broca’s area’ (considered the speech motor planning area). Although the receptive language memories are located in the posterior lobes, the columns allowing us to actively use language are theoretically in the frontal lobe. If accurate, our internal verbal dialogue, which has often been considered synonymous with ‘consciousness’ or self-awareness, involves only a limited area of the left frontal cortex. Therefore, if there are no direct cortical connections to allow the verbal interpreter to be aware of specific cortical activity located elsewhere, the other activity is ‘unconscious’ relative to verbal awareness.

A major question is what is connected to the verbal interpreter’s location? Obviously, left cortical functions are the most likely to be accessible by the interpreter, particularly in the lateral cortex that processes information from the world around us. Columns in the medial cortex process internal and self-referential information and these are less likely to connect to the verbal interpreter circuitry. This is based on the expectation that medial receptive columns are connected to their respective medial frontal columns. Additionally, right cortical connections to the verbal interpreter are very limited. It appears that frontal connections from one hemisphere connect only to the corresponding location of the opposing hemisphere. The same is true of the posterior cortical regions. This suggests that most right hemisphere processing is not directly connected with the verbal interpreter. The result is that there is inaccurate awareness of, and an inability to control, right posterior hemisphere activities by the verbal interpreter. As previously stated, non-verbal emotional processing involves the right hemisphere.

A clinical example will help illustrate these concepts. I used (Moss, 2015; 2016) the example of a woman who is forcefully held by her wrists during a sexual assault. At a later time, she was grabbed by the wrist by someone she trusts and experiences a panic/fear response. Based on my theory the tactile columns for the wrist lead to the activation of the column circuits where the various right cortical non-detailed (e.g., contextual aspects, voice intonations of the perpetrator, general body size and facial features of the perpetrator) sensory and emotional aspects are represented.

The victim is able to verbally state (from the left verbal interpreter) she had a panic attack that logically makes no sense based on the identity of the person who held her wrist. She is unable to describe all of the right hemisphere column circuits that were activated. In fact, the psychological treatment in which the patient verbally describes what occurred with every possible detail recalled over three to four repetitions results in her being able to recall many more specific details in the latter descriptions. As those details are discussed, the verbal interpreter circuit becomes aware as she visualises those in her right cortex. Thus, she had the memories present cortically with the verbal interpreter circuit remaining unaware. Obviously, there can be other memories present that the victim fails to recall even during the treatment process. The point is that these are clearly episodic memories, but without consciousness as defined by the verbal interpreter being initially involved.

Type G and Type T relationship patterns

I have suggested that there are two different, but basic, patterns by which individuals have learned to activate positive feelings and deactivate negative ones within relationships. These two patterns involve either the giving (Type G) or taking (Type T) of power, control, attention, and/or things. At the simplest level, this is consistent with the basic motivational rule and refers to both the sensory emotional memories (i.e., how one feels) and action (i.e., how one behaves) in relationship interactions. Although hereditary/genetic factors (e.g., temperament) play a role in the development of one pattern over another, a major influence involves each person’s own learning history. This learning history involves what was most effective in acquiring positive and avoiding negative consequences with all influential people within an individual’s early social system. Once developed, an individual continues to relate to
the current social system in the same basic manner of giving or taking since their earlier emotional memories define which of these patterns results in positive or negative internal states.

Type T individuals experience positive feelings in relationships by taking power, control, attention and/or things and experience negative emotions when having to give at their own expense. Therefore, they give only if something more desirable can be obtained or maintained. For a Type T desiring attention more than anything else, this same person may be willing to give up direct power and control. In such a case, this person may be very dependent and whiny, often being in the position of engaging in behaviours that would logically appear very maladaptive. In contrast, one who desires power and control more than attention may be willing to let others receive the attention publicly as long as he can ‘pull the strings’.

Type G individuals activate positive feelings in relationships by giving power, control, attention and/or things, while experiencing negative feelings if they have to take things at someone else's expense. They can behaviourally ‘take in’ certain situations, but have to develop specific rules to do so. These rules allow them to define for themselves when it is acceptable to take from others. However, the major positive experience for this type occurs when an individual spontaneously decides to give in a way to someone, feels they have done a good job, and the person on the receiving end demonstrates a genuine appreciation for what has been done. The most negative experience is one in which the giver has to accept something from someone has typically done, has no means to repay what was done, and is made to feel guilty due to statements from others.

Given a parallel processing model of the brain in which non-detailed emotional memories are stored in the right cortex and the prime directive of the system is to maximise the positive and minimise the negative emotions being experienced, the development of the described patterns is considered logical. These patterns reflect the motivation for the behaviours seen in each type. The sensory emotional memories are the factors responsible for the way a person is able to have positive and negative emotions stimulated and, thus, are responsible for the motivation to maintain the behaviour (i.e., frontal action memories) patterns.

Emotional memories are stored very early in development and are independent of the verbal-thinking process (Crutcher, 1994). As a result, these emotional memories serve to guide the future memories that develop since there will be an attempt to maximise positive and minimise negative emotions. Obviously, the best way to maximise the positive feelings is to stimulate the previously stored positive memories and to avoid the stimulation of the previously stored negative memories. Once an individual stores memory associated with either a pattern of giving or taking to activate positive emotions, it is logical that this pattern will continue and intensify.

In the brain, the columns tied to emotional memories form circuits (Moss, 2013). Based on these emotional memories, the right and left frontal regions will develop their own circuits of columns that guide the person's actions, which, in turn, can activate or deactivate the non-detailed emotional memories based on environmental sensory input (e.g., observing another person's behaviour) to the right posterior hemisphere. Once established, it is likely that the frontal columns controlling behaviour tied to old emotional memories will be the first employed in response to new environmental stimulation that results in either positive or negative feelings. Thus, the likelihood is that similar patterns tied to what environmentally leads to desirable and undesirable emotions, as well as how this is behaviourally controlled, will be maintained.

Taking this point one step further, it is not surprising to anyone that in most circumstances, one’s native verbal language (e.g., English) continues to be used in social interaction. That applies to new and old relationships, including relationships with friends, spouse, and individuals at school and work. For
example, if someone never learned to speak Chinese, why would you expect him to speak Chinese in social situations? When considering emotional communications in relationships, would it not be equally expected that one would continue to employ that learned over the course of one’s developmental years?

CONCLUSION

The behavioural descriptions serve a major purpose in the emotional restructuring session which is directed toward neutralising negative emotional memories tied to problematic past and current relationships. Many other aspects exist in relation to these theories, including specific treatment approaches in dealing with influential negative emotional memories (e.g., problems tied to parents, spouse and peer bullying).

References


An exploration of the taxonomy and intersection of clinical psychology and psychopathology: Basis for redesigning psychology curriculum

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Interest in clinical psychology has been growing as indicated by large numbers of undergraduates applying for admission to graduate programmes and the professional degrees granted. Clinical psychology is one of the largest branch and the most popular subfields within the broad branch of psychology that integrates science, theory and practice to address psychological problems. It is the study of individuals, by observation or experimentation, with the intention of promoting change (Compas & Gotlib, 2002). As clinical psychology has evolved over the years into a complex and diverse area within psychology, it has become important for psychologists, teachers as well as students to integrate between science and theory. Today, clinical psychology is the largest and certainly one of the most vigorous fields of psychology (Reisman, 1991). At this juncture, an important question arises. What is clinical psychology and should it be taught to students? Essentially, clinical psychology aims to reduce psychological distress and enhance and promote psychological well-being.

Keywords: clinical psychology; higher education; mental health psychological well-being; university students
Clinical psychology relates to understanding wide range of psychological difficulties including relationship problems, learning difficulties, child and family issues, mental health problems, addictions, and most starkly, psychopathology which is the study of the causes, development and manifestations of psychological or behavioural disorders (Blair, Peschardt, Budhani, Mitchell, & Pine, 2006). The main areas of clinical psychology are psychopathological, emotional, and behavioural. As psychopathology is an important area, it is pertinent to ask for the student if it is a redundant concept. Psychopathology is a branch of knowledge that includes description, interpretation, explanation and classification and further of particular mental phenomena that have clinical meaning. It is also important that the student is aware that there are many specialisations in psychology, like educational psychology, occupational psychology, organisational psychology, health psychology, forensic psychology, environmental psychology and sport psychology, but the only psychologists specifically qualified to offer therapy are the clinical psychologist and the counselling psychologist.

It is also relevant when the student is taught clinical psychology, that the study of clinical psychology differentiates – though often overlapping – itself from counselling psychology in the following manner. Clinical psychology deals with more serious mental health conditions like psychosis, neurological damage, and dementia; while counselling psychology has more focus on treatable mild to moderate conditions, where shorter term psychological interventions can be effective like depression, anxiety disorders (Relojo-Howell, 2019). Clinical psychology has greater emphasis on assessment and formulation while more emphasis is given to the therapeutic process in counselling psychology. Meanwhile, according to Ansari, Noor and Haque (2005), the global demand for clinical psychologists reflects the rapid expansion in the application of cognitive approaches to clinical as well as social problems, which is evident in surveys conducted looking at the range of activities in order of per cent involvement: psychotherapy (84%); diagnostic tests (74%); teaching (50%); clinical supervision (62%); research and writing (47%); and, consultation and administration (52%).

An important question which arises in the above context is why clinical psychology should be taught to students? One reason is that since clinical psychology is the study of psychological disorders and the treatments designed to improve the day-to-day lives of people suffering from them it is becoming important that students studying psychology understand how clinical psychology integrates the science of psychology and the treatment of complex human problems with the intention of promoting change. Other reasons why clinical psychology should be taught to students is that the curriculum of most universities have developed to churn out clinical psychologist. Apart from the introductory courses, most of the higher educational institutions teach theoretical framework within clinical psychology. The curriculum entails a focus on the role of assessment and the emerging importance of formulation, using the five P's model and applying the model to case studies. Here, students learn to conceptualise an individual's mental health through predisposing, precipitating, perpetuating, protecting and presenting. Specifically these are: (1) predisposing factors, which are any factors that contributed to an individual's problem over the lifetime (bio-psycho-social); (2) precipitating factors, which are any factors that trigger the onset of the illness or cause a related behavioural response; (3) perpetuating factors, which are any factors that maintain the negative symptoms of an illness or condition; (4) protective factors, those that prevent or lessen a particular behaviour or distress (an individual's children may prevent them from committing suicide for fear of their well-being); and, (5) presenting factors, the problem which is faced by the individual and any obvious signs or symptoms upon assessment.

Students also learn the formation from different perspectives (e.g., cognitive behavioural therapy and psychodynamic approaches) in the study of clinical psychology. In their curriculum, students should be encouraged to read about anxiety disorders, mood disorders, and personality disorders. This encompasses the study of: (1) anxiety disorders, where students learn preliminary considerations to reassessment of anxiety; (2) mood disorders with focus on early developmental issues and attachment problems; and, (3) personality disorders that give rise and fall as a distinct clinical category leading to
new wave treatments like DBT (dialectical behavioural therapy). Hence, students should also be taught the contemporary developments in clinical psychology using case studies of working across the lifespan in childhood, middle life and older adulthood. Students should also be taught clinical psychology to make them aware of the role of clinical psychologist in society today. Students should be aware that they have to learn to assess, formulate, intervene, evaluate, reflect and carry out research as clinical psychologist. Healthcare and continued professional development like supervision of trainees, further qualification and specialism should also be provided. These are the fundamental roles of clinical psychologists

Undergraduate students who are applying to graduate training programmes in clinical psychology and are struggling with making what they perceive to be the difficult, but necessary, career choice between science and practice (McFall, 1991) are often confused. This is another reason why students must be educated in clinical psychology with a firm grounding in research, theory and practice. There are many areas where a clinical psychologist can help. Clinical psychologists are now considered experts in providing psychotherapy, psychological testing and in diagnosing mental illness (Baharvand, 2012). The demand for mental health professionals especially with clinical psychology background is expected to increase over the next decade. Psychologists who provide clinical psychology services have to be trained in a wide range of techniques and theoretical approaches that equip them with the knowledge and skills necessary to advance the science of psychology, the professional practice of psychology, and people’s general health and well-being.

Knowing that the study strategies of students using college textbooks can be a powerful predictor of performance in the classroom, we examined the extent to which students in different psychology courses reported reading their textbooks. In psychology courses overall, students read on average 27.46% of the assigned readings before class and 69.98% before an exam, which corresponds to previous research. Researchers furthermore found that these percentages were highly influenced by the course in which the students responded. In fact the percentages ranged from 21.21% to only 42.96% before class and from 60.83% to 91.20% before an exam, with significant differences existing between courses. Given that the majority of university students spend less than three hours reading textbook material and that they feel the instructor is responsible for reviewing material during class time, as well as, telling them what is important in the reading, instructors must find ways to encourage more reading by students, even if this involves giving quizzes over reading material.

Historical perspective

Clinical psychologists are experts in the assessment, diagnosis and treatment of a wide range of psychological and mental health issues across the lifespan. They are most often involved in the design and implementation of treatment strategies in settings such as primary care, psychiatric hospitals, community based mental health services and private practice, but also may be involved in research and teaching. Clinical psychologists work in a variety of settings (hospitals, clinics, private practice, universities, schools, etc.) and in many capacities. All of them require these professionals to draw on their expertise in special ways and for different purposes. Clinical psychologists assess and treat people with emotional work, school, or other physical health concerns and chronic conditions like schizophrenia, phobias and depression. Clinical psychologists are usually members of several professional organizations. Like all professions, clinical psychology has both features that it shares with other professions and characteristics that are peculiar to itself (Pilgrim, 2004). Clinical psychology is closely related to medicine as it is quite as closely related to sociology and to pedagogy (Witmer, 1907). The profession faces many challenges including pressure to deliver training to larger numbers of recruits in a more flexible way (Pilgrim, 2004).
The field is often considered to have begun in 1896 (Baharvand, 2012). In fact, early influences on the field of clinical psychology include the work of the Austrian psychoanalyst Sigmund Freud who was the first one to focus on the idea that mental illness was something that could be treated by talking with the patient, and it was the development of his talk therapy approach that is often cited as the earliest scientific use of clinical psychology (Cherry, 2019). While psychology was born as a distinct discipline with the founding of the American Psychological Association in 1892, the birth of clinical psychology as a speciality area occurred four years later in 1896 with the opening of the first psychological clinic at the University of Pennsylvania by Lightner Witmer (1867–1956). In 1885, Alfred Binet, a French scientist and attorney, founded (along with Henri-Étienne Beaunis) the first psychology laboratory in France. Binet and his colleagues were especially interested in developing tests to investigate mental abilities in children.

The first two decades of the twentieth century witnessed tremendous growth in the field of clinical psychology. Clinical psychology in both UK and the US (Pilgrim, 2004) has promoted itself as a science-based enterprise and has used this to establish its professional jurisdiction (Abbott, 1988). Academic psychology in Australia developed from the academic subject called ‘mental philosophy’ introduced in the 1890s by British colonial scholars (Geerlings, Thompson, & Lundberg, 2014). The first applied psychology practitioners were appointed in 1920s and the Second World War created a niche for clinical practice, which stimulated the development of clinical psychological education. Today, psychology undergraduate education is offered at 38, and postgraduate clinical programmes at 30, out of four Australians educational institutions – the majority of which are national, government-supported universities.

Similar with Australia, psychology was first introduced in Indonesia during the colonial era. In 1941, towards the end of colonisation, the Dutch set up clinics and taught psychology courses to teachers and medical students (Geerlings, Thompson, & Lundberg, 2014). The early work of clinical psychologists involved primarily psychological and intellectual testing. Psychotherapy and other treatment services for those suffering from mental illness were conducted primarily by psychiatrists. Most psychotherapy during this time utilized Freud’s psychoanalytic principles and techniques. Research and practice in clinical psychology has found certain approaches to understanding and treating problems may be especially for certain people and problems while different approaches may be helpful for others (Plante, 2010). Many clinical psychologists use psychological tests and procedures to assess or diagnose various psychiatric (e.g., depression, psychosis, personality disorders, dementia) as well as non-psychiatric issues (e.g., relationship conflicts, learning differences, educational potential, career interests and skills).

**Brief history of the DSM system of classification**

It was in 1952 that the DSM (Diagnostic Statistical Manual) was introduced under the title ‘Diagnostic and Statistical Manual of Mental Disorders’ later referred to as DSM-I. It was introduced because the American Psychiatric Association was asked by the American military and healthcare insurance companies, to produce a universal classification of mental disorders in order to standardise health claims. The original listed 108 disorders. Primarily adopting an aetiological rather than descriptive approach to diagnosis, it was characterised by: (1) diagnoses based on theories of underlying psychological cause behind symptoms; (2) heavily influenced by dominance of psychoanalysis and European psychiatry; and, (3) rested on a primary distinction between neurosis and psychosis.

DSM-II moved toward a more descriptive psychopathology in 1968. This move resulted in a decline in psychoanalysis, growth of empirically supported therapies like behaviour modification and lastly the increasing dominance of drug companies wanting symptom based diagnosis to target the development of medication. In 1980, the DSM-III was the turning point in that response to controversies around
diagnosis saw and increase dominance of the bio-medical model in psychiatry. In the DSM-IV, there were introduced five main diagnostic axes from Axis 1 to Axis 5 from disorders of childhood and adolescence to personality disorders to the Global Assessment of Functioning (GAF) scale. In 2013, there were changes made in the DSM-5, where the DSM-IV was criticised for being too complex. The British Psychological Society gave this statement on a draft of the new DSM-5: ‘clearly based largely on social norms, with ‘symptoms’ that all rely on subjective judgements … not value-free, but rather reflecting current normative social expectations.’ This comment was a very important thought for all students of clinical psychology.

Individuals pursuing clinical psychology careers will often find that they will be able to secure employment in a number of different healthcare facilities, such as hospitals and mental health facilities. Depending on their specialties, clinical psychologists might also be able to find employment with a number of other private and government-run organisations. Universities often employ clinical psychologists, for example, to perform research and help steer eager young minds toward clinical psychology careers. Schools, police departments, and military branches are also usually in need of professional psychologists as well. The systems and structures that many people live in do not always help them negotiate these life challenges particularly well, so clinical psychologists often also work indirectly, with carers or families to encourage them to develop a more psychologically satisfactory way of engaging with people in distress. In some cases, the system is the client; hence psychologists may also work with teams, families or communities.

CONCLUSION

A clinical psychologist must first and foremost be a psychologist in the sense that he or she can be expected to have a point of view and a core of knowledge and training which is common to all psychologists. This would involve an acquaintance with the primary body of psychological theory, research, and methods on which further training and interdisciplinary relationships can be built. In summary, clinical psychology is one of the various branches of psychology that aims at helping patients with mental, emotional and psychological disorders better their condition. The disorders that the psychologist addresses include substance abuse, eating disorders, anxiety and depression. Depending with the specialty he or she possesses, a clinical psychologist can render services in various institutions, including hospitals, mental health facilities, police departments, military branches and universities, or may decide to practice his profession privately.

References


The emotionally intelligent school leader: Enhancing adolescents' social-emotional competence

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Adolescence, a period of physical, cognitive, and socio-emotional transition, is a crucial age for development. The child once entering in this phase requires intensive readjustment to school, social, and family life. Several studies suggest that adolescents in schools face mental and emotional problems such as depression, loneliness, stress, anxiety, substance abuse, anti-social behaviour, and suicidality. Social and emotional learning, which involves enhancing social and emotional competencies of students in schools, has been found to be an appropriate way of dealing with such mental health issues. Social and emotional competence refers to the capacity to recognise and manage emotions, solve problems effectively, and maintain positive relationships with others. Evidence suggests that school leaders play an effective role in students' learning and well-being. Keeping this in view, the purpose of this paper is to review how an emotionally intelligent school leader can enhance social and emotional competence among students. The emotionally intelligent school leader can demonstrate repeatedly the ability to solve problems, to adapt to change and to overcome obstacles. They are more likely to create an enriching and conducive environment. They balance the increasing demands and complexities of the role with a positive, optimistic outlook, reflecting aspects of social and emotional competence. Thus, these qualities are apt in the effective development of social and emotional competence in students. An emotionally intelligent school leader, through the instilling of social and emotional competence, therefore, provides a medium in the restoration of many of the mental health problems among adolescents in schools.

Keywords: adolescence; emotional intelligence; mental health; school leadership; social-emotional competence
Eric Erikson (1968) defines adolescent as the period of physical, cognitive, and psychological transition, which makes it a crucial phase of life in the development of an individual. Adolescence involves a shift from the familiarity of primary school surroundings to a secondary school involving unacquainted teachers, buildings, and older students. Any problems in adjusting to these changes can result in the emergence of school refusal, anxiety, maladjustment and other mental health issues (Dabkowska et al., 2011; Greenberg et al., 2000). Adolescent mental health has, thus, been one of the growing concerns for psychologists and educators worldwide.

Research suggests that children with mental health problems perform less well in school and attain lower levels of education compared to other children (Acharya & Relojo, 2017; DeSocio & Hootman, 2004; Fergusson & Woodward, 2002). Studies also show that this relationship holds throughout the early life development – in elementary school (Alexander et al., 1993; Farmer & Bierman, 2002), in middle school (Fletcher, 2010; McLeod & Karen, 2004) and into the post-secondary years (Hunt et al., 2010). These problems are reflected in many ways such as distress and depression (Needham, 2009), emotional and developmental disorders (Staff et al., 2008), and attention deficit hyperactivity disorder (ADHD) (Galera et al., 2009).

Educators have found that social-emotional learning, which involves learning social and emotional competence, helps in the restoration of many of the mental health problems. Social and emotional competence has been found to improve students' academic performance, adaptive social and emotional behaviour, peer relationships, and reduces other forms of antisocial and maladaptive behaviour (Consortium on the School-Based Promotion of Social Competence, 1994; Weissberg & Greenberg, 1998). Enhancing social and emotional competence among students, the school leader plays a significant role. Hence, this paper proposes specific characteristics of a school leader, which can be effective in enhancing social and emotional competence in adolescents. The paper begins with a description of social and emotional competence, shedding light on its various benefits with respect to mental health. The paper, then, discusses the proposed characteristics of a school leader, and how these characteristics play a role in instilling social and emotional competence.

Social and emotional competence

Social and emotional competence is the capacity to use social and emotional aspects of one's life in an effective manner. It helps in the managing learning, forming relationships, solving everyday problems, and adapting to the complex demands of growth and development (Parker & Gottman, 1989). Social competence refers to skills that facilitate interpersonal interactions in the social environment, including the expression and control of verbal and nonverbal communication (Friedman et al., 2003). Emotional competence refers to skills in the identification, regulation, and expression of emotion (Saarni, 1999). Thus, social-emotional competence is defined as cooperative and pro-social behaviour, maintenance of peer and adult relationships, managing aggression and conflict, developing a sense of mastery and self-worth and emotional regulation (Parker et al., 2005). These skills have come out from the research on emotional intelligence (Goleman, 1995; Salovey & Mayer, 1990). A growing body of research suggests that social and emotional abilities linked with emotional intelligence are strongly related to an individual's ability to cope with the demands and stressors of life (Mayer et al., 1999). Emotional intelligence is considered as an essential factor in the quality of social and emotional well-being (Taylor et al., 1999).

Many researchers have found that social and emotional competence has a positive impact on mental health and academic performance (Payton et al., 2008; Zins et al., 2003; Zins et al., 2004). Social and emotional variables, in the context of schools, include positive interaction with teachers, positive representations of self, derived from attachment relationships, emotion knowledge, emotion regulatory abilities, social skills, and non-rejected peer status (Carlton, 2000; Howes & Smith, 1995; Izard et al., 2001; Jacobsen & Hofmann, 1997; O’Neil et al., 1997; Pianta et al., 1995; Shields et al., 2001). Students who exhibit higher social emotional competence attend school more regularly, are less likely to experience emotional distress (anxiety or depression), are less likely to reveal conduct problems such as
substance abuse or violence toward others, and are generally perceived by others as more intelligent and attractive compared to those who are less competent socially and emotionally. It is for these reasons that it is required to understand how social-emotional development plays itself out in the school setting. Students who have limitations in their social-emotional development often demonstrate poor social, emotional and academic success. Students are not only at risk for academic problems due to their mental health issues but often demonstrate difficulties with social skills such as getting along with peers and following school rules, placing them at additional risk for the development of academic difficulties (Wallach, 1994). In order to meet the social and emotional competence of adolescents, different approaches within the school may be needed to help children develop these competencies. It is, therefore, the responsibility of the school leader to provide an enriching environment and to have a positive influence on adolescents' mental health and academic achievement as well.

Leadership and social-emotional competence

Research suggests that leadership is vital to school effectiveness (Marzano et al., 2004). School leadership is second only to classroom instruction, has direct effects on school organisation, school ethos, and staff morale and satisfaction (Relojo et al., 2015), all of which have a direct effect on student outcomes (Geijsel et al., 2003; Leithwood & Jantzi, 2005; Leithwood et al., 2004). Leadership is a social phenomenon, where an individual or set of individuals collectively move forward along a goal path. Researchers define leadership as an interaction between two or more members of a group that often involves a structuring or restructuring of the situation and of the perceptions and expectations of the members (M. Bass & R. Bass, 2008). Leadership is also defined as the ability to inspire confidence in and support among the people who are needed to achieve goals. Thus, leadership is the process that involves interpersonal relationships between the leader and members of the group.

Research indicates a strong association between social and emotional abilities and emotional intelligence, which enables one to cope with the demands of life (Mayer et al., 1999). Emotional intelligence has come to be viewed as an essential factor in the quality of an individual's general emotional and social well-being (Taylor et al., 1999), as well as an important predictor of an individual's ability to succeed in the classroom (Parker et al., 2004; Zeidner et al., 2005). Salovey and Mayer (1990) define emotional intelligence (EI) as the ability to analyse and understand relationships, take others perspective, resolve conflicts, and manage one's own emotions. Goleman (2011) drawing from this description posits that a leader's emotional intelligence has a greater influence on its members and organisation than the leader's intellectual capability. Empirical evidence suggests that EI abilities are linked with positive leadership behaviours at various levels within any kind of group (George, 2000). Recent trends suggest that EI appears to contribute to positive leadership behaviour in several basic ways. Individuals with above average levels of EI tend to have advanced communication skills (often in both verbal and non-verbal forms). This is an essential skill for leaders who need to communicate goals and objectives to subordinates on an ongoing basis. Individuals who have above average levels of emotional and social competency often have above average coping abilities (Parker et al., 1998). The ability to cope with stress is very important for successful leadership; this is the skill that helps a leader generate and maintain enthusiasm, confidence, and cooperation.

An emotionally intelligent leader allows people to build a set of skills and attitude to manage effectively the relationships. It enables an individual to recognize and regulate emotions of her/his own and others as well and to use this skill to manage thinking and behaviours. An emotionally intelligent leader, thus, develops the emotional and relational capacity, which builds a common ground and trust among the group members. Individuals with high EI are perceived as better leaders compared to those with lower EI (Thiel et al., 2012). Goleman and colleagues (2002) have found that there are clear positive relations between emotional intelligence and highly effective leadership and organisational performance. Additionally, leaders who are emotionally intelligent, tend to positively influence others, motivate others by controlling and understanding their own emotions and also create strong relationships with others (Chastukhina, 2002; Feldman, 1999; Noyes, 2001).
Goleman (1998) describes five components of emotional intelligence: self-awareness, self-regulation (or management), motivation, empathy (social awareness), and social skills (relationship management). Self-awareness deals with knowing about one's own feelings and emotions. Leaders high in self-awareness are attuned to their inner signals, recognising how their feelings affect them and their performance. They are attuned to their guiding values, intuit the best course of action, see the big picture in a complex situation, can be candid and authentic, and are able to speak openly about their emotions. Self-regulation entails self-control. Leaders with high self-control find ways to manage their disturbing emotions and impulses and channel them in positive ways. A leader with good self-control can stay calm and clear headed in high stress or difficult situations. Motivation implicates consistent work towards achieving the goals. Motivated leaders are usually optimistic, no matter what they face, even in challenging situations. Empathy involves taking the other person's perspective. Goleman argues that leaders high on empathy are able to attune to a wide range of emotional signals, letting them sense the felt, but unspoken emotions in a person or group. Empathy makes a person able to get along well with people of diverse backgrounds or from other cultures. Social skills, the last component of emotional intelligence, involve relationship management. Leaders who are high in this aspect are able to understand the differing perspectives and find a common ideal that everyone can endorse. They are able to identify the conflict, acknowledge the feelings and views of all sides, and then redirect the energy towards a shared ideal. The components of emotional intelligence, thus, can be viewed as important aspects of leadership. Further, these components, in a leader, play a significant role in developing and enhancing aspects of social and emotional competence.

It has been found that the aforementioned components of emotional intelligence play a role in the prevention and management of behaviour problems in school. Moreover, these aspects can help students become more effective in their communication and solve many of their problems that are leading to problem behaviours (Killick, 2006). In schools, the teacher plays an important role in terms of being a leader. The teacher having authority without being authoritarian is able to tackle the many different aspects of managing behaviour, such as to create the safe and respectful environment that encourages cooperation, to be able to calm flashpoints and to intervene and give assistance to those whose behaviour presents particular and ongoing challenges. The objective is to create a calmer, safer environment for learning. Effective communication skills in teachers reduce the need to rely on sanctions and punishments. These skills and strategies are about helping students express emotions and solve problems appropriately within acceptable limits. In students, it has been found that it is often strong emotions that underlie many behavioural problems. Feelings such as revenge, anger, fear, guilt, shame or jealousy may underlie acting-out behaviour, which in turn may have negative consequences on their mental health as well as the environment. In such a scenario, teachers can find ways of helping the student deal with these complex emotions. It is through behaviour that these emotions are often communicated so it is important to see challenging behaviours as having a function and a communicative aspect. This is helped by a climate where feelings and emotions are frequently discussed. Communication skills of reflective listening and effective feedback are as critical, if not more so than giving praise or sanctions. Further, school leaders who are emotionally and socially competent have a strong sense of self and the ability to understand and manage emotions both in themselves and others. They engage the heart (emotions) and then the mind of key stakeholders as the gateway to gaining support for school improvement initiatives. Such leaders have the ability to develop collaborative learning environments that focus on student learning and empower new leaders within their educational community to assist in the pursuit of provincial and system goals and standards. They also demonstrate repeatedly the ability to solve problems, to adapt to change and to overcome obstacles. These leaders, thus, balance the increasing demands and complexities of the role with a positive, optimistic outlook – all reflecting aspects of social and emotional competence.

Conclusion

Mental health problems among adolescents are widespread and constantly on the rise. Many of these psychosocial problems are of temporary and often ignored. The many transitional phases that take
place such as the transition from childhood to adolescence and moving from early elementary to middle school or moving from high school to college can present new challenges for such children. Several policies, programmes and studies have emphasised serious concerns for positive adolescents' mental health, therefore, need of the hour. Increasing numbers of adolescents are suffering from mental and emotional stress, depression, loneliness, anxiety, suicidal attempts and adopting behaviour such as bullying and substance abuse. They adopt risky behaviours primarily because they lack certain skills to manage the risky challenges. Social and emotional competence is, therefore, an undeniable way to prevent adolescents from mental illnesses and to enhance their social, emotional and physical well-being. Social and emotional competence is the capability to help an individual to manage social and emotional aspects of one's life such as cooperative and pro-social behaviour, maintenance of peer and adult relationships, managing aggression and conflict, developing a sense of mastery and self-worth and emotional regulation. These social and emotional skills can be provided through a variety of diverse efforts and the role of school leaders is one of them. School leaders that are high on emotional intelligence can be said to be effective in instilling social and emotional competence in students, and thus, groom them for many of the mental health issues that they face.

Such leaders involve maximising human and organisational capabilities; facilitation of multiple levels of transformation (self and others); group development; democratic, developmental, and transformational activity based on equality and growth; curriculum development; involvement; and innovation. They are socially and emotionally competent and are able to enhance the mental health of students by instilling those social and emotional skills among them. They are more likely to create an enriching and conducive environment. Therefore, a school leader high on emotional intelligence, through the instilling of social and emotional competence, provides a more promising approach to overcome many of the unforeseen challenges and mental health problems.

References


The art of healing: Book review of ‘J.L. Moreno and the Psychodramatic Method’

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The growing interest in psychodrama, in its origins and applications, are the main reasons for the publication of Jacob Levy Moreno’s first volume on Psychodrama (1946). According to him: ‘The growth of practice in psychodrama and group psychotherapy has been so rapid since the start of World War II that a careful evaluation of the theoretical and practical issues can no longer be postponed. Their use, even in their most diluted forms, is fraught with dangers in the hands of the uninformed and unskilled.’

Psychodrama is a method of group and individual psychotherapy in which people are helped to explore their psychosocial issues by using sensitively guided enactment and a wide range of action-based techniques. During a psychodrama session, the person in focus recreates significant events, relationships, or internal processes in order to explore their impact, integrate new responses, and gain insight, healing, and growth (Baim, 2010, pp. 1–3).

Since its introduction in the 1940s, the application of psychodrama, as well as its theoretical implications, have been far-reaching. Fast forward in 2019, the incisive book *J.L. Moreno and the Psychodramatic Method* is written by John Nolte (2019), a respected trainer and practitioner of psychodrama in the US. He trained both with the creator Dr J.L. Moreno and his wife Zerka. His experience in the method of psychodrama and its application in different settings spans some 50 years.

The book is an easy read and is full of examples of different aspects of the psychodrama process (Dutton, 2019). It takes the reader through the basic component parts of a psychodrama session and breaks them down into a description as well as examples which include the areas of initial interview, scene setting, soliloquy, role reversal, the double, the mirror, the empty chair, and concretisation.

There are other parts also described of the method of psychodrama which the reader might want to use on an individual basis to enhance or add to a therapy session or use in a training event to add a new way of looking at a particular issue/dilemma or highlight a specific concept/idea in a training session. We are, after all, thinking, feeling, physical, social, and spiritual beings – which Dr J.L. Moreno was most interested in in his work.
John Nolte works through the stages of a psychodrama over the next chapters moving through the warm up phase and creating the drama (Cruz et al., 2018). Each part has good descriptions of the specifics of these areas of a psychodrama as well as excellent descriptions of the director (therapist) interviewing or guiding the protagonist (client/patient) during a particular phase of the developing psychodrama. Often in psychodrama the old saying don’t just tell me show me is heard- here John Nolte is showing us through his writing how a psychodrama is and what it looks like through his description of such things as the first scene or future projections.

The author looks briefly within this chapter on creating the drama about specific issues such as working with childhood abuse scenes, expressing anger, dreams, and role training. In Chapter 5, he describes and gives voice to four protagonists and also of the writer himself as an auxiliary of seven psychodrama’s they and him have been involved in. Life is given to each session which gives the reader an insight into how a psychodrama session has an effect upon the protagonist.

The chapter which delves beyond psychotherapy shows how psychodrama techniques can be used outside of the traditional therapy space which include role playing and its use in education which I have often used within schools and in particular the use in educating and preparing trial lawyers in the US at the Trial Lawyers College. John Nolte has a long association with this since 1994 along with Don Clarkson. During his time there it is estimated that three to four thousand trial lawyers have had some experience of psychodrama. Meanwhile, the last couple of chapters look at psychodrama theory, its history, and the aspirations of Dr J. L. Moreno and how his methods permeate across different areas which include therapy, social science, and spontaneous theatre.

The book seeks to offer a nuanced perspective to that of the classic psychodrama session: warm-up, action, sharing and the subsequent processing. Chapters on psychodrama in action cover discussions on the innovative use of psychodrama in the treatment of depression, and the relationship of the discipline to other constellation of psychotherapies. Nolte’s book is a welcomed addition to the text’s on psychodrama and will I think encourage the reader to go read some more as well as try out the different aspects of this creative and dynamic therapy.

References

https://doi.org/10.1002/0470479216.corpsy0721

https://doi.org/10.3389/fpsyg.2018.01263


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Open access publication of Psychreg
ISSN: 2515–138X

www.pjp.psychreg.org