SCHOOL OF PSYCHOLOGY NEWSLETTER: CONVERSATIONS IN PSYCHOLOGY

Comments from the Editor

Welcome to issue six of the newsletter! The last couple of months have given us all a lot to deal with and think about. Adapting to our new normal, our priorities have changed and our routines with them. At Arden we have seen a beautiful mix of solidarity and support, of humour and of humanity. I am proud to share some of the things that our team have been up to regarding their self-care and creative outlets during these challenging times. It is wonderful to peek behind the job title or STU number and get a glimpse into what makes us all individuals, especially when that human touch is so appreciated right now.

This June issue begins with some welcomes as we open our arms to new members of the team, before leaping into some fascinating articles from staff and students alike. Health Psychology is our career spotlight, and Dr Baber Malik is featured in our Staff Profile.

ARDEN PSYCHOLOGY

Follow us on Twitter!

@ArdenUniPsych

Finally, though the world is changing around us as we speak, I want to echo the sentiments of my colleagues by saying that we are committed to ensuring that your experience with us is a stable and consistent one, and that you do not need to put your dreams or aspirations on hold. We have you covered, and we'll be with you every step of the way. Stay safe and Go Get Going!

If you would like to contribute to the next issue of the newsletter, please contact myself at krooney@arden.ac.uk for more information.

I welcome any feedback and content suggestions also

Kieron Rooney, Editor.

Page 2: **School of Psychology News**

Page 4: Career Spotlight: Health Psychologist

Page 5: Public Health Issue: Chemsex by Natalie Quinn-Walker

Page 7: Getting to Know the Psychology Team: Dr Baber Malik

Page 8: Children, Young People and Families Division Conference by Dr Sue Pattison

Page 9: Raising Our Spirits During Lockdown!

Page 11: The Question That is Always Asked, But Rarely Answered: The Primary Cause for Sexually Predatory Behaviour by Alicia Hughes

Page 13: Bad Seeds? The Tragedy of the Unnurtured Child by Sarah Newlyn

Page 15: Psychological Intervention as a Part Of Palliative-focused Care in Motor Neurone Disease/Amyotrophic Lateral Sclerosis by Ariel Mai Maria Helgudottir

Page 17: Flexibility and Adaptability of Primary Classrooms: Interventions and Strategies to Support Learners with Insecure Attachment by Hannah Sharrad

Page 19: Dr Imose Itua – COVID-19 Webinar

SCHOOL OF PSYCHOLOGY NEWS

WELCOMES

We would like to extend the warmest of welcomes to the new additions to our team over the last few weeks. Arden University is a dynamic and exciting place – now more than ever. Putting names to faces, as well as some other important information (I will be sure to check Konstantinos has had enough sleep!), here are some of our newest family members at Arden!

Daniella Nayyar

Areas of academic/ research interest: Applied social psychology - I am interested in social identity and how that impacts intergroup perceptions and biases. I am also interested in any research targeting closing the BAME gap in higher education.
Favourite food: Burgers or burritos
Favourite holiday destination: Athens, Greece
Worst habit: Starting ambitious jigsaw puzzles and taking months to finish them. There is often a part done puzzle taking up room somewhere.
Best quality: I have a talent for recognising patterns, it's why I love instrumental movie soundtracks so much. The only problem is this talent does not often translate to useful skills.

Konstantinos Arfanis

Areas of academic/ research interest: I am a Social Psychologist and my particular interests are Identity, Emotions, Gender, Work Life Balance, Patient safety, and Masculinity.
Favourite food: I consider myself a citizen of the world when it comes to food. I love to try new flavours from all over the world, but I have a soft spot for spicy (flavoursome as well as chilli-hot) food and Greek cuisine.
Favourite holiday destination: The Alps in the winter, the Greek islands in the summer.
Worst habit: I tend to sleep less than I should. I often get carried away reading poetry, listening to music or watching movies.
Best quality: I am a good loyal friend.

SCHOOL OF PSYCHOLOGY NEWS

Andrew Holliman

Areas of academic/ research interest: Developmental Psychology; Psychology of Education; Teaching and Learning; Literacy Development; Others – Adaptability, Motivation, Engagement, Achievement, Wellbeing.
Favourite food: Crispy aromatic duck in pancakes.
Favourite holiday destination: Anglesey – certainly not because of its sunny weather, but it has deep sentimental value to me and stirs up fond memories of my precious family.
Worst habit: Ask my wife! Some say I struggle to relinquish control…
Best quality: I think I genuinely try to be nice to people and make them feel happy, positive, and of value. I despise rudeness and injustice wherever I see it. I try my best to help others – probably why I ended up in the education sector!

Beth McManus

Areas of academic/ research/ applied interest: Emotional labour; Volunteer Experience; Sustainable leadership - my wider role is as a freelance organisational psychologist and illustrator.
Favourite food: Lancashire Oven Bottom Muffins (preferably Sheldon's)
Favourite holiday destination: Amsterdam
Worst habit: Saying yes to things without considering the impact on my life/ work balance!
Best quality: Connecting the dots – helping people/ teams/ projects to spot creative ways to problem solve and move things forwards.

ARDEN UNIVERSITY

CAREER SPOTLIGHT : HEALTH PSYCHOLOGIST

What is the role of a Health Psychologist?

Health Psychology is a growing discipline that involves applying psychological theory and knowledge to promote well-being and physical health in society. Health Psychologists are well-positioned to give insights to institutions such as the government, or businesses, in interventions aimed at improving people's health. Remember Change4Life? This is a large campaign that involved many Health Psychologists, in consultation with the government, to help improve physical activity levels and eating-habits within the UK. Additionally, Health Psychologists can help people with the psychological and emotional facets of physical health, such as stigma and comorbid anxiety and/ or depression in those with a chronic health condition, for example. Many Health Psychologists are employed within the UK in the NHS as smoking or weight-loss experts, assisting people in improving their lives! A good way to conceptualise Health Psychology is to think of it as bridging the gap between physical and mental wellbeing. A doctor or nurse may be knowledgeable regarding the physical aspects of health, and a Clinical Psychologist may be adept at addressing the mental aspects, but a Health Psychologist can marry the two concepts and deliver holistic care.

What is the relevance of my Psychology degree?

A degree in Psychology is of direct relevance to an MSc in Health Psychology due to it equipping you with key skills that will be further developed during your postgraduate study to become a Health Psychologist. Having BPS accreditation is a requirement for enrolment on a Health Psychology MSc, which is a crucial step in becoming a Health Psychologist. A Psychology degree will hold you in good stead as it introduces you to many key aspects of applied psychological work, such as: Working with a variety of data, being able to present findings, being able to source appropriate information, being able to evaluate effectively, and being able to work independently or as part of a team to a high standard. These will be further built-upon during your postgraduate study, but in a far more applied way!

How do I become a Health Psychologist?

"Health Psychologist" is a protected term, meaning that only someone who has completed the appropriate level of training and education can call themselves a Health Psychology. Firstly, you will need Graduate Basis for Chartered Membership (GBC), which is achieved by completing a BPS accredited degree (BSc Psychology, for example) or conversion course (MSc Psychology, for example).

This will then need to be followed by a BPS accredited Masters in Health Psychology. At this point you are Stage 1!

Then you will need one of the following, in order to complete your training:

- The BPS's qualification in Health Psychology Stage 2 – this is a predominantly work-based qualification and is an independent route for those already in a health-based field.
- A BPS accredited Doctorate in Health Psychology – this would involve applying for a Doctorate at a university and would comprise placement-based work alongside on-campus study and research.

The British Psychological Society Accredited

After having completed one of these, you will be a Health Psychologist!

Public Health Issue: Chemsex

Natalie Quinn-Walker: Lecturer in Healthcare

Although drugs and alcohol have been often linked to hidden sexual activities for decades, the introduction of new drugs such as Black Mamba and the role of technology are enabling people to arrange Chemsex parties easier. Chemsex is defined as a sexual activity while under the influence of drugs; these include mephedrone and crystal meth. Although these drugs used are illegal, Know the Score (2016) states suppliers of mephedrone within large cities such as London are using bath salts, plant food to ensure they are undetectable but could potentially result in lasting damage to internal organs. GBL /GHB is readily available in industrial solvents, paint stripping chemicals; this creates a sedative, potentially resulting in the loss of consciousness.

Technology is providing new pathways for people to meet others, develop relationships, as well as providing a platform for people to arrange Chemsex parties. Chemsex is a concern, as it is considered to be a new threat proposing harm to society in-particular men who do not define themselves as gay or bisexual but engage in sex with men (MSM). In Chemsex, multiple partners engage in sexual activity, often without knowing one another before meeting at the party. Therefore, creating further issues, to track and diagnose all those who may be infected. Bain et al. (2016) found that 83% MSM who were HIV positive from their study, had engaged in condomless sex at Chemsex parties.

The introduction of pre-exposure prophylaxis, also known as PrEp, was considered a positive move to reduce HIV. I Want PrEp Now (2016) states that PrEp has a 90% success rate. Therefore, it could be recommended for those engaging in high-risk sexual activity; however, this does not reduce the risk of other STIs. The current rate to purchase PrEp online is £44, creating inequality within the community, leaving those who are unable to afford it, not have access to a long-term HIV prevention plan (I Want PrEp Now, 2016).

A comparative need could be a possible method to tackle Chemsex within the MSM community, thus, reducing STI rates There is a need to influence the community to change their behaviours. The need for new services and potentially more national coverage, such as media intervention, could be beneficial. To support the MSM community, several sexual health centres and charities have set up, MSM friendly drop-in sessions or sessions. This had led to the development of strong connections with clients, encouraging them to engage with sexual health services, counselling, and other supportive services. Nevertheless, adding new services may not immediately result in an increase in uptake on the services. Possible use of media intervention providing an education platform, maybe more suitable, addressing the potential risks. One of the main concerns that Bourne et al. (2014) mentions that there are concerns regarding those who are engaging in high-risk sexual activity, purposefully infections others with STIs, also known as HIV Roulette or Gift Giving, where high-risk sex is performed without the use of a condom.

Public Health Issue: Chemsex

To tackle this Public Health issue, a more in-depth health needs assessments are needed to address the steady increase of rates of Chemsex, in-particular in areas of London, including Lambert, Southwark, and Lewisham (Bourne et al., 2014). There has been some success with the introduction of free STI self-sampling kits, which became available online, resulting in the distribution of 9,456 kits in London (Bourne et al., 2014). However, there has been no apparent connection, linking this to the increasing prevalence of Chemsex within the city. London Friend (2017) reports that 35% of MSM from Lambert, Southwark, and Lewisham are accessing drug and alcohol support. Many people travel vast distances to attend these parties across the UK, as they do not only occur in London. Therefore, creating a problematic health issue, as its increasingly difficult to track and engage the participants. Not all participants wish to disclose their involvement out of fear of criminal charges and the stigmatisation associated with high-risk sexual activity. Chemsex has become one of the Public Health England's priorities, due to the nature of high-risk sexual activities, there is an increased risk of STI's, violence, and sexual abuse due to the lack of awareness and inability to consent (McCall et al., 2015). Thus, the need to review not only the behaviour of the individual but also the economic and social aspects affecting the individual resulting in high-risk activity (Marmot, 2007). Hence The Public Health England (2016) vision that all MSM have a healthy life with an action plan to address all aspects within their wider determinants of health. Moving forward, rather than creating scare tactics, which may cause further public health issues, an introduction of non-didactic education materials would be appropriate (Palamar & Halkitis, 2005). Therefore, encouraging education could impact positively on their health. Thus, enabling them to make safer, healthier choices.

Key References

Bourne, A. , Reid, D. , Hickson, F. , Rueda, S. & Weatherburn, P. (2014). The Chemsex study: drug use in sexual setting among gay and bisexual men in Lambeth, Southwark and Lewisham. [Online]. Available at: <http://sigmaresearch.org.uk/files/report2014a.pdf>.

London Friend. (2017). *Monty thoughts:The Chemsex Study* [Online]. Available at: <http://londonfriend.org.uk/montys-thoughts/the-chemsex-study/>.

Marmot, M. (2007). Achieving health equity: from root causes to fair outcomes. *Lancet, 370*, 1153-1163.

McCall, H. , Adams, N. , Mason, D. & Willis, J. (2015). What is Chemsex and why does it matter? *The BMJ, 1,* 10-11.

Palamar, J. & Halkitis, P. (2005). A qualitative analysis of GHB use among gay men: Reasons for use despite potential adverse outcomes. *International Journal of Drug Policy, 17*(10001), 23-28.

Public Health England. (2016). *Inequalities in sexual health; Update on HIV and STIs in men who have sex with men in London* [Online].

Public Health England. (2014a). *Promoting the health and wellbeing of gay, bisexual and other men who have sex with men. Initial finding.*[Online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/339041/MSM_Initial_Findings__GW2014194.pdf

Public Health England. (2014b). Sexually transmitted infections and chlamydia screening in England 2012. *Health Protection Report, 8*(24).

Please contact the editor, Kieron Rooney (krooney@arden.ac.uk), for a full list of references.

GETTING TO KNOW THE PSYCHOLOGY TEAM: DR BABER MALIK

Can you summarise who you are and your role at AU?

My Name is Baber Malik and I am a Psychology lecturer at Arden University. I completed my PhD in Clinical Neuroscience from Sheffield in 2015 and have since been working at various University institutes, as Research Associate and Fellow, on projects related to dementia. I am currently the module leader and tutor at AU for Introduction to Biological and Cognitive Psychology and Individual Differences and Abnormal Psychology (currently authoring on this module also). My role as ML amongst teaching involves oversight and managing module related queries. I also supervise on the dissertation module for Psychology students.

Can you tell the readers about your main research interests?

My background as a researcher is clinical neuroscience, however, this topic is quite broad. So to narrow it down, my research interests are mainly focused on dementia related studies and as a quantitative researcher I am all about numbers and statistical modelling. I have been involved in several research studies, from offender health, social care and policy to diagnostic and clinical research that have focused on early diagnostic tools to development of care pathways, and more recently in being able to measure integration in devolved healthcare systems in Greater Manchester. The main interest in these studies being the development of tools in the diagnosis and treatment of dementia in the context of cross cultural and individual differences.

If you had to choose just one, what is your favourite academic experience?

My favourite academic experience is so far with AU, specifically being a part of the module writing/authoring for the Individual Differences and Abnormal Psychology module. This is a first time experience, and although very challenging, it is really an eye opener for me in terms of being able to develop content that is both engaging and exciting to learn. Something I will no doubt continue to learn about during the process.

What is your favourite thing about being part of AU?

This is a tough one, but my favourite thing about being part of AU, is working with the Psychology team, not only is everyone super friendly and approachable, even though it is only via e-mail for now, but they all have a similar attitude to wanting to learn more and improve constantly. This is something which I admire in the team for wanting to grow all the time, and of course needless to say it is motivating and inspiring.

CHILDREN, YOUNG PEOPLE AND FAMILIES DIVISION CONFERENCE

Dr Sue Pattison, Lecturer in Psychology

I've had the pleasure (and hard work) for several years of taking a key role in setting up the annual Children, Young People and Families Division conference for counsellors, psychotherapists and play therapists. The February 2020 Conference 'Building Resilience and Self- Esteem' challenged me in my role of Joint Chair of the British Association for Counselling and Psychotherapy (BACP) CYP&F Division. What were the challenges? The first was to source excellent key presenters, one to open the conference and another to close it, and then invite several workshop presenters to provide high quality experiences for their participants. This is primarily a practitioner conference aimed at providing CPD, support and networking for the Division's members.

Building resilience and self-esteem is an integral part of counselling children and young people and supporting their families in a range of contexts. This often extends to working with parents or carers as their self-esteem and confidence can impact how they manage relationships and boundaries with their children. In addition, where there are issues with one young person in a family, siblings may need strategies for building their self-esteem and resilience. The conference included a real time webcast recorded to become part of BACP's CPD Hub. The conference venue was the excellent St Paul's at Aldersgate, London.

The day went well, with excellent attendance and great networking. The key speakers and workshop presenters provided information and experiential work on ways to help children build emotional resilience and trust, through age appropriate conversations, gaining an understanding of how to help young children through the grieving process, developing confidence to include parents and families in interventions with children and young people, where and when it is appropriate, particularly around building resilience and self-esteem, exploring the rationale behind involving family members in the therapeutic relationship. Discussion also focused on learning how a counselling approach can support children and young people in care, understanding the ways that counselling can build resilience and self-esteem in children and young people who may have experienced multiple moves within the care system and some of the adaptations that are often beneficial when working with people with autism in the therapy room. We learned how to work therapeutically with children and young people with ASD, how to support schools and strengthen families and were introduced to focusing work with children.

Raising our spirits during lockdown!

With Mental Health Awareness Week running from the 18th to the 24th of May this year, we thought it a wonderful opportunity to highlight and celebrate some of the things that the team have been up to whilst enjoying some well-deserved rest.

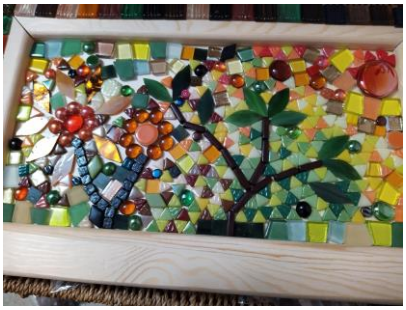
Taking out time for ourselves is a very important factor in our wellbeing, especially in light of the current pressures on our mental health due to the lockdown measures in place across much of the globe. Something as simple as a quiet walk can be hugely impactful, so feel free to take inspiration from the following collection of the team's exploits during their downtime. It has given us much to talk about, share, and feel grateful for.

Be sure to reach out with your own arts and crafts, hobbies or passions, or top tips and techniques for spending some quality time on your mental health – you may even be featured in a future issue!

Sophie and Gail have been getting crafty! Creating hearts to be given to those in hospital, and butterflies to be placed in local parks as a sign of kindness and solidarity to passers-by.

For the artists out there – Holly is becoming a budding watercolourist. Beautiful floral pieces, and a tranquil hobby, too!

Fiona Lintern has been getting creative with mosaics. Incredibly tactile and summery – very suited to the gorgeous weather we're having!

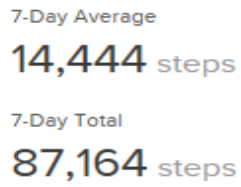


Out and about

We have been blessed with some periods of beautiful weather here in the UK, and so getting out and enjoying nature has been a wonderful way to spend the time for many of us.

This can be to cycle, run, go for long meandering walks, or to scope out some good photography opportunities!

Our resident stats-expert, James, has been cycling up a storm. 42km in one journey - it takes a statistician to think of long-distance cycling as a leisure activity!



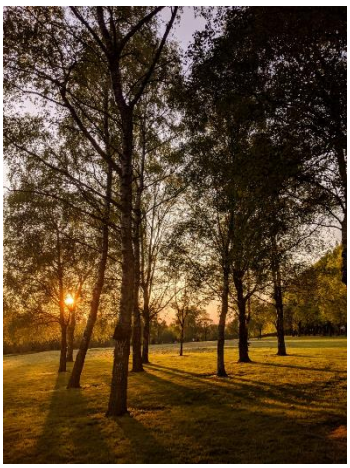
Yours truly (Kieron) has been getting more active – walking every day and even taking up running!

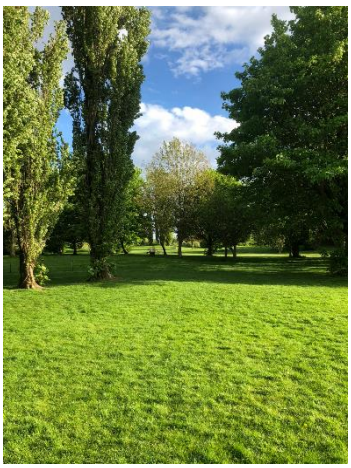
Raising money for a fantastic cause!

Our Deputy Programme Team Leader for Psychology Sophie Ward (@SophieMBPsS) has been raising money for @MindCharity over the last few weeks by sewing non-medical masks for family and friends. Stylish and safe!

Just act natural!

Photo credits for the following go to Holly, Sophie, and Gail. Beautiful photos!





CONVERSATIONS IN PSYCHOLOGY Issue 6, June 2020

The Question That Is Always Asked, But Rarely Answered; The Primary Cause For Sexually Predatory Behaviour

By Alicia Hughes, BSc Psychology Student

Primarily, what characteristics are held by a sexual predator? Unfortunately, the sexual predator is a chameleon; they do not often stand out in the crowd and often present as 'normal'. Brown, Pillinger and Walker (2018), defined three types of sexual predators; the 'ostensibly normal', who present as emotionally stable, the 'emotionally inadequate', who often lack self-confidence and portray loneliness and lastly, the 'sexually deviant', who appear to be egotistical and pro-offending. This article explores the possible causes behind the behaviour of sexual predators, through the contemplation of a biological/evolutionary approach and a psychosocial approach.

Born to be a sexual predator?

Sexually predatory behaviour can be observed in other species, of which share multiple behaviours with humans. When this animal behaviour was analysed, it was explained to be the drive to pass on genes and to increase reproduction (Declue, 2005). This drive to reproduce could be linked to the hormone testosterone. Several studies have been undertaken on the level of testosterone, in conjunction with the desire to reproduce. Rosenzweig (1996) researched into additional levels of testosterone and discovered that higher levels had no influence upon the compulsion to copulate. However, Ramsland and McGrain (2010) highlighted that a person with a higher sex drive may actually be suffering with a problem in their central nervous system, which could result in them using all methods to try and satisfy their sexual needs.

Although DeClue (2005)'s research has demonstrated that often rapists are not actually sexually deprived, or have a shortage of sexual partners, predatory behaviour may be considered an addiction. It is the pleasure chemicals released from the brain, which can result in the individual requiring further stimulation (Ramsland & McGrain, 2010). Even so, does this need for additional stimulation provide an adequate reason for sexually predatory behaviour? It was concluded that testosterone provided the option of sexually predatory behaviour, but it was something else that decided whether to engage in it (Rozenzweig, 1996).

The interrelation between psychosocial factors and sexually predatory behavioural

Many childhood tribulations can be considered to be an influence on sexually predatory behaviour. Veeraraghavan (1987) discussed how the theory of socialisation explains rape through absent fathers, sexually promiscuous fathers, overprotective mothers, frequent casual relationships and alcohol and drug dependency. Simultaneously, the trauma theory is also fundamental in understanding how childhood sexual abuse anxieties are temporarily suppressed, during the act of rape, hence the creation of a loop of behaviour (Veeraraghavan, 1987). However, it is important to question how these elements have impacted the behaviour of the individual and their thinking.

Predatory behaviour can provide the individual with the opportunities needed to overcome masculine anxieties and a way to counteract a lack of wealth, status or perceived attractiveness (Wilson Quarterly, 2000). If the predator believes they have been hurt by women, this behaviour can be interpreted as an act of revenge. Ramsland and McGrain (2010) discussed the case of Leonard Fraser, who admitted to raping Julie Turner, because she had rejected him. Following a series of rapes, Fraser believed the women had taken pleasure in the sexual activity and held their hands afterwards (Marriott, 2013).

In contrast, Veeraraghavan (1987) argued that these behaviours were the result of low intelligence, of which can be linked to the low intelligence level of Fraser. However, a similar hatred for women can be seen in the case of Jerome Brudos, who did not have a low intelligence; his crimes all linked back to hating his mother and achieving revenge (Ramsland & McGrain, 2010). He also mutilated the bodies and expressed no guilt or remorse for his crimes (Marriott, 2013). It is this need to power, interlinked with feelings of inadequacy, that may lead to sexually predatory behaviour. Wilson (2000) discussed how an overprotective mother can lead to the desire to humiliate women and assert power.

This can be linked to Freud's Oedipus Complex, in which the son has oral, anal and urethal fantasises towards his mother, with the desire to take his father's place in the couple (Jakovljev & Mata~i, 2005). Klein's (2020) interpretation of the Oedipus Complex may provide an explanation for sexually predatory behaviour, in how she describes that some children do not form a resolution to the Oedipus Complex and continue to hold a severe superego or even a destructive superego. Veeraraghavan (1987) discussed how there is an alternative form of superego that can be found in sexual criminals, of which allows violence and does not resist sexual urges. This destructive superego may be what leads to the sexually predatory behaviour.

The interrelation between psychosocial factors and sexually predatory behavioural

Although there is evidence to support a biological/evolutionary explanation of sexually predatory behaviour, I propose that a psychosocial approach can provide a more substantial interpretation. In the cases of both Fraser and Brudos, both the trauma theory and the socialisation theory can be applied with significant relevance. Although there is some deliberation of a problematic nervous system and the influence of additional testosterone, the evidence is limited and requires further investigation. Justifiably, in order to identify the primary cause of sexually predatory behaviour, I suggest that each specific case would need to be studied for psychosocial explanations.

If you have been affected by the topic of discussion in this article and feel you need support, you can contact the following organisations:

The Survivors Trust on **08088 010 818**
Live Fear Free 0808 80 10 800/ (text) 07860077333
Male Survivors UK on 07491 816 064.

For a full list of references, please contact the editor at krooney@arden.ac.uk

ARDEN UNIVERSITY

Bad Seeds? The Tragedy of the Unnurtured Child

By Sarah Newlyn, BA (Hons) Criminology & Human Psychology Student

Twenty-seven years after the murder of two-year-old James Bulger, the mention of his murderers' names still provokes hatred and vitriol in a large section of society. Robert Thompson and Jon Venables were just ten years old when they committed their terrible crime, a fact which undoubtably added to the horror expressed by people as they struggled to come to terms with this most baffling phenomenon – children who kill. The Press brandished the pair 'monsters', and 'evil', but the psychological wellness, or otherwise, of these two young boys was left virtually unexamined at the time, and the question of 'why?' went unasked, and unanswered.

Is it possible that abuse or neglect in their own lives could have played some part in altering normal development in these young minds, and could this have rendered them more likely to commit such a dreadful act?

While it is (thankfully) rare, the crime of Thompson and Venables is far from an isolated case. In fact, there have been almost 400 children convicted of murder in the UK over the past two decades (Telegraph, 2016). In most cases where the convicted person is a child, the judge upholds an anonymity order, and they remain unidentified, but there have been cases in which the decision has been taken to release the offenders' names, and a look into the backgrounds of these children provides some interesting insight, with a troubling pattern of abuse and neglect emerging.

Both Robert Thompson and Jon Venables had experienced a large amount of neglect in their young lives. Robert was one of five brothers, the older of whom were known to bully the younger children relentlessly. Their father left them, and their mother was a violent alcoholic. Jon had a younger sibling with learning difficulties, and his parents, who were separated, both suffered depressive illnesses, leaving Jon and his sister to their own devices much of the time. It was noted by teachers that Jon's behaviour was problematic, and he exhibited many signs of mental disturbance (Smith, 2017). On examining another infamous case, from 1968, that of Mary Bell, the 10-year-old girl who killed two toddlers, we find that she had been sexually abused, and was the daughter of a prostitute (Telegraph, 2016). Kim Edwards, the 15-year-old who murdered her own mother and sister, had previously been taken into care after her mother had hit her, and had attempted suicide at least once. She reported that she felt "unwanted, unloved and cut adrift" (BBC, 2017). And so the list goes on.

Research has shown that early childhood abuse and neglect has a devastating effect on neurological development. Brain scans reveal a marked difference between the brain of a child who has not experienced abuse or neglect, and one who has – abused, neglected children have noticeably smaller brains, as well as severe underdevelopment of the cortex (Perry, 2005). Significantly, the types of behaviours that this type of damage can illicit include "poor impulse control" and "episodic aggression" (Hart, 2012).

Of course, not all abused and neglected children will become young murderers, or perpetrators of any other violent crime, but it is worth noting that a large number of children who commit murder suffer from neuropsychological abnormalities, and that all have experienced extremely troubled homelives (BMJ 2001). But all too often children experiencing this kind of early trauma are not identified until after an event which brings them onto the radar of the criminal justice system, despite the fact that there are usually clues far earlier, such as behaviour issues in school. With careful management at an early enough stage, before the damage becomes irreversible, these vulnerable children can be helped. Repeated exposure to appropriate care, love and affection can help to influence the altered parts of the brain, and begin a process of healing (Perry, 2005).

Early intervention is therefore essential, but it needs to be effective, even if this means the removal of the child from the home. Admittedly, the care system is already over-burdened. In England alone, there are over 78,000 children in care, of which 63% have been placed there due to abuse or neglect (Department for Education, 2019). Many of these children are placed with foster families, but funding cuts which have been made in the sector are having a profound effect upon outcomes for these children. Over 53% of foster carers in a recent survey felt that funding cuts had impacted both the quantity and quality of training, and over 65% felt there had been a negative impact on their ability to access support services (The Fostering Network, 2016). It is vital that investment is made in funding for recruiting enough foster carers, and for providing them with adequate and meaningful training and support, so that they have the tools needed to kickstart that healing process, and give these children a chance.

A child may commit a ‘bad’ act, but that does not make them bad at their core. Love and nurture should be a basic right for all children. Without it, they cannot develop into loving and nurturing people themselves, and the cycle, sadly and inevitably, is repeated. Children cannot always find words to tell us what they are experiencing, but their behaviour will always be telling a story, and we must listen. In the words of Annette Breaux, “Nine times out of ten, the story behind the misbehaviour won’t make you angry. It will break your heart.”

References

Cann, R. & Lawson, K. (2016). *Cuts – the view from foster carers.* The Fostering Network. Available from: https://www.thefosteringnetwork.org.uk/sites/www.fostering.net/files/content/c uts_report.pdf

Department for Education. Children looked after in England, year ending 31 March 2019. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/att achment_data/file/850306/Children_looked_after_in_England_2019_Text.pdf

Evans, M. (2016). *What happens when children kill?* The Telegraph [online]. Available from: https://www.telegraph.co.uk/news/2016/04/07/what-happens-when-childrenkill/

Perry, B.D. (2005). *Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture*. Available from: https://www.childtrauma.org/brain-dev-neuroscience

Smith, D.J. (2017). *The Sleep of Reason*. London, UK: Faber & Faber Ltd.

Wright, O. (2017). *Kim Edwards: The girl who killed her mother and sister.* BBC. Available from: https://www.bbc.co.uk/news/uk-england-lincolnshire37648194

Psychological Intervention As A Part Of Palliative-focused Care In Motor Neurone Disease/ Amyotrophic Lateral Sclerosis

By Ariel Mai Maria Helgudottir, BSc Psychology Student

ALS is a progressive (often rapidly) and fatal neurodegenerative disease affecting both upper and lower motor neurons (Oster & Pagnini, 2012), while sparing the sensory neurones, the autonomic neurones, and neurones that innervate the sphincter muscles (Howard & Orrell, 2002). The eye muscle movement is affected in much later stages, which leads to a total locked in state (Leigh et al, 2003). It presents as muscle atrophy and weakness, progressive paralysis, dysphagia, dysarthria and progressive respiratory failure, which is usually the cause of death (Yedavalli et al., 2018). In the most patients it presents first in the limbs, but more rarely it has a bulbar (brainstem) onset (Leigh et al., 2003). ALS is in some cases associated with frontotemporal lobes degeneration (frontotemporal dementia) (Mora et al., 2013; Cimbolli et al., 2019). Life expectancy is on average 3 years from onset, though the progression or symptoms appearance varies among patients (Oliver, 2014).

Currently there are no curative treatments, and the only approved medicines lengthen life for few months (Dharmadasa & Kiernan, 2018), so the focus of treatment is improved quality of life, symptom focused intervention and preservation of autonomy as long as possible, so the patient is often referred to a multidisciplinary palliative team since the diagnosis (Leigh et al., 2003; Panagiotopoulos, 2019). A psychologist is often a part of it and has a very important role in all the stages of the disease both for the patient, and the family as well as for the other specialists in the team. Due to the nature of ALS it's reasonable to assess the patient's and caregiver's mental health (Pagnini et al., 2010) to improve support in coping with the disease which includes evaluating the illness parameters, cognitive state and presenting coping strategies (Real et al., 2014; Matus et al., 2012).

How to Communicate Diagnoses

Communication of the diagnosis can be traumatic and cause uncontrollable emotions as a response (Pagnini et al., 2010). The physician can suggest a psychological support meeting shortly after the diagnosis (Cerutti et al., 2012). The patient needs a space where they can express their emotions, hopelessness, despair and uncertainty or fear for the future (Pagnini et al., 2010). The psychologist can as well work with the clinician to improve the quality of the communicating procedure (Pizzimenti et al., 2015). Relatives should be able to receive psychological support while coping with the feelings of burden or bereavement (Pagnini et al., 2010) that the diagnosis carries and further communicate the diagnosis to the children (Calvo et al., 2015). In this stage the psychologist can assess the patients' expectations, worries, beliefs, resources and personality (Pagnini et al., 2010), awareness of the disease and cognitive status (Ryoh et al., 2014) and potentially presence of frontotemporal dementia (Cimbolli et al., 2019). Introducing the patient into a support group can be also useful (Cerutti et al., 2017).

Living with the Disease

While living with the disease spirituality and existential issues might be worked on (Panagiotopoulos, 2019), loss of function discussed, and supportive devices or interventions introduced which could be devastating to the patient as a confirmation of dependence (Pagnini et al., 2010). At this stage alternative forms of communication might be needed (Pagnini et al., 2010). Feelings of fear, depression, anxiety, being a burden might appear or worsen and a feeling of denial or rebelling against the disease, as well as apathy, indecisiveness, or controlling behaviours, loss of their roles, isolation, embarrassment, physical symptoms might create hopelessness (Oster & Pagnini, 2012; Kleinbub et al., 2016). Strategies like acceptance, distraction, reappraisal and adaptation enable hope, and empowering or emphasizing autonomy is crucial (Soundy & Condon, 2015; Matuz et al., 2015). Also finding the right point to communicate life saving/lengthening interventions such as PEG or artificial ventilation as well as end of life decision is something that the psychologist can definitely contribute (Cerutti et al., 2017). Caregivers experience the burden of the care, guilt, isolation, limitation, anxiety and depression as well (Baxter et al., 2013), and children often experience withdrawal or aggressive behaviours (Calvo et al., 2016), therefore psychological support is crucial for them as well as guiding towards more understanding of the patient's feelings (Pagnini et al., 2010). Depression is associated with both decreased quality of life and has an effect on cognitive performance as well, so it should be addressed and treated (De Wit et al., 2018; Jelsone-Swaine et al., 2012). When ventilation becomes necessary it often creates claustrophobic feelings or anxiety (Pagnini et al., 2010), therefore the psychologist should be there to discuss the fears and discuss if the patient would want to have a tracheostomy performed when external ventilation is no longer successful (Pagnini et al., 2010; Ambrosino et al., 2009).

The End of Life Stage

Psychological support is even more important in this stage both for the patient and the family. The family dynamics should be evaluated and support provided by the psychologist to approach the concept of death while being in touch with the clinician (Cerutti et al., 2017). Euthanasia might be asked, or questions about a painful suffocating death (respiratory failure) (Pagnini et al., 2010; Ray et al., 2012). Psychological support should be given to the caregiver and family after the death of the patient, as they are often despite the information, not prepared for it, and it is often traumatic especially if the patient's wishes were not discussed or were not followed (acute intubation, hospitalization etc.) (Ray et al., 2012). If the patient is part of a support group, then the psychologist can support the others' questions about the patient's absence (Cerutti et al., 2017).

ALS is often seen as a family disease because of its devastating course. In such progressive and fatal neurodegenerative diseases, a multidisciplinary palliative team should be introduced immediately with the diagnosis, during the progression and at the time of death. Evaluating the presence of frontotemporal dementia or clinical depression or anxiety, the family dynamics and potential dysfunction, supporting the fears, doubts, spiritual issues, and end of life decisions while examining as well the ability to consent on intervention, helping to establish communication within the family and evaluate the feelings of children, mental health of the caregiver, and bereavement management before and after death make the psychologist essential in the team, contributing to the quality of life of the patient, the caregiver and supporting the other members of the team both in the treatment and their own mental wellbeing during the stages and especially the death of the patient.

Flexibility and adaptability of primary classrooms: Interventions and strategies to support learners with insecure attachment

By Hannah Sharrad, MSc Psychology Student

"What about the other 31?"

A phrase often heard in the staffrooms of mainstream primary schools. With teacher expectations and class sizes rising (O'Connor & Colwell, 2002), there is no wonder why teachers utter these five words; however, what they forget to consider is the child they are referring to may require their attention, care and support to feel safe and valued in their environment. For some children, the world, and people within it, can be a scary place. Schools can provide a secure, stable environment for children and the teachers and teaching assistants within them: supportive and caring role models (Ubha & Cahill, 2014; Tucker et al., 2017). However, due to issues previously mentioned, the relationship between teacher and 'difficult' child can become a vicious circle of attention seeking behaviour and negative responses, resulting in tattered relationships.

As discussed in my previous article, before expecting the child to adapt and change their behaviour (which we should never expect anyway) we as practitioners must first look at ourselves: our own behaviour, attitudes and attachment style (Parker & Levinson, 2018; Verschueren & Koomen, 2012), remembering we are the adults in this relationship! After self-reflection, we can begin to focus on individuals' feelings instead of their behaviour. Parker and Levinson (2018) discuss this shift as crucial for impacting educational processes and teacher-child relationships. Behaviour is communication and, although sometimes difficult to recognise, it must not be seen as a personal challenge or vendetta.

Ubha and Cahill (2014) conducted an experiment exploring the effectiveness of an intervention group for children identified as having an insecure attachment style. The intervention was based on Mary Boxall's 'Nurture Group' setting which has proven to be successful over the years when supporting children with social and emotional difficulties (Cooper & Whitbread, 2007). An adaptation of 'Therapeutic Story Writing' (Waters, 2004) was also used. The sessions ran weekly over ten weeks, led by a Learning Mentor. The same group of children met with the same Learning Mentor, in the same room, the same time each week. The order of each session was also the same, beginning with a greeting song, news time, story time- with specific books chosen for emotional content. Children were invited to draw or write 'whatever came to mind' in their own workbooks and they could share with the group. This reflection was a choice and none of the individuals were forced to share.

The sessions were consistent and individualised, allowing for choice and decision-making for each child. This created a safe and secure environment, whereby individuals felt heard, valued and part of a community (O'Connor & Colwell, 2002). This is supported by the results of the interventions, showing positive outcomes for children's behaviour and experiences. Post-intervention interviews highlighted common themes: forming a sense of belonging; managing and articulating emotions; quality of friendships; and being noticed and acknowledged. These themes all display a phenomenal adaptation of children's views of themselves and those around them, supporting a shift in their Internal Working Models (IWM). These children thrived in an environment where they felt accepted and truly listened to. When all is unvarnished, is that not what everyone desires?

O'Connor and Colwell (2002) emphasise the importance of individualised, child centred approaches for supporting children with social and emotional difficulties and I could not agree more. I concur with the importance of early intervention for those individuals displaying signs of insecure attachment. Tucker et al. (2017) carried out a play-therapy based intervention for preschool children (3-4 years old) which included adult-led play, gentle touch, eye contact and movement. They found that post-intervention, children were better able to self-regulate behaviours and attend well to others, further evidence of specific, individualised and early intervention for children who may suffer with insecure attachment. Teachers trained in nurture interventions were more likely to reflect on a child's behaviour as an internal struggle in relation to their environment rather than them just being 'naughty'. They also stated how their teacher-child relationships had improved post-intervention. It is evident from these studies that early intervention with a trusted adult can have dramatic effects on children's IWM. Therefore, specific training on attachment theory and how we can support children in a primary classroom is needed within schools and in teacher training (Parker & Levinson, 2018; Ubha & Cahill, 2014; Verschueren & Koomen, 2012).

O'Connor and Colwell (2002) also comment on the importance of a whole school approach to support and intervention. Too often academic interventions will take priority over interventions supporting a child's social and emotional wellbeing. School policies should be flexible and adaptable for teachers to use specifically for their class and the individuals within it (Parker & Levinson, 2018). One of the issues stems from the curriculum teachers must work with. In 2016, the Department for Education (DfE) expressed a desire for supportive school environments; however, this focused too heavily on the children within those environments 'fitting' the environment rather than vice versa (Parker & Levinson, 2018).
Children who struggle to conform are reprimanded and the vicious circle begins. The phrase 'round hole and square peg' comes to mind. Personal, Social, Health and Economic (PSHE) education is taught in schools, or something of a similar ilk; however, this offers a far too general study of these four components to warrant much success for those children who struggle to place themselves in the world. This is just not enough, child-focused interventions are also crucial for individuals to gain a more rounded sense of self and belonging.

As Albert Einstein once so beautifully wrote, "Everybody is a genius. But if you judge a fish by its ability to climb a tree, it will live its whole life believing that it is stupid." This wonderfully highlights the importance of an individualised, child-centred approach with a foundation of care, support and mutual-respect. In my own opinion, this quote should be painted onto the walls of every school hall, and it should be painted there by the children to which it means so much.

Dr Imose Itua – COVID-19 Webinar

Tune in on Wednesday the 10th of June at 1:30-2:30pm for a webinar by our very own Dr Imose Itua! She is the deputy programme team leader for the Healthcare Management programme, holding a PhD in Medicine.

This webinar is a fantastic opportunity to soak up some evidence-based wisdom relating to the current pandemic and its impact upon us both physically and psychologically, especially as it is so easy to fall prey to misinformation or disingenuity within the news or social media.

To attend, the registration link can be found below. Dr Itua is also happy for questions to be asked, and she will endeavour to address these during the session. Enjoy!

https://attendee.gotowebinar.com/register/2720080023763067148?source=PsychologyNewsletter

Contributing to the next edition of the newsletter

I would like to thank all contributors to this edition of the School of Psychology newsletter. If you would like to contribute a topical article or news item related to Psychology for the next edition, please contact myself at krooney@arden.ac.uk for more information. I also welcome your hobbies or new habits!

I look forward to hearing from you!

Next Issue: August 2020.