Special issue on Health Psychology including:

Is Talking to Frank doing more harm than good?

Measuring stress in children and adolescents with saliva testing

Challenges of health risk communicating health risks to people with psoriasis

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It gives me great pleasure to introduce the 93rd edition of the *PsyPAG Quarterly*, our first ever Special Issue on Health Psychology! I hope you enjoy the variety of articles from our contributors and find them as interesting as I have. We also include our usual range of Hints & Tips and Conference Reviews – there’s something for everyone!

Health psychology and research into improving public health has been of key interest to me since my undergraduate degree. My interest in the breadth of applicability of its principles was spurred by the teaching of Professor Lynn Myers, whose experiences and advice I gained through interview for this issue. This passion for the diversity of health psychology research has remained through my PhD in physical activity promotion to children. Following in the footsteps of our earlier Developmental and Conspiracy Theory issues, I was eager to showcase postgraduate research in the field of health psychology in *The Quarterly*.

We begin with an exploration of how health psychology principles can help reduce symptoms in insomnia, before exploring principles applied to other health issues such as psoriasis and drug reduction. We also have hints and tips on how to make the most of your health psychology Master’s programme and a discussion of saliva-based stress testing in children. Amongst other articles, we also have a review of our 2014 PsyPAG Annual conference, as well as a review of the Health Psychology symposia within this event.

I am sure you will agree that this diversity of articles highlight the exciting opportunity of health psychology to have tangible effects on public and individualised health. I would like to take this opportunity to thank Martin Toye in this issue, his last as a member of *The Quarterly* Editorial Team. His June 2014 Special Issue on Developmental Psychology was hugely well received and his support during the last year has been invaluable. We wish him the best of luck in his new role as PsyPAG Treasurer. By the time of publication we will have elected a new member of *The Quarterly* Editorial Team to work with us on our next March 2015 issue.

I hope you enjoy this Special Issue on Health Psychology. Special Issues are still a new thing for *The Quarterly* so please let us know your opinions. As ever, we give a huge thank you to all of our contributors who make *The Quarterly* possible. If you have any ideas for articles or comments on *The Quarterly*, please let us know via email or Twitter. We are currently especially looking for ‘Psychology People in Profile’ contributions, interviews with landmark figures in psychology.

Happy reading!

**Emma Norris**
On behalf of the *PsyPAG Quarterly* Editorial Team
30th Annual Psychology Postgraduate Affairs Group Conference 2015
University of Glasgow
22nd-24th July 2015

More Information available soon!
Keep up to date on twitter and at
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Hello and Welcome, psychology postgraduates, to the Winter 2014 edition of the PsyPAG Quarterly! I hope you are all settling into the new academic year well and looking forward to the Christmas break. I have now been the PsyPAG Chair for over a year and have been reflecting upon the support PsyPAG has been able to offer and consequent number of psychology postgraduates who have benefitted from the assistance of PsyPAG. I have been very pleased to see that our social media channels are continuing to increase in popularity and we are also receiving record numbers of submissions for the PsyPAG Quarterly and the bursaries that we offer. This all demonstrates the increasing awareness and reputation of PsyPAG but more importantly the valuable support that PsyPAG is able to offer to UK psychology postgraduates.

The PsyPAG committee are always looking for ways in which we can continue to help you; our members in your studies and in doing this, we recently extended the current range of bursaries that we offer through the introduction of a new research grant bursary. The bursary of up to £300 is available to assist with conducting research as part of psychology postgraduates studies. For example, this fund may help with paying participants in exchange for taking part in research or helping with travel costs when collecting data away from university. For more information about all of the bursaries PsyPAG offers and to apply please visit our website at: http://www.psypag.co.uk/bursaries-2/

PsyPAG has also recently provided funding for three workshops with the dedicated fund we have for this. The first was entitled ‘Poster Preparation and Presentation: How to Create a Successful Conference Poster’ and was held at Canterbury Christ Church University, Kent. The aim of this workshop was to provide support and guidance for students who were aiming to present a poster at future events. This was followed by a workshop aimed at Stage 2 training for Health Psychology students at the BPS Division of Health Psychology Conference in York. This workshop ‘Stage 2 Training: Programmes, Pitfalls and Presentations’ aimed to deliver the most current advice on the revised competencies now in force for the qualification and the various routes through which these can be achieved from people who have themselves gone through the process. The most recent workshop supported, ‘Communication Skills for Motivational Training,’ was at the University of Strathclyde, Glasgow, and aimed to teach and provide skills practice in the core communication skills needed for motivational interviewing. All three workshops were well attended and received great feedback about their value. If you are interested in finding out more information about our workshop fund see: http://www.psypag.co.uk/workshops/

I am delighted to announce that PsyPAG’s 30th Annual Conference is to be held at the University of Glasgow from 22–24 July 2015. Registration for the conference will become available on 12 January 2015 at our low-cost, postgraduate rates. There will be an early bird rate available, so be sure to get this date in your diary and registered early for what we anticipate will be a very popular conference next year. The PsyPAG conference is our annual flagship event and next year is set to be bigger and better than ever in celebration of PsyPAG’s incredible 30th anniversary. We are early in the planning of the conference, yet a very special celebration, a welcome drinks reception at the prestigious City Chambers, has already been arranged. This event is going to be attended by the Lord Provost of Glasgow (City) to personally welcome the delegates to Glasgow. Many more arrangements will be being made over
the coming months and our website (www.psypag.co.uk), and dedicated conference Twitter (@PsyPAG2015) and Facebook (facebook.com/PsyPAGAnnualConference) will keep you up to date with all of the latest information and conference developments. We look forward to welcoming many of you to Scotland next July!

Suggestions, feedback or ideas as to how PsyPAG is able to provide further support for UK psychology postgraduates is always welcomed, so please contact me at chair@psypag.co.uk if you have any ideas or suggestions you would like to share.

Thank you to the BPS Research Board for their continued support and the PsyPAG committee for their hard work and commitment to supporting UK psychology postgraduates.

Wishing you all a very Merry Christmas and Happy New Year!

Laura Neale
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Discussion paper:
How health psychology can contribute to improving symptoms, health-related quality of life, and daytime functioning for those experiencing insomnia
Belinda Hemingway

Sleep is a key issue in maintaining good mental and physical health, yet health psychology as a discipline has so far had little involvement in improving the psychological impact of poor sleep and insomnia. This article explores the important role health psychology has to play in the treatment of insomnia – a rapidly growing field of interest across health care.

Insomnia remains an area dominated by clinical psychology and psychiatry. There are good reasons for this, in that many people experiencing insomnia also have other medical conditions (e.g. pain) or mental health problems (e.g. depression), and therefore may require mental health or psychiatric assessment – particularly if other sleep conditions need to be considered (e.g. sleep apnoea). Insomnia is also listed in the Diagnostic and Statistical Manual (DSM-5), the manual used by clinicians and researchers to diagnose and classify mental illnesses; so as a result is often viewed as a purely psychiatric condition. However, if after assessment, other sleep or psychiatric disorders have been ruled out, for those presenting with the most common type of insomnia – psychophysiological insomnia – health psychology could make a very valued contribution.

Psychophysiological insomnia is a combination of thoughts, behaviour and physiology, associated with arousal of our mind and body (Robatham, 2011). Typically people complain of a racing mind and fall into a cycle of poor sleep, which can lead to them having concerns about their sleep. Such patterns of thoughts and behaviour then perpetuate the cycle (Robatham, 2011). People with insomnia typically experience higher rates of relationship difficulties, poorer health-related quality of life and perception of lifestyle choices, depressed mood, elevated anxiety and fatigue, reduced daytime functioning, inability to concentrate, and impacts on memory and attention (Espie et al., 2007; Kyle & Espie, 2010; Mental Health Foundation, 2011).

The perceived impact this has on the individual’s daytime functioning, rather than simply the perceived sleep loss, appears to serve as an important factor in driving help-seeking behaviour (Morin et al., 2006). This is where health psychology becomes of importance. For example, using evidence-based techniques to promote health and support behaviour change, improvements can be made to reduce the psychological and physical impact of this acute and chronic condition – in the same way that psychological input is recommended in physical health rehabilitation, such as cardiac (British Association for Cardiovascular Prevention and Rehabilitation, 2012) and pulmonary rehabilitation (Department of Health, 2012) programmes.

One of the current interventions for insomnia is Cognitive Behavioural Therapy (CBT). CBT is a way of talking about how someone thinks about themselves, the world and other people, as well as how what they do affects their thoughts and feelings. CBT can help to change how someone thinks...
(cognitive) and what he or she does (behaviour), in order to feel better (Royal College of Psychiatrists, 2013). Unlike other therapies which focus on the causes of distress or symptoms in the past, CBT focuses on present problems and difficulties, and looks for ways to improve state of mind now (Royal College of Psychiatrists, 2013). CBT for insomnia (CBT-I) is a brief, focussed and multimodal intervention (Edinger & Carney, 2008; Morin & Espie, 2003), which has the objective to change factors that perpetuate insomnia, including behavioural factors (such as poor sleep habits, irregular sleep schedules), psychological factors (such as unrealistic expectations, worry, unhelpful beliefs), and physiological factors (such as tension) (Morin & Benca, 2012).

Espie and Kyle (2009) describe the key components of CBT for insomnia (CBT-I) in clinical practice as sleep education and sleep hygiene, stimulus control treatment, sleep restriction therapy, cognitive control, thought suppression, imagery and relaxation, cognitive restructuring and paradoxical intention. These components have been shown to not only improve sleep, but also daytime functioning and health-related quality of life (Espie & Kyle, 2009). These are all areas in which health psychology expertise in improving coping and self-management, and health promotion, behaviour change and motivational techniques, can enhance treatment – even from the starting point of sleep education and sleep hygiene, where the impact of caffeine, nicotine, alcohol, diet and physical activity can be explored.

It has been suggested (Kyle et al., 2010) that the future research agenda should include the comparison of different treatment modalities on health-related quality of life outcomes within the same study. My own pilot study, as part of a Professional Doctorate in Health Psychology, is comparing the effectiveness of three recently developed evidence-based CBT-I treatment delivery interventions – a manual-guided five-week group, a one-day workshop, and an online programme – on insomnia severity, daytime functioning and health-related quality of life.

The research, underway following research ethics committee and research and development approval in May 2014, is currently recruiting, consenting and randomising participants to the treatment interventions. The study is employing mainly quantitative questionnaire measures to assess insomnia severity, daytime functioning and health-related quality of life (Insomnia Severity Index, Dysfunctional Beliefs and Attitudes about Sleep Scale, Patient Health Questionnaire 9, Generalised Anxiety Disorder 7, and Work and Social Adjustment Scale), with a small qualitative aspect to explore patient’s experience of participating in the different interventions. This study aims to recruit at least 50 patients over the six-month period of data collection in order to meet the study objectives, and to determine whether a full-scale study is warranted.

Should this study show that one intervention is more effective, or participatory experience varies across interventions, this may provide evidence for different options being available in the future. Different people may require different treatment approaches, and the more options available; particularly those that can be made widely accessible, the greater likelihood that those seeking help can obtain it (Ritterband & Thorndike, 2012).

As the interdependence between mental and physical health is more widely recognised, health psychology can, therefore, make a valued contribution to improving symptoms, health-related quality of life and daytime functioning for those experiencing insomnia.

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People are becoming increasingly exposed to different sources of health risk information, via the internet, in patient information leaflets, or during health care professional-patient interaction (such as routine appointments with a General Practitioner (GP)). This makes effective risk communication a fundamental skill particularly for health care professionals, who are perceived as a respected, trustworthy and expected source of advice (McPhail & Schippers, 2012). Effective health risk communication should form part of interventions aiming to promote healthier lifestyles in patients, particularly those identified as being at risk of common long-term conditions (LTGs) such as diabetes and cardiovascular disease (CVD) (Department of Health, 2008). However, communicating often complex information about health risk is a considerable challenge for health care professionals (Gigerenzer et al., 2007).

From a patient perspective, how information about health risk is presented is likely to influence: (1) risk perception; and (2) decisions about whether to make lifestyle changes (such as decreasing alcohol intake or increasing the amount of exercise) to reduce health risks (Edwards et al., 2001; Rothman et al., 1993). Poorly presented health information may lead to patients making ill-informed health decisions. It is therefore crucial to present patients with personalised health risk information in a way that increases understanding and consequently leads them to make personally appropriate health decisions (Ahmed et al., 2012). The challenge is, therefore, to find the most effective risk communication methods that serve to increase patient understanding of personal health risks.

Psoriasis, behavioural risk factors and the association with CVD

Psoriasis is a long-term inflammatory skin condition that affects around two per cent of the UK population (Parisi et al., 2013) and often manifests in skin redness, increased thickness and flaking in ‘plaques’. There are a number of psychological comorbidities associated with psoriasis, such as high levels of depression and anxiety (Richards et al., 2001) and stigmatisation due to the visibility of the condition (Kimball et al., 2005).

People with psoriasis are also known to engage in a number of problematic lifestyle behaviours (excess alcohol intake, smoking, and being sedentary) at higher levels than people without psoriasis (Samarasekera et al., 2013) all posing significant health risks. These behavioural factors not only contribute to psoriasis onset and/or exacerbation (Kirby et al., 2008; Naldi et al., 2005), but lead to additional risks of other long-term conditions such as CVD (Gelfand et al., 2006), diabetes (Gottlieb, Chao & Dann, 2008), inflammatory bowel disease and psoriatic arthritis (Dauden et al., 2012).

The relationship between psoriasis and CVD is receiving particular attention, with more severe forms of psoriasis being associated with CVD (Gelfand et al., 2006). Whilst these mechanisms are unclear, there is now a convincing body of evidence showing that people with psoriasis engage in a number of behavioural risk factors traditionally asso-
associated with CVD. Health promotion and lifestyle behaviour change is, therefore, central to psoriasis disease management strategies, and is reflected in the recent public health guidelines in the UK (National Institute for Health and Care Excellence, 2012). Making positive lifestyle changes has many advantages for improving psoriasis outcomes. Increasing physical activity can reduce psoriasis severity (Frankel et al., 2012) and weight loss can improve the effectiveness of psoriasis treatments (Gisondi et al., 2008).

Given the importance of lifestyle behaviours in relation to psoriasis onset and severity, and its association with an increased risk of CVD, health promotion must, therefore, be at the forefront of health communication strategies during every patient contact (National Health Service (NHS) Yorkshire and the Humber, 2010). Being able to effectively communicate information about CVD and associated behavioural risk factors is central to health communication.

**Current understanding of CVD risk communication**

Cardiovascular disease, one of the biggest killers globally, is preventable by modifying risk factors related to poor lifestyle such as smoking, obesity and tobacco use (Yusuf et al., 2004). Department of Health guidelines insist that CVD prevention should include lifestyle interventions conducted with patients. However, engaging in discussions about health promotion with patients is not always at the forefront of the practitioner-patient consultation (Nelson et al., 2014) or reflected in any detail as part of health care professionals’ core training (Keyworth et al., 2014), with health care professionals often citing lack of knowledge and skills as barriers to engaging in such activities (Nelson et al., 2013).

Effective communication ideally involves a two-way exchange of information between a patient and practitioner leading to better understanding of personalised risk information and decisions regarding the clinical management of patients (Ahmed et al., 2012), and better informed choices to change. The literature, however, fails to provide clarity about the most effective CVD risk communication methods.

A systematic review of CVD risk communication methods was largely inconclusive, based on the paucity of research and studies using hypothetical risk scenarios (such as the dangers of a hypothetical drug, or being at risk of a hypothetical disease) rather than an actual health threat (Waldron et al., 2011). Waldron et al. suggest that making patients aware of their own risk may lead to more accurate risk perceptions and consequently decisions about reducing risk through behaviour change.

Knowledge about CVD risk is needed to ensure patients understand their own health risks and are able to make informed health decisions. Recent public health guidelines emphasise the importance of informing patients of their CVD risk (National Institute for Health and Care Excellence, 2010). It is, therefore, crucial to examine the type of information patients are often exposed to, and establish the most effective practice for increasing patient understanding of risks to their own health.

**Importance of risk format (numbers, words, or both?)**

There have been a number of risk communication strategies examined in the literature, such as visual methods (pictures, bar graphs) (Goodyear-Smith et al., 2008; Lipkus & Hollands, 1999), numerical (percentages, frequencies) (Gurmankin, Baron & Armstrong, 2004), and verbal information (‘your risk is high’, ‘smoking increases your risk’) (Knapp et al., 2009). However, there still remains a level of uncertainty as to which methods are the most effective for increasing patient understanding. For example, whilst Gurmankin and colleagues (Gurmankin et al., 2004) argue that numerical information may facilitate understanding of risk information, others suggest numbers may be difficult for people to process and interpret (Lipkus, Samsa & Rimer, 2001).
Understanding how people process numerical information is particularly important given the number of freely available individual ‘risk calculators’, such as the internationally-recognised Framingham risk calculator (D’Agostino et al., 2008). This allows individuals to calculate their own risk (commonly presented as a percentage) of CVD based on a number of predictor variables such as smoking status and body mass index. Whilst risk calculators may be effective in terms of increasing motivation to make lifestyle changes, they may also lead to inaccurate risk perceptions and misunderstandings of CVD risk (Bonner et al., 2014a). Further work must examine the conditions under which such calculators are effective in terms of increasing risk perceptions. This may include examining whether risk calculators are more effective when used as part of a routine health care consultation with a GP or a nurse, for example, to facilitate understanding.

We suggest a need for further research in the context of actual primary care consultations where CVD risk is discussed. Neuner and colleagues (2011) found that verbal expressions of risk (often referred to as qualitative format; ‘your risk is high’) were used by GPs in 73 per cent of primary care consultations (Neuner-Jehle et al., 2011). This suggests a clear preference by the clinician, but one that may fail to facilitate patient perception of risk. Practitioners may also use different risk communication strategies depending on how they perceive patient risk, with numerical expressions of risk often leading to unnecessary patient misunderstandings (Bonner et al., 2014a, 2014b). This apparent lack of consistency in risk communication strategies adds to the debate about the most effective methods to enhance patient understanding.

**Theoretical frameworks for risk communication**

Informing patients about risks to their health is further complicated by a number of ‘cognitive biases’ (often referred to as ‘systematic errors in thinking’) which affects how people interpret risk information (Berry, 2004). People may for example be ‘unrealistically optimistic’ about a given health problem (Weinstein, 1984). According to Weinstein’s theory, people may believe that because a health problem has yet to appear, it never will (‘I’ve been smoking for 20 years and haven’t yet had a heart attack’). Therefore, continuing to engage in unhealthy behaviours may be due to inaccurate perceptions of risk and susceptibility. Such cognitive biases can have detrimental effects on individuals such as continuing to practice unhealthy behaviours. Traditional approaches to judgment and decision making emphasise the importance of considering cognitive biases when communicating health risk information to patients (Kahneman & Tversky, 1979; Rothman et al., 1999) and testing understanding.

An example from the literature relates to a concept known as message framing (Rothman & Salovey, 1997). Put simply, messages about behaviour change can be presented as positive or negative messages associated with carrying out, or not carrying out, a particular behaviour. For example, ‘quitting smoking lowers your risk of lung cancer’ and ‘by not quitting smoking, you increase your risk of lung cancer’ is essentially the same health message, with a different message frame. This phenomenon has been shown to have a significant effect on the likelihood of individuals making positive behavioural changes (Rothman & Salovey, 1997). Message framing has been examined in experimental studies for a range of behaviours from using sun cream (Detweiler et al., 1999) to food choice (Pavey & Churchill, 2014) and promoting vaccinations (Abhyankar, O’Connor & Lawton, 2008).

Whilst the effectiveness of message framing has often been debated, more recently there have been some encouraging findings. A systematic review found an advantage for positively-framed health
messages for the promotion of prevention behaviours (such as smoking cessation and weight loss) (Gallagher & Updegraff, 2012). Research has also found that health communication messages would benefit from being tailored to individuals’ characteristics, such as whether people consider immediate or future health consequences (O’Connor et al., 2009). Such findings have important implications for effective public health intervention strategies and public health campaigns as well as individual level communication.

Providing risk information alongside effective interventions aimed at changing behaviour has shown considerable promise (Marteau et al., 2010). Communicating risk information may influence a number of psychological constructs that are traditionally associated with behaviour change, such as increasing emotional responses to information, increasing motivation to seek appropriate behaviour change interventions and beliefs concerning the effectiveness of interventions (McBride et al., 2010).

**Conclusions and future developments in health communication research**

More consistency in the way that health care professionals communicate health risk information, which considers the patient’s own preferences, would move towards a more shared understanding during the risk communication interaction. The ability to communicate complex health information to patients is recognised as a key skill for health professionals, and risk communication strategies (such as being able to use medical statistics) are currently being incorporated into the undergraduate medical curricula with promising results (Han et al., 2013; Sedgwick & Hall, 2003).

Health promotion is a fundamental skill for health care professionals (National Institute for Health and Care Excellence, 2014), and a key aspect of recognised NHS public health strategies, such as using the GP appointment to communicate key health messages for the promotion of healthy lifestyles (National Health Service (NHS) Yorkshire and the Humber, 2010). It is also important to consider the views of health care professionals, who often express the need for clearer guidelines in relation to expectations of conducting health promotion and lifestyle behaviour change with patients (Chisholm et al., 2012).

As poor lifestyle is not only linked to the onset and severity of psoriasis but also poses a significant health risk for common LTCs such as CVD and diabetes; it is crucial that health care professionals are equipped with the necessary knowledge and skills to engage in and deliver appropriate health risk communication to patients. This includes communicating complex health information and following through with actively engaging in recognised behaviour change techniques with patients (Michie, 2008) with the ultimate goal to improve population health.

The care of people with psoriasis should be focused on identifying and managing relevant lifestyle risk factors and preventing future comorbidities that will bring an additional health burden, in particular CVD. Further developments are needed to the evidence base that seek to determine optimal methods of communicating complex health information in such a way that patients with psoriasis, and patients generally, are empowered to make lifestyle modifications to reduce the risk of long-term health threats. Health psychologists are currently at the forefront of understanding the psychological mechanisms involved in health risk perception, and using these insights to develop effective behaviour change interventions and inform public health guidelines for individual and population level behaviour change.
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THE 2013–2014 UK British Crime Survey indicates that approximately one-in-three adults have taken illicit drugs at some point in their lifetimes. Around one-in-11 or 8.8 per cent of adults aged 16 to 59 had taken an illicit drug in the last year, and out of these, 40 per cent were defined as frequent drug users (British Crime Survey, 2013, 2014).

Research has shown that anti-drugs adverts are enormously successful in reaching target audiences (Reis et al., 1994), getting their attention (Black, 1991), and changing their attitudes to become more anti-drug (Davis, 1997). The importance of utilising social marketing to positively change health-related behaviour is, therefore, becoming more and more prevalent (National Social Marketing Centre for Excellence, 2005). Social marketing utilises advertising marketing techniques such as those from television, magazines, billboards, and phrases (for example, slogans and spoken word). These are targeted at particular groups of society (such as teenagers), to try and reduce their harmful health behaviours and increase their positive health behaviours. Local and national services routinely utilise social marketing as an intervention within health promotion campaigns to target illicit drug misuse, however, there is little evidence to suggest if it is effective in positively changing an individual’s health-related behaviour (Sumnall & Bellis, 2007).

Since the UK’s national drugs campaign ‘Talk to Frank’ was launched in 2003, numbers of frequent drug use have declined from 11.6 per cent in 2002–2003, to 6.6 per cent in 2013–2014 (British Crime Survey, 2013/2014). However, as no drug use outcome evaluation data has been published by FRANK, there is no evidence to suggest that this reduction is as a direct result of the campaign (McGrath et al., 2006). Furthermore, other studies conducted elsewhere on the effectiveness of social marketing campaigns on drug misuse have found that exposure to the campaigns have had no effect on initiation or cessation on drug use (e.g. United States Government Accountability Office, 2006). Additionally, the reported statistic for frequent drug users aged 16 to 59 has remained relatively constant (at around three per cent) since data on this area was first collated in the 2009–2010 survey (British Crime Survey, 2013–2014). This suggests that although social media campaigns may possibly have some effect on preventing new users from trying an illicit substance, they do little for those who are already currently using.

Is there a possibility that harm reduction adverts are influencing people to take drugs?

One of the most interesting debates to have emerged within the substance misuse field is the ‘normalisation’ of recreational drug use within the UK youth population (Parker, Aldridge & Measham, 1998; Parker, Williams & Aldridge, 2002). These researchers suggest that drug use has become so preva-
lent within youth culture that social accommodation of sensible recreational drug use has become accepted by abstainers and those who cautiously engage in drug involvement. It has been recognised that the problems associated with drug use should facilitate the development of more effective drug education and harm minimisation strategies (Parker et al., 1998). Arguments from those who suggest that illicit substances are already normalised suggest that drug policy must adapt to accommodate the ‘safer use’ of the substances, rather than solely focussing on strategies intended to prevent or punish the uptake of recreational drug use (Duff, 2004; Wodak & Moore, 2002).

Comparatively, the FRANK campaigns have primarily focussed on encouraging those at risk of using, or those who are currently using to ‘find out the facts’ – by providing education and neither punishing nor outwardly preventing use. The FRANK campaigns also do not provide overt harm reduction messages and although some harm reduction messages can be found on their website, the information is limited and difficult to find.

Additionally, a study conducted by Dermota et al. (2013) suggests that regular substance misusers appear to be more informed and knowledgeable about the risks of substance use than non-users, and have a marginally better ability to understand health information than abstainers. This is unusual as many studies frequently report that frequent drug users come from lower educational backgrounds than those who abstain from using (Chatterji, 2006). Consequently, interventions that only focus on information provision will not be helpful to those who regularly use. Therefore, the campaigns are limited in capturing those who are already frequently using, or who have experience in illicit drug use.

Furthermore, it was found that greater exposure to the US anti-drug campaigns was associated with a belief among young people that their peers used drugs regularly, referred to as ‘descriptive normalisation’ (Hornik et al., 2008). This corresponds with the Priming Effects Theory, which suggests that elements of a media campaign stimulate related thoughts among viewers; therefore, televised depictions of various behaviours can lead to an exaggerated sense of the behaviour’s prevalence in society (Berkowitz, 1984). Those who viewed the campaign took from them the message that their peers were using drugs. The effects of priming themselves can be salient and much longer lasting than simple recognition memory. If this is correct, then the FRANK campaign can potentially be unintentionally encouraging drug use as individual misperceptions of higher drug use prevalence in populations are strong predictors of intention to use (Donaldson et al., 1994; Rimal & Real, 2005).

Additionally, it is important for campaigns such as FRANK to accurately depict the effects of illegal drugs on the health of the individual. For example, FRANK suggests that using Ecstasy can result in users developing mental health problems. However, the majority of community-based studies have failed to find a definitive cause between Ecstasy use and developing a mental health condition, as these disorders are also found in non-ecstasy users (e.g. Schifano et al., 1998). This leads to Ecstasy users potentially being influenced in a negative way by these social marketing campaigns. By routinely suggesting that drug users may be more at risk of developing a mental health condition as a direct consequence of ecstasy, users and ex-users may begin to believe that they are experiencing such detrimental effects (Cole, Sumnall & Grob, 2002) and, therefore, may experience low mood, motivation and paranoia ‘not as a direct result of the drug but through psychological mechanisms induced through high-profile social-marketing campaigns that effectively ‘sell’ such negative effects’ (Sumnall & Bellis, 2002, p.930) This can have major repercussions for public health campaigns that are trying to deliver a health promotion message.

Another issue is the effect that an anti-drug message can have on the individual.
Wagner and Sundar (2008) examined whether anti-drug adverts initiate an individual to become more curious about drugs. Results indicated that participants whose stimuli contained anti-drug adverts were more curious about using illicit drugs than those whose stimulus did not contain anti-drug adverts. This is in agreement with Lowenstein’s (1994) information-gap theory on curiosity, who has argued that curiosity is a crucial motivational force in influencing human behaviour. Lowenstein (1994) suggests that if an individual has an experience with something that is ‘mysterious’ such as drugs, this may lead to the individual experiencing a ‘cognitive deprivation’ that results from their own perception that there is a gap in their knowledge, understanding or experience. Furthermore, once this curiosity is activated, it has the ability to grow unless the curiosity is satiated. He argues that as people obtain more information about a subject, the prospect of future curiosity arousal can become even more likely because as an individual acquires new information, they are reducing their perception that they are ‘missing information’. This means that the individual is likely to think that the more information he or she acquires, the better they are able to manage their knowledge gap.

The above theory may help to explain why those who regularly consume illicit drugs are more informed about the potential dangers of the drugs they take. It, however, may also be harmful for those who have never tried drugs before, as this ‘cognitive deprivation’ may lead to those who have not used prior to watching the advert to acquire more information to fill their knowledge gap by using. Due to greater personal interest and concern, substance users may be more likely to search on information concerning their health, and, therefore, may become more educated on the risks, just as patients are more likely to search for information on their disease and treatment patterns, and therefore, are more educated on their particular health condition (Bansil et al., 2006; Ranahy, Parizot & Chauvin, 2008; Siquilini et al., 2011).

**Cognitive dissonance**

Another reason why campaigns such as FRANK may have limited effects on those who regularly consume is due to cognitive dissonance between health behaviour and health knowledge, (Kenkel, 1991). The Health Belief Model (Becker, 1974; Rosenstock, 1974) suggests that one’s beliefs about a perceived health-related risk results in them making specific choices about their health behaviour, as inconsistency is disturbing and emotionally costly. However, cognitive dissonance takes an opposite stance, whereby it suggests that circumstances often cause acts, and then health beliefs are either adjusted, or made in some way consistent with the acts by rationalisations (Aronson, 1979; Festinger, 1967). Therefore, an individual is able to maintain consistency between their beliefs and behaviours by adjusting their beliefs if their behaviours are incongruent with their prior beliefs. Therefore, campaigns such as FRANK may not effectively challenge a regular users beliefs as in order to do this, they need to deliver information that the user is unaware of (i.e. challenging their current risk perception, which has been altered by the individual in question so that it is consistent with their current health behaviour). This in itself is difficult, as a regular user has learnt to deny their risk-taking behaviour, as their experience of early risky behaviour has not resulted in any immediate detrimental effects on their health. Therefore, according to this theory, a regular user is likely to ignore the claims made by anti-drug adverts, as they themselves learn to deny the advert’s claims of health detriment through their own personal use (Peretti-Wattel, 2006). This can be dangerous, as their perception of risk may ultimately be continually lowered every time they watch an anti-drug advert.
A possible consideration for future campaigns: Risk and the Other

The above research indicates that if an individual has the intent to use an illicit substance, they will find a way to use them, and possibly find a way to rationalise their behaviour. Campaigns to reduce the amount of risk that a drug user is susceptible to should, therefore, be designed. The perception of risk that a regular user has on their drug-related behaviour is undoubtedly an important indicator of their future consumption patterns (Becker, 1974; Rosenstock, 1974). Therefore, it is an important variable to consider when designing a future campaign aimed at reducing harm in regular drug users. Additionally, Joffe (1999) argues that one’s perception of risk also depends on the ‘Other’; that is, an individual evaluates their own risk behaviour by comparing it to how at risk they imagine others to be. For example, a regular cannabis user would negate the amount of risk they feel they are placing themselves in by comparing their risk-taking behaviour by scapegoating ‘another’ who they consider to be a ‘hard drug’ user. Consequently, the particular user would feel that their risk taking behaviour is justified, as there are others in the world that do far worse than them. They, therefore, establish a systematic differentiation between so-called ‘hard’ and ‘soft’ drugs. This is in order to deny the risk associated from their regular cannabis use.

So according to this theory, if an anti-drug campaign were to be successful at targeting regular drug users, it would need to include the importance of ‘the other’ for the campaign to be effective.

Conclusions

This paper has highlighted the importance of considering the effectiveness of drug campaigns for those who regularly consume illicit substances. The contention that current drug education programmes that are based on education, law enforcement and prevention efforts are likely to meet the needs of regular drug users is inaccurate. While governments are committed to providing a harm reduction policy, the focus really needs to be placed on how to influence the ways in which people consume different drugs in order to start encouraging the adoption of more moderate use behaviours. To do this, the focus of harm reduction should be placed on understanding why an individual continues to use, and to challenge these ideologies. After all, the majority of harm that arises from drug use is from immoderate, frequent and sustained drug use (Bonomo, 2004; Durrant & Thakker, 2003; Keane, 2002).

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Discussion paper:
Measuring stress in children and adolescents: The past, present and future of saliva testing
Tamsyn Hawken & Tara Cheetham

SALIVA, blood and hair samples can all be analysed to examine the levels of various hormones. Blood sampling is the most established method of hormone analysis and is often the first port of call for assessing other health issues such as confirming infections, checking organ function and screening for genetic conditions (NHS choices, 2014). However, blood sampling is quite invasive and a lot of people find it painful and frightening, therefore saliva sampling has become the prevailing method for analysing hormones. There has also been some recent work investigating the use of hair sampling as a method for analysing hormones, for example, Sauve, et al. (2007) found that hair was a useful tool for measuring the long-term production of cortisol (as hair grows approximately one centimetre per month) thus levels of stress can be effectively tracked over time. Although it is extremely useful for analysing long-term stress, hair sampling is still in the exploratory stages.

Saliva sampling has a strong evidence base and has been applied to populations across the lifespan; therefore, this article will discuss the past, present and future of saliva testing in the context of measuring stress levels in children and adolescents. A brief background of saliva testing and its underlying biological mechanisms will be discussed, followed by a discourse on the current applications of some of the key stress hormones, cortisol and dehydroepiandrosterone (DHEA), and the introduction of salivary nerve growth factor (sNGF) as an emerging measure of stress resilience.

The past: A brief history of saliva testing
Saliva testing began in the early 1800s and has been used to look at a variety of hormones at all stages of the lifespan (Johnson & Johnson, 1836). Saliva-based research has been used to help diagnose and treat many health conditions such as obesity (Pervanidou, et al., 2013), diabetes, post-traumatic stress disorder (PTSD; Carrion et al., 2002), and cancer (Walco et al., 2005) as well as providing insight into life course changes such as ageing, puberty and child development along with health issues such as stress and sleep (Salimetrics, 2014).

It is possible to examine hormones in saliva because of the interaction between important stress hormones and the body’s physiological stress response system including the hypothalamic-pituitary-adrenal (HPA) axis and the sympathetic adrenomedullary (SAM) which is responsible for the fight-or-flight response (see Figure 1). When the HPA axis is activated by a stressor this causes the hypothalamus to release corticotropin-releasing hormone (CRH) which, along with other hormones, stimulates the release of adrenocorticotropic hormone (ACTH) from the pituitary; ACTH then travels through the bloodstream and reaches the adrenal cortex where it triggers the release of cortisol (Nicolson, 2008). Therefore, cortisol levels are regularly used as a gauge of HPA axis functioning (Dieleman et al., 2010).

Modern saliva testing laboratories are able to test for cortisol as well as about 25 other hormones relevant to numerous
health-related issues (Salimetrics, 2014). The hormones of particular interest in stress research include alpha-amylase (a proxy measure of SAM activity), cortisol (a measure of HPA axis activity), DHEA (an adrenal hormone), melatonin (an anterior pituitary hormone), and oxytocin (a posterior pituitary hormone) (Salimetrics, 2014; Turner-Cobb, 2014). A new method for measuring resilience to stress is salivary nerve growth factor (sNGF), however, this is has only been examined by a small number of researchers (Laurent, Laurent & Granger, 2013, 2014).

Cortisol testing is widely used in research across the lifespan, however, other hormones such as DHEA have only been used to measure stress in young people in the last decade (Cichetti & Rogosch, 2007; Voorhees et al., 2014). Neurotrophins such as sNGF have the potential to be useful biomarkers of resilience but have yet to be applied to the measurement of stress and resilience in children and young people.

**The present: Cortisol and DHEA**

The measurement of salivary cortisol, a key stress hormone, is a valid measure for assessing stress levels in children and adolescents. It is a reliable, non-invasive method which does not cause any unnecessary distress, and is efficient when repeated assessments are required across a relatively short time period (Jessop & Turner-Cobb, 2008).
In terms of practicality it is essential to take into account the circadian rhythm and diurnal pattern of cortisol, that is, that it follows a 24-hour pattern with a peak 30 minutes after awaking (the cortisol awakening response; CAR), followed by a slow decrease throughout the day (Turner-Cobb, 2014). Due to this pattern most studies assessing cortisol levels tend to take several samples throughout the day, or alternatively they take samples at a specific time to capture certain aspects of the pattern, for example, the CAR or the lower late afternoon/early evening levels.

Research with children and adolescents has shown some age and gender differences in cortisol levels. For example, there are inconsistent findings in terms of gender differences but it is generally accepted that cortisol levels in very young children (under 4 years of age) are quite diverse before beginning to follow the typical circadian pattern observed in adults (Gunnar & Donzella, 2002).

Cortisol assessment has been used in studies with children from birth up to adulthood to examine stress responses to both natural and laboratory stressors. Naturalistic stressors such as colds and coughs and environmental stressors such as starting school have been examined using salivary cortisol sampling (Turner-Cobb, Rixon & Jessop, 2011). Large-scale longitudinal studies like the Avon Longitudinal Study of Parents and Children (ALSPAC), also known as the ‘Children of the 1990s’ study, have been collecting data from over 19,000 mothers and their children since the 1990s including cortisol measurement and information about life stress (http://www.bristol.ac.uk/alspac/).

One of the most commonly used lab stressors for adults are social stress tests which involve public speaking to an audience such as the Trier Social Stress Test (Kirschbaum, Pirke & Hellhammer, 1993) and the Leiden Public Speaking Task (Westenberg, 2009). These social stress tasks have been adapted for use with children, for example, the TSST-C (Buske-Kirschbaum et al., 1997) and the TSST-M (Yim et al., 2010). The adult Leiden Public Speaking Task involves a discussion of films whereas the child-based TSST-C involves finishing the telling of a story and serial subtraction (for example, counting backwards in three’s) and the TSST-M requires participants to introduce themselves as they would if they had started at a new school and also includes serial subtraction. These tasks are performed in front of live audience in order to induce Social Evaluative Threat (SET). This theory proposes that social stressors can have a physiological as well as a psychological effect because people fear negative social judgements, and have been found to reliably induce an increase in cortisol in children and adolescents (Dickerson, Gruenewald & Kemeny, 2009).

Although a great deal of research has focussed on the cortisol stress response, recent studies have demonstrated that DHEA also plays a significant role (Saczawa et al., 2013). Cortisol and DHEA are both secreted following activity in the HPA axis and it is reported that they have opposing effects (Goodyer et al., 1996). Whilst cortisol can negatively impact health; DHEA has been identified as a powerful anti-ageing hormone with the potential to reverse the immune suppression and negative effects that can result from elevated cortisol (Herbert, 1998). Cortisol and DHEA are, therefore, viewed on a ratio and like many other physiological systems, the body aims to achieve balance in order to maintain optimal health (Sapolsky, 1992).

DHEA has mostly been investigated in adults; however, studies are beginning to explore this hormone in children and adolescents. The course of DHEA levels across the lifespan are well established and due to the variation in children and adolescents it is important to consider this when studying a younger population. DHEA levels are high at birth and then decrease until 6 to 8 years of age, before they rapidly increase, peaking during puberty and then beginning a long, slow decline with age (Rasmusson,
Sex differences have also been found, with males typically having greater DHEA levels than females (Netherton et al., 2004). It has also been noted that DHEA levels may be affected by menstrual status which is particularly important to consider when studying an adolescent population (Rasmussen, 2008). Much like cortisol DHEA is influenced by individual differences such as emotionality, personality, cognitive function and health and behaviour (Cichetti & Rogosch, 2007).

DHEA measurement has mostly been applied within the context of child maltreatment. The first study to explore DHEA in maltreated children was carried out in 2007 (Cichetti & Rogosch) and found that those who had been maltreated showed a rise in DHEA levels from morning to afternoon that was absent in controls. More recently the measurement of DHEA and cortisol has been applied in studies investigating childhood exposure to trauma and post-traumatic stress disorder (PTSD). Results showed that exposure to trauma was significantly associated with both cortisol secretion and the cortisol/DHEA ratio (Voorhees et al., 2014).

In many instances, the measurement of DHEA is applied with regard to it being a resilience factor and thus aids knowledge surrounding the outcomes of adverse events or circumstances in children.

The future: Salivary nerve growth factor

Retaining a focus on resilience, studies have found that the neurotrophin salivary nerve growth factor (sNGF) has been implicated in the stress response and may impact immune system regulation by acting as a potential buffer against the effects of stress caused by systems such as the HPA axis (Laurent, Laurent & Granger, 2013). sNGF plays an important role in the growth and plasticity of the brain (Hennigan, O’Callaghan & Kelly, 2007) and the release of this neurotrophin during acute or chronic stress may encourage the remodelling of damaged tissues (Aloe, Alleva & Fiore, 2002). The measurement of sNGF began through blood samples and its applications are still in their infancy, with the mechanisms underlying the neurotrophin’s effects still being explored. Research from Laurent, Laurent and Granger (2015), however, is paving the way by exploring adults involved in psychosocial stressors such as romantic conflict. They have found that people with greater sNGF report lower negative emotion when encountering a stressor and suggest that the reactivity and recovery of this biomarker are indicative of psychological health. More recent research has also determined that greater sNGF reactivity was related to stronger coping, ability and agency and concluded that dynamic sNGF responses are adaptive (Laurent, Laurent & Granger, 2014). This evidence suggests that the involvement of sNGF in the stress response may have a protective function. The benefit of exploring it within research is that it focuses on positive attributes and therefore, rather than being a marker of risk such as with cortisol, sNGF can indicate resilience: an area of great interest to researchers studying outcomes in children and adolescents.

Conclusion

In conclusion there has been rapid progress in the measuring of stress biomarkers through saliva and the understanding of the mechanisms underlying their effects. Cortisol is the most established, with DHEA following suit and sNGF still in the exploratory stages. The applications of salivary cortisol measurement thus far are guiding research surrounding DHEA and together, the literature surrounding both these stress hormones may direct future research surrounding sNGF.

Although cortisol is currently the most applied and evidenced of the stress biomarkers, it is argued that focussing entirely on this hormone as the most important is a limiting and narrow perspective (Goodyer et al., 2001). Indeed it is imperative to recognise that each biomarker is unlikely to impact biological processes independently (Marceau et al., 2014) and thus addressing a number of hormones and
neurotrophin’s acting collectively is vital in order to develop a stronger understanding of what roles these factors play and their involvement in stress outcomes.

The measurement of stress biomarkers in saliva is an ongoing endeavour which is currently filled with potential. With a solid foundation in cortisol research, a growing literature surrounding DHEA and the excitement of the neurotrophin sNGF gaining momentum: researchers in this field are set to make many innovative and compelling discoveries in the near future.

References

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As part of this Special Issue, Editor Emma Norris interviewed Health Psychologist Professor Lynn Myers at Brunel University. Lynn shares her experiences working in the field and gives advice to postgraduates seeking a career in Health Psychology research and practice.

Emma: How did you come to work in the field of Health Psychology?

Lynn: It was really a whole lot of lucky accidents really. Originally I’m a pharmacist, then I got this neurological problem and it looked like I wouldn’t be able to go back to the physicality of pharmacy so I started reading Psychology for fun and I really liked it. Then I started a Psychology degree at the University of Hertfordshire in the 1990s and then my PhD at the Institute of Psychiatry. Like so many people at the time, I thought that I was going to do Clinical Psychology training because Health Psychology didn’t actually exist as a profession so I just got my way into it. After my PhD I did a post-doctoral research fellowship at the University of Reading looking at de-biasing people’s risk perceptions of driving and then took that into health behaviours like smoking. Then a fixed-term lectureship came up in Health Psychology at Royal Holloway and I was there for nine months and then a permanent lectureship came up at University College London running an MSc Health Psychology which I did for 10 years. We were the first batch of MScs to receive BPS accreditation a few years later. With Health Psychology gaining momentum, it was a very exciting time.

Emma: You’re a national expert on comparative optimism and its effects on health behaviour. Please could you outline the term and your research in the area?

Lynn: Comparative optimism is where people are more likely to think good things are going to happen to them compared to other people and bad things are less likely to happen to them than others. That can’t be right as not everyone can be better off than everyone else, so it is a type of bias. Work that I have done includes on smoking, so smokers tend to think they will get less smoking related illnesses than other smokers (Myers, 2014). What we’ve tried to do is de-bias this belief out of people. One of the earliest studies we did was getting smokers to rate their likelihood of getting their diseases after this and we found that the comparative optimism bias was reduced or removed (Myers & Frost, 2002). More recently we’ve given smokers a DVD to watch to trigger this imagination (Myers, 2014) and also use the same technique for drinking (Ayers & Myers, 2011). I’m looking to do some more work with this internationally with teenage binge drinking.

Emma: Can you tell me briefly about the research you are doing at the moment?

Lynn: A couple of things, mostly around repressive coping style. Some people have
what’s called a repressive coping style, where they are low on reported anxiety but high on defensiveness and avoid negative affect. There’s lots of research to show that although they tend to be physically unhealthy, with longitudinal studies showing they don’t recover well from major health events myocardial infarctions and breast cancer (Myers, 2010). One project in particular is looking at comedy and why people with different coping styles might attend stand-up comedy. Myself and Dr Sharon Lockyer, who is a Sociologist here at Brunel, are assessing the reasons for attending stand-up comedy and repressive coping style is the thing that really stands out (Myers & Lockyer, 2014). We’re finding that repressors were more likely to go to stand-up comedy than others and were more likely to go to other live performances. Attendance at comedy events may be one way of them to deal with their negative emotions. I would like to take this further and find out more investigating any relationship between repressive coping, live performance and health. I’m also working on assessing the relationship between recovery from having a stroke and repressive coping. My work is quite varied – I never like to just do one thing! My main work is on repressive coping, adherence to treatment and risk perception but I do like to do different things.

**Emma:** What is your proudest moment of your career so far?

**Lynn:** My Inaugural Professorial lecture at Brunel University where I talked about my work on repressive coping was very special. It was great because people I know from so many different walks of life came – my current and former colleagues, students, my friends, my family, wow! After it I thought ‘I don’t care if I don’t do any research after that!’ That feeling didn’t last long and I was continuing research very quickly. Also eight years ago when I was offered a Professorship at Brunel was a real boost to my self-esteem. I was thinking ‘Why me? What am I doing as a Professor?’ It took my colleagues and family to make me realise that I have achieved a lot and I wasn’t a fraud or impostor!

**Emma:** That imposter syndrome is definitely something that seems to be common especially as a postgraduate! How do you think that Health Psychology can contribute to population health?

**Lynn:** I think we need to promote ourselves better. I know there’s been more collaboration with the Department of Health with leaders like Professor Susan Michie but we do not promote ourselves well – social marketing does. We can contribute so much to interventions to change health behaviours and we need to get out there and say ‘We can do this! We have the evidence base and we’re in the real working world as well’. We are getting there but it’s slow. Another thing is to do with funding. Health is the big thing now. A lot of colleagues from other research spheres are now asking for my help for my health and practical experience which is really gratifying. If you’re health, you’re in it at the right time! Academic life has changed so much since I started in the 1990s. Then you could do work without getting funding but now you can’t do that. Also you need to be involved in cross-disciplinary research.

**Emma:** That’s a really interesting point about academia changing. With the introduction of the Research Excellence Framework (REF) and more of a focus on ‘impact’, do you think this will change the outputs that will be produced?

**Lynn:** I think it will. It used to be that impact factors were the be all and end all. Now it’s more about ‘h-index’ of each individual researcher (Bornmann & Daniel, 2007) and how you have made a difference in the real world. Certainly there will be more of a focus on open access journals because the public and more of the developing world and public can access them. I think paper journals are getting a bit old fashioned. I think student should not worry about the REF at the moment but be aware for later on in their careers.

**Emma:** What advice can you give to today’s Health Psychology postgraduates?
**Lynn:** For Health Psychology training as opposed to research I would say to make sure that you have competent Behaviour Change skills which you can apply in all sorts of ways. It’s also important there to keep up training on your research and reviewing capabilities.

For PhD or research I always say that whatever you’re doing you have to really like it. It’s got to keep you going. If you are bored you won’t continue. If it’s a PhD it’s probably the biggest piece of individual research you’ll ever do and you’ll also never have the freedom again to spend that time on something. I think also be aware of the next steps in your career as it is more competitive than ever. I see people going for lectureships now who could have been going for senior lectureships not that long ago. I think you are now expected to do more and publish more than ever before. As a postgraduate I wouldn’t worry about the REF, just getting your research out there in peer-reviewed journals.

It’s also good to teach but that’s not the thing that gets you lectureships, it’s generally your research. It’s also important to go to conferences and discuss your research. If it was a toss-up between conferences and writing though, I’d definitely say write the paper if you want a career in academia. People often forget that presenting and lecturing is scary! I used to get very nervous meeting new students. I suddenly knew I was senior when I lost the scared-ness! When you’re a PhD student, nine times out of 10 people are very kind to you when you present but sometimes they’re not. My favourite thing to say with tricky questions is ‘That’s a really good question. I’ll think about that!’ and then it gives you time to discuss it afterwards. When you are presenting at a conference, make sure people know that you’re a PhD student, nine times out of 10 people are very kind to you when you present but sometimes they’re not. My favourite thing to say with tricky questions is ‘That’s a really good question. I’ll think about that!’ and then it gives you time to discuss it afterwards. When you are presenting at a conference, make sure people know that you’re a PhD student from the start so they’ll be kind to you! Multi-disciplinary work is a hot topic right now. You need to be known as widely as possible for when you apply for jobs. Increasingly I’m going to conferences other than Health Psychology to make sure I speak to other professionals as well.

**Emma:** As a PhD researcher, it seems to me there is a definite trend towards multidisciplinary research (my own PhD has links between health and educational psychology), what are your views about that?

**Lynn:** Yes it’s good to write and present but you need to be multidisciplinary if you can. Maybe not when you start as you’re still finding out your interests but later on. Your supervisor can help with that. Get out there and get recognised! PhD is training across all areas including conferences. Posters are a gentle way to break you into conferences. The earlier you can get out there, the better! I’ve always recommended Master’s students to present or give a poster and get publications where they can.

**Emma:** At PsyPAG we have lots of conference and travel bursaries available for postgraduates so it’s a great way of opening access for Master’s and PhD students as well as those working in broader psychology. What advice would you give to postgrads?

**Lynn:** PsyPAG is great. I remember it from my time on the Health Psychology committee. It allows you a great introductory access into committee roles, support and advice. As for other advice, don’t be put off by paper reviewer comments. When you submit papers, most of the time the reviewers hide behind anonymity. Some of them will be quite cruel, don’t be put off. If you think it’s good keep going! You need to think where do I pitch this and impact factors are a good guide. One of the ways is to see what journals are publishing. Another thing I’m passionate about for students is authorships and ordering as it can be quite unclear. Make sure you and your co-authors are clear of the author list order according to contribution. You need to be careful but as long as you have a good relationship with your supervisors, you should be ok! If you’re doing a PhD and you are designing and writing up the studies, you must be first author. It can be a bit more of a grey area depending on funding and if you haven’t designed the research yourself. I think all Master’s students should have a session on
writing for publication because that empowers them to go ahead and submit.

**Emma:** How do you see Health Psychology changing in the future?

**Lynn:** Well it’s changing already. I think it shouldn’t be so prescriptive in the requirements of qualifications needed to train and recognise a broader range of experience. I also think it will need to be more multi-disciplinary and work with professionals from other areas and embracing this. We need to get out there and become better known. The work of Professor Susan Michie is a great example of this, applying Behaviour Change and aspects of Health Psychology in a broader way (Michie, van Stralen & West, 2011; Michie et al., 2014). We have to be practically out there, changing behaviours and working with others!

**References**


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Discussion paper:
Post-traumatic growth ... the story so far
Lisa Sanderson

Post-traumatic Stress Disorder and resilience

ALTHOUGH many people experience trauma evidence increasingly suggests that the majority do not develop post-traumatic stress disorder (PTSD) (Yehunda & McFarlane, 1995). Studies of the general population indicate a lifetime prevalence of traumatic events in more than 50 per cent (Breslau, Davis & Andreski, 1995) but yet the estimated lifetime prevalence of PTSD is only one to three per cent in the general population (Kessler, 2000). Further, epidemiological studies showed an incidence of PTSD of about 55 per cent after rape, 35 per cent after childhood sexual or physical abuse, 17 per cent after physical and armed assaults and seven per cent after severe accidents (Maercker et al., 2004).

Much research has been undertaken to investigate why some individuals demonstrate resilience in the face of potentially traumatic experiences whilst others in the same situation become traumatised and multiple predisposing factors such as demographics, trauma history, type of trauma, lack of social support, history of childhood abuse have all been suggested as possible explanations (Boals & Schuettler, 2011). However, the majority of this research has been conducted with clinical samples which is somewhat biased and may have led to misdirected understandings of post-traumatic reactions. Certainly there is widespread recognition within psychology that our current available explanations for resilience versus susceptibility to traumatic events are inadequate (Boals & Schuettler, 2011).

What is post-traumatic growth?

One area of increasing interest to researchers over the last decade is post-traumatic growth, which is the idea that individuals can experience positive changes as a result of exposure to trauma (Tedeschi, Park & Calhoun, 1996). According to O’Leary and Ickovics’ (1995) model of discontinuous change, exposure to trauma can result in three possible outcomes: survival, those who merely survive never regain their previous level of functioning; recovery, those who recover return to their previous level of functioning or thriving; those who thrive move beyond their original level of psychosocial functioning, flourish and grow as a result of their experience. Post-traumatic growth, therefore, is not just about learning to live with the effects of trauma, or bouncing back from trauma, but is instead likened to a springboard to further individual development and higher levels of psychological well-being (Tedeschi et al., 1996). Typically, 30 to 70 per cent of individuals who experience a traumatic event report positive changes of one form or another (Linley & Joseph, 2004) and five main areas of growth have been identified: increased personal strength, identification of new possibilities, increased appreciation of life, improved relationships with others and positive spiritual changes (Tedeschi et al., 1996).

Who can experience post-traumatic growth?

Post-traumatic growth has been observed in various trauma exposed-populations including earthquake survivors (Vazquez et al., 2005), bereaved individuals (Collins, Taylor & Skokan, 1990), victims of sexual abuse (Burt & Katz, 1987) and individuals involved in military combat (Feder et al.,
Therefore, what seems to be important is not the event itself but what the individual brings to it and how they appraise events (Woodward & Joseph, 2003). Several psychological/cognitive and social factors are associated with post-traumatic growth such as bravery, fortitude and perseverance (Peterson et al., 2008) optimism, extraversion, sense of coherence, positive reappraisal and problem-focused coping (Linley & Joseph, 2004) and increased perceptions of social support (Dirik & Karanci, 2008). However, it still remains largely uncertain why some individuals grow in the aftermath of trauma and others do not (O’Leary, Alday & Ickovics, 1998).

Recent models of growth
Several models have been put forward to explain the existence of growth but Organismic Valuing Theory is a recent model of growth which suggests post-traumatic growth occurs during the therapeutic process of resolving post-traumatic stress (Joseph, 2012). This theory shows trauma leads to a breakdown in self structure, signalled by the experiences of post-traumatic stress indicating the need to cognitively process the new trauma related information. People are intrinsically motivated towards processing this new information in ways that maximise their psychological well-being (Joseph & Linley, 2005). Thus the implication of this theory is that post-traumatic stress is the catalyst for post-traumatic growth (Joseph, 2012). There is also some evidence to suggest that the relationship between post-traumatic growth and post-traumatic stress is a function of the intensity of post-traumatic stress. For example, Butler et al. (2005) in their study following the attacks of September 2001, found that greater post-traumatic stress was associated with greater post-traumatic growth but only up to the point, above which post-traumatic growth declines. This gives rise to the possibility that a curvilinear relationship exists between post-traumatic stress and post-traumatic growth (Joseph, 2012). However, findings in this entire area of research are far from consistent and there are also a number of studies that have failed to find any systematic relationship between post-traumatic growth and the symptoms of post-traumatic stress, for example, in samples of former East-German political prisoners (Maerckker, 1998) and individuals with spinal cord injuries (Znoj, 1999).

Why study Emergency Services personnel?
To improve our understanding of the complexity of possible reactions to traumatic exposure, research that focuses on non-clinical populations, who despite being routinely exposed to traumatic events are not showing signs of pathology is needed. Emergency services personnel, such as firefighters, police and paramedics, are routinely exposed to traumatic experiences as part of their daily working lives, thus putting them at risk of developing symptoms of post-traumatic stress or even PTSD (Brunsden & Lawrence, 2012). However, despite facing these ongoing stressors the majority of personnel remain healthy and it is only in rare cases that individuals actually experience such a high level of reaction (Brunsden, Hill & Maguire, 2012). In fact research looking at ambulance personnel found that 98.6 per cent of participants experienced positive changes as a result of work-related traumatic experiences (Shakespeare-Finch et al., 2003). Lawrence and Barber (2004) argue that a crucial part of the resilience of emergency service personnel is the individual and collective coping mechanisms that naturally and organically come into play following exposure to a potentially traumatic incident. Any homogenous group has an implicit set of understandings by which it operates usually including a level of self-help, by which the emotional defence mechanisms are activated to protect the integrity of the group when a threat is perceived (Brunsden & Lawrence, 2012). Such findings add weight to the argument that we may have underestimated the...
human capacity to survive and thrive in the aftermath of trauma (Bonanno, 2004).

My research
I am in the first year of my PhD and my research is specifically focusing on the Fire and Rescue Services with the aim of developing an alternative model of post-traumatic growth. Although firefighters are routinely exposed to traumatic events they have a natural support network in their fellow team members, who share the same experiences and act as one another’s first line of debriefing and diffusion (Brunsden & Lawrence, 2012). This peer support is particularly important as firefighters are extremely resistant to external professionals in terms of support for psychological distress as they believe that someone who has not shared their experiences can never understand how they are feeling (Brunsden & Lawrence, 2012). Given that the majority of firefighters never require the professional therapeutic interventions that are available to them it would appear that these close co-relations are acting as a stress buffer through the provision of social support (Regehr, 2009).

Several studies have shown that the support of the family is also paramount in reducing the impact of this highly stressful work on these emergency services personnel (King et al., 1998). Families promote personnel’s operational capability by debriefing and diffusing their relative’s stresses, buffering negative health issues before they become problematic (Brunsden, Hill & Maguire, 2012). Thus a good support network would appear to be sufficient as a primary coping strategy for the majority of emergency personnel exposed to work-related trauma (Deahl & Bisson, 1995) as they allow individuals the opportunity to re-evaluate and make meaning of the traumatic events through verbal or even written reflection (Blaney, 2003).

My PhD will use a sequential mixed methods design beginning with in-depth semi-structured interviews with emergency services personnel exploring their traumatic exposure and subsequent reactions and experiences. This data will then be analysed using grounded theory and from this a theoretical model will be constructed to explain how psychological growth can emerge post-trauma and possible reasons for the variability within this. This theoretical model will then be operationalised using psychometric measures. The data collected, across a large sample, will be subjected to structured equation modelling in order to ascertain whether the model fits the data (Kline, 2011). The model will be refined as appropriate and re-tested until a theoretical model can be confidently offered as both an explanation for the variability in post-traumatic growth and an indication of the processes and factors underpinning this variability.

Conclusions
Research has traditionally focused on the detrimental effects of trauma and consequently our understanding of trauma recovery has for too long been confined to a deficit-orientated model (Zoellner & Maercker, 2006). Therefore, post-traumatic growth is indeed one of the most exciting topics in modern psychology because it changes the way we think about psychological trauma and expands our clinical perspective (Joseph, 2012). This research will advance our understanding of the factors that promote growth and this knowledge is central to the development of positive psychological interventions that promote well-being and improve treatment outcomes in clinical settings (Pietrzak et al, 2010).

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References


Hints & Tips:

When your degree becomes more than an education: Reflections on a Master’s in Health Psychology

Tamsyn Hawken

THROUGHOUT MY STUDY on a taught Master’s in Health Psychology we were encouraged to reflect on our learning experiences in order to develop, learn and grow both professionally and personally. Having now completed the course, I decided to take some time to reflect on the lessons I’ve learnt this year, and offer some pearls of wisdom for those thinking of starting or currently starting a Master’s in Health Psychology.

Before the course

Previous work experience

Upon applying for my course I was somewhat new to the area of Health Psychology and eager to learn more. Many courses in the UK require applicants to have some experience of working within a health or health psychology setting. A Health Psychology MSc is the first stage of training to becoming a chartered health psychologist and having prior experience within a health setting was invaluable during the course due to its applied nature. The ability to apply examples and recognise situations in which theory or skills have been represented made the course engaging and relevant. Even if the entry requirements of your chosen course do not require it, I would strongly encourage you to seek experience in a health care setting prior to starting your studies as it will allow you to appreciate and apply the content on a much deeper and practical level which will only be of benefit to your learning.

Funding

Unlike undergraduate degrees, postgraduate study is not eligible for government funding or loans and as a result this can prevent many people from pursuing a masters. Although career development loans were a popular option amongst my peers, I would highly recommend those searching for funding are creative in their quest. There are numerous charities and alternative funding bodies who can offer bursaries, grants and loans based on a wide variety of criteria, ranging from the city you were born in to your parent’s occupation. Websites like www.turn2us.org.uk and www.postgraduate-funding.com are extremely useful databases to search for funding that might be available. It is notoriously difficult to secure funding towards a taught Master’s degree, however, it is not impossible. Through the turn to us website I was able to secure a small bursary towards the cost of my fees after much persistence and numerous applications to a number of charity funding bodies.

Be prepared

It goes without saying that studying at postgraduate level requires a great deal of commitment and hard work than required at undergraduate study and ‘self-directed study’ is most definitely a large aspect. Be prepared to take ownership of your education and be heavily involved in and responsible for your own learning from the very beginning. What you put in, you will get out. Undergraduate study may have consisted of being ‘taught at’ and being sent
away to revise for exams or produce assignments. You will not be a passive learner at postgraduate level; should you choose to engage in the material, probe further than you are taught and pursue your own interests you will find yourself shaping your own learning experience. Undoubtedly, taking responsibility for your degree can be daunting, but it is also an exciting opportunity to play an active role in what you gain from the course. I personally found that engaging, contributing and fully participating in my learning experience was tremendously rewarding.

During the course
Know how you work
It is unlikely that your colleagues will form a homogeneous group of students. Instead they will likely come from a variety of backgrounds, be of different ages and have a range of experiences and expertise. As a result, the ways in which you learn may differ significantly and it is important to remain confident in your own learning style and not be swayed by others. By all means share study skills and ideas, in fact I would encourage it, as discussing content with others is a fantastic way to broaden perspectives and views, however, do not fall into the trap of comparing yourself to others. Theodore Roosevelt said that ‘comparison is the thief of joy’ and ultimately your Master’s course is there to be enjoyed, albeit stressful and challenging at times. Therefore, pursue your own interests, work in the way that is best for you and stay focussed on your own progress and development during the course.

Networking
Many health psychology courses now feature a number of highly successful health psychologists who are leaders or specialists within their field. My experience of being surrounded by these people is to use them. Staff are a resource and whilst they can teach you the content of a course throughout your Master’s, there is also a great deal more they can teach you with regard to skills.

Networking is a vital component of a psychology profession and taking the opportunity to make connections with the staff in your department and fellow colleagues is highly recommended. In addition to this however, simply observing staff at events, conferences or seminars can be a highly effective way to develop networking skills as well as a way to learn how researchers discuss their work in an effective and engaging way. The staff working in your departments are experts in their field and to underuse such a valuable resource would be a shame, therefore, I would urge you to make contacts, express interest and develop ongoing conversations wherever you can. Be sure to make use of the range of bursaries offered by PsyPAG to help postgraduate students attend conferences and networking opportunities (PsyPAG, 2014).

Focus on skills – not marks
As previously mentioned, a Master’s in Health Psychology is stage one of the training to become a chartered health psychologist and it is important to bear this in mind when studying. You are not only developing a sound knowledge and understanding of the discipline, but you are being given an opportunity to develop skills and qualities that you will need for a career in psychology. You are surrounded by expert staff and colleagues in the same position as you, it is a perfect chance to identify weaknesses and work on them in a supportive environment. Take every opportunity to nurture and test your critical appraisal, communication and time management skills as these are all extremely necessary for future work. On a similar vein, I would urge you to remember you are gaining these skills when it comes to receiving grades and feedback. Throughout your course you will be learning things that cannot be measured or assessed through assignments and it is useful to hold onto this when the pressure of assignments or exams may become heavy.
Reflect
To know where we are going with regard to personal and professional skills it is imperative to know where you have come from. Throughout your training keeping a reflective diary is an invaluable practice that will allow you to record experiences, how you managed them, what you learnt and how you might improve in the future. Reflection allows aims and objectives to be tracked and are very useful with regard to identifying strengths and weaknesses and seeking to improve them where necessary. Many professions require evidence of professional development and a reflective diary is an excellent way to demonstrate this. Your Master’s will provide you with a wealth of material to begin and develop a reflective writing practice that you can continue throughout your career, wherever that may lead.

My final hint for those starting a Master’s in Health Psychology comes from Professor Karen Rodham who is now at Staffordshire University. In one of our first lectures at the University of Bath, Karen read us the story of Ish (Reynolds, 2004), a children’s book about a young boy who gave up his hobby of drawing because he felt his drawings didn’t look like they were supposed to. He eventually began to see his drawings as ‘ish’ (sun-ish, house-ish, flower-ish) giving him the freedom to draw without pressure or concern about the outcome. This was a lesson to us (as eager new students) to remember that we had chosen to study this course because it was a subject we were intrigued by and ultimately that we enjoyed. Amidst the stress of assignments, revision and deadlines it is easy to lose sight of the reasons for studying the course and the pursuit of ‘perfection’ and grades can cause a great deal of pressure and stress. The lesson of ‘ish’ and Karen’s words encouraged us to remember that our best is always good enough, and that enjoyment is key, and I would encourage anyone embarking upon any course to endeavour to remember this at all times.

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References
http://www.psypag.co.uk/bursaries-2/
Hints & Tips:
The engaging researcher: How to make your presentations more interactive via Twitter
Lisa Graham

A late-comer to Twitter; I am only now beginning to acknowledge its considerable versatility within academia. If in any doubt as to Twitter’s usefulness, one only need observe the sheer volume of followers engaged with psychology’s top tweeters, as updated every year by the BPS (BPS Research Digest, 2014). Twitter has been incredibly beneficial to many an (at times isolated) early career researcher in helping to establish a connectedness to their broader research area, including the case at which it allows for updates on publications and relevant events. Workshops on the use of Twitter as fundamental to an academic’s tool-kit are now commonplace in conference programmes and within university departments. The main focus of this training is often on managing an online presence. One aspect, which in my experience I have found to be overlooked, is how best to integrate Twitter into academic presentations, both in teaching and at conferences.

With the increasing emergence of online courses resulting in some heralding the end of the ‘traditional lecture’ (The Guardian, 2013) and a subsequent change in pedagogical approach, it is now more important than ever to explore opportunities to add value to our presentations. The use of social media tools such as Twitter allow for a bridge across the divide between the lecture and internet learning, as well as allowing for greater interaction – the lecture’s key strength. With an interest in integrating Twitter into my own presentations, the following article is a reflection of my research into the opportunities.

Getting started with Twitter
Increasingly, conference organisers are establishing a Twitter policy prior to an event in order to maximise on their returns. If organising a conference yourself, you may consider creating a ‘Delegate Guide to Twitter’, defining best-practice in addition to including the fundamentals to enable those who haven’t yet used social media to become involved. This can take various forms; from an explanatory flyer in a conference pack to a highly visual Prezi presentation, or perhaps even a training session scheduled early in the conference proceedings. If planning on introducing Twitter to a series of lectures, the same consideration should be applied.

If there is a social media policy at a conference, chances are a hashtag, for example, #BPS2014, is already in circulation on Twitter. Olivia Mitchell’s highly informative eBook (How to present using Twitter and other backchannels, 2009) recommends establishing a hashtag for your own presentation in conjunction with the conference hashtag, perhaps using simply your initials, for example, #BPS2014 #LG. With this format, your tweets will be grouped in with the main conference tweets. An alternative to this includes appending a hashtag for the broader research area, for example, #BPS2014 #survivorship. This will ensure tweets discussing your presentation are flagged up for those in a relevant area, who may otherwise be unaware of the conference.

Regardless of what you decide on, ensure the hashtag is sufficiently short and that it isn’t already in use (searching
http://search.twitter.com can help determine possible duplications).

Start the conversation ahead of your presentation
For a novice presenter, interacting with the audience represents an unknown-quantity. This doesn’t necessarily have to be the case, as with careful prior preparation you may ensure the presentation meets with the audience’s expectations.

Kathy Reiffenstein (2009), of blog Professionally Speaking, recommends introducing the hashtag you plan to use before delivering your presentation to tweet questions or resources. The use of blogs is very much aligned Twitter, so it may be beneficial to write a post on your upcoming presentation topic and use your Twitter profile to advertise this. A blog is a useful adjunct to Twitter discussions in allowing students and conference delegates to engage with the topic in more than 140 characters.

In addition to fostering interest (and possible attendance) for your presentation, at this early stage information supplied by the audience can be used to develop your talk. This may occur through discussion, or by more directly asking what tangible outcomes your followers would like to achieve from the upcoming presentation.

Add value to the discussion during your presentation
Twitter may be used during a presentation to develop a discussion, to reach interested parties who may not be present, or to gain a grasp of areas your audience were unclear on.

- Encourage audience members to engage in a Twitter discussion by giving the appropriate hash-tag (#) or Twitter name (@) at the beginning of your presentation
- Remind audience members of the backchannel during the presentation, or keep a visual reminder of the discussion in the footer of each slide, for example, join the Twitter discussion #BPS2014
- Present conclusions in short, tweetable sentences throughout your presentation to encourage sharing of your message online.

Displaying tweets on board/monitor/footer
Consideration needs to be given when deciding whether to display a live Twitter stream during a presentation, the risks and benefits of which Olivia Mitchell explores in her blog (Speaking About Presenting, 2009).

Timo Elliott of SAP Web 2.0 (http://timoelliott.com/blog) has developed eight tools for integration of Twitter into PowerPoint slides. With this package of tools you can display tweets in the footer of your PowerPoint slides during the presentation. If you feel this may be too distracting, there is also the option to display the tweets in a dedicated slide at points during the presentation, that is, ‘Now let’s check on the online discussion…’

If you plan to display the Twitter feed for audience members in a separate monitor alongside your presentation (or perhaps in a conference foyer) there are a range of choices. Twitcamp (http://www.daniel-dura.com/code/twitcamp) is a highly visual and customisable option, alongside VisibleTweets (http://visibletweets.com/) which displays tweets slowly – perfect to foster interest as a background feature. Tweetwall (http://www.tweetwall.com/) on the other hand has more functionality for during the presentation itself, with fast updates from the backchannel presented in a sensible yet attractive Twitter stream.

Maintaining control of the backchannel
Appoint a moderator to monitor the Twitter feed, and highlight any question points or discussion to you during the presentation. Alternatively, ask co-ordinators to display a monitor on stage facing you to see hashtags, use your mobile telephone, or have your computer on stage to quickly see the stream (Web Strategist Blog, 2009).

When displaying the Twitter feed on a separate monitor, Paratweet (http://www.paratweet.com/) offers a free
version of their software which automatically screens out inappropriate language. Alternatively, TweetChat (http://www.tweetchat.com) allows usernames to be manually screened.

Rather than leaving it to your audience to establish a discussion, you may be interested in giving some direction yourself. Timo Elliott of SAP Web 2.0 (http://timo-elliott.com/blog) has developed a Twitter plug-in called ‘Auto-Tweet’. Auto-Tweet allows messages to be written into PowerPoint slides, which are then tweeted in real-time as the presentation progresses. In addition to reflecting your presentation content, this tool may be used to tweet additional resources at relevant points during the presentation (e.g. websites, journal articles). Always remember to ask potential followers to ‘please re-tweet’ any material you post yourself in order to maximise your reach.

Q & A
Engaging the audience with questions is the key contribution of Twitter to presentations, and if introduced at an early stage can serve as an effective platform to stimulate further discussion.

Backchan.nl (http://backchan.nl) is a fantastic tool that not only allows audience members to submit questions by tweets which may be displayed on screen at the end of a presentation, but also enables audience members to vote on each other’s questions so the presenter may make best use of limited time at the end of a lecture.

It is also worth exploring whiteboard alternatives which audience members do not need a Twitter account to engage with. Padlet (http://padlet.com) is one of the best examples, allowing links, photos and files to be posted, where audience members may provide resources to each other’s questions.

Lastly, Poll Everywhere (http://www.poll-everywhere.com/) is a great example of an interface which allows for both a Twitter response to questions and a response for non-Twitter users over a website. With a few seconds of a delay, responses are then aggregated to display on an interactive graph. Only requiring a mobile device with an internet connection, this can serve as an alternative to personal response systems, using technology your audience will already be familiar with.

Keep the conversation going after you have left
Maintaining the backchannel discussion after the presentation has ended is absolutely key. Be liberal with re-tweeting other users’ thoughts, and use this as an opportunity to follow others in your area. Treat the online discussion in the same revere as in-person questions after the presentation, thanking other Twitter users for their feedback. Programmes such as Hoot-Suite (http://hootsuite.com) allow for ease in tracking this conversation, with Klout (https://klout.com/home) providing an analysis of your Twitter reach over time. Using the search Twitter platform (http://search.twitter.com) allows the conversation to be saved as a PDF, which could be emailed to delegates/students at a later stage or archived to feed in to your later work.

Cliff Atkinson (2009) recommends creating a simple webpage with resources relating to your presentation for the audience to access at a later point. This could include a copy of the Twitter discussion, alongside additional resources. Audience members could be signposted to these resources by a link at the end of the presentation, or by use of a QR code (generated at http://www.qrstuff.com/), which they can scan with their mobile phone.

In summary
I hope this has been of some use to those considering using Twitter in their conferences or teaching. With some imagination (and bravery!), social media can provide the opportunity to stimulate and maintain a discussion long after the presenter has left the podium. This article reflects a range of...
basic and more advanced techniques, with monitoring of the live backchannel during the presentation a challenge for even the most adept public speaker. There is also the issue of temperamental Wi-Fi to contend with, a consideration if planning to use Twitter to ask questions requiring an immediate response. Identify opportunities to practice these techniques in environments where you already feel confident, and where possible support others attempting to stimulate backchannel interaction in their own presentations.

Good luck!

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References
Discussion paper:
Examining the relationship between combined defeat and entrapment and rumination
Alys Griffiths

Psychobiological theories have attempted to understand mental health difficulties in terms of the dysregulation of basic processes that were once adaptive for humans in their evolutionary past (Gilbert, 2001). This has suggested a central role for defeat: representing a sense of failed social struggle, and entrapment: representing perceptions of there being no way out of an aversive situation in the development of psychopathology in humans (Gilbert & Allan, 1998). Defeat and entrapment have been associated with the development and maintenance of mental health problems such as depression, anxiety and suicidal ideation in clinical and non-clinical populations (see Taylor et al., 2011, for a review).

Recently it has been proposed that the progression from feeling defeated to feeling entrapped is moderated by specific factors such as rumination and use of poor coping strategies (O'Connor, 2011). Many definitions of rumination have been provided, for example, repetitive thinking about the underlying causes, symptoms and consequences of negative moods (Nolen-Hoeksema, 1991), or as a maladaptive cognitive process that involves the presence of intrusive and aversive thoughts (Carson & Cupach, 2000). This has since been sub-categorised to sadness rumination and anger rumination (Peled & Moretti, 2007). Sadness rumination involves continually thinking about, and aiming to understand more about the causes of one’s sadness (Conway et al., 2000). Whereas anger rumination has been conceptualised as focusing attention towards the causes and consequences of angry moods, and recalling previous anger experiences (Sukhodolsky, Golub & Cromwell, 2001). Both forms of rumination have been associated with an increased likelihood of experiencing symptoms related to depression (Conway et al., 2000; Rusting & Nolen-Hoeksema, 1998).

The potential relationship between defeat, entrapment and rumination
Ruminating about perceptions of defeat and feelings of inferiority may act as a direct attack on the self, which would precede further feelings of defeat and inferiority (Carvalho et al., 2013). In such a situation, internal feelings of failure may amplify rumination, even if an individual has successfully escaped from the initial situation of defeat (Trachsel et al., 2010). Furthermore, Gilbert and colleagues (Gilbert, Gilbert & Irons, 2004) suggested that ruminating about perceptions of entrapment and desire to escape, when escape is not possible, could lead to the development of depression. Recent empirical evidence has demonstrated that brooding rumination, defined as passively focusing on the reasons for distress, predicted an absence of positive thoughts about the future amongst healthy young adults following a negative mood induction (O’Connor & Williams, 2014). However, there is currently no research considering whether defeat and entrapment have a direct relationship with the rumination process.
The current study
This research was conducted as preliminary evidence to support the final study of a PhD being conducted. The study sought to establish whether a basic relationship exists between perceptions of defeat and entrapment and anger and sadness rumination. This would hereby provide preliminary evidence that rumination should be considered as a moderating factor in the relationship between combined defeat and entrapment and mental health problems.

Method
Participants and procedure
One-hundred-and-sixty-nine undergraduate students (age range 18 to 26 years; M=19.52, SD=1.50) studying for Psychology courses were recruited from the University of Leicester. Participants completed self-report measures of defeat, entrapment and rumination. As would be expected for an undergraduate psychology student sample, there was a large gender bias (87 per cent female), and analyses were conducted controlling for this bias.

Measures
The Defeat Scale (Gilbert & Allan, 1998) is a self-report measure consisting of 16 questions that assess perceptions of low social rank position and failed struggles during the past seven days, for example, ‘I feel there is no fight left in me’. The scale has demonstrated concurrent validity with submissive behaviour (r=.35) and hopelessness whilst controlling for symptoms of depression (r=.35; Gilbert & Allan, 1998). The alpha coefficient for this scale when completed by undergraduate students has ranged from α=.88 to .93 (Gilbert & Allan, 1998) to α=.85 (Taylor et al., 2009) and in the present sample, the alpha coefficient was α=.94.

Several models have been developed considering the structure of defeat and entrapment. The majority of models have suggested that defeat and entrapment are best conceptualised as one construct (e.g. Johnson, Gooding & Tarrier, 2008; Taylor et al., 2011). Two studies have supported this by demonstrating a one-factor structure for defeat and entrapment using exploratory and confirmatory factor analysis when measured by the Defeat Scale and Entrapment Scale (Griffiths et al., 2014; Taylor et al., 2009). On this basis, within the current study an overall score was calculated for combined defeat and entrapment for each participant.

The Sadness and Anger Rumination Inventory (SARI; Peled & Moretti, 2007) is a self-report measure consisting of 22 questions divided into two sub-scales; anger rumination and sadness rumination. Participants indicate on a five-point Likert scale ranging from ‘never’ to ‘always’ how often they behave in certain ways when they are angry or sad. The two subscales have been shown to have specificity to relevant outcomes; scores on the sadness rumination subscale predicted depression whilst scores on the anger rumination subscale did not. Scores on the anger rumination subscale significantly predicted levels of relational aggression, a form of aggression related to purposefully damaging the social relationships of others, whilst scores on the sadness subscale did not (Peled & Moretti, 2010). Alpha coefficients in an undergraduate sample were α=.91 for 10 items of the anger rumination scale, and α=.92 for the sadness rumination scale (Peled & Moretti, 2010). Similarly in this study, α=.92 was demonstrated for the anger rumination scale and α=.94 for the sadness
rumination scale. As research has suggested that anger rumination and sadness rumination should be considered as two distinct constructs (Peled & Moretti, 2007, 2010), separate scores were hereby calculated for each subscale rather than providing an overall score for rumination.

Results
Preliminary analyses were conducted to examine the frequency distributions of combined defeat and entrapment, anger rumination and sadness rumination across the sample. These analyses demonstrated that generally the sample had low scores on defeat and entrapment ($M=34.52, SD=19.17$; out of a possible 128). Additionally, within the sample, moderate levels of sadness rumination ($M=23.59, SD=8.12$; out of a possible 44) and anger rumination ($M=23.52, SD=8.88$; out of a possible 44) were found.

To test the relationship between combined defeat and entrapment and anger and sadness rumination, hierarchal regression analyses were conducted. This tested the relationship of defeat and entrapment predicting the two forms of rumination and also rumination as a predictor of defeat and entrapment. For anger rumination, in Step 1 of the analysis the rumination sub-scale score was regressed on a combined defeat and entrapment score. In Step 2, gender was added as an additional predictor to control for the gender bias within the sample.

Combined defeat and entrapment was a significant predictor of both sadness rumination (Table 1) and anger rumination (Table 2). Gender was not a significant predictor for either outcome, suggesting that this relationship operates in the same way amongst males and females.

Discussion
This study provided the first evidence that defeat and entrapment are associated with anger rumination and sadness rumination. This suggests that the established and well-studied relationship between defeat, entrapment and mental health problems (see Taylor et al., 2011, for a review) may be influenced by whether or not individuals ruminate on their thoughts.

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Table 2: Regression analyses for defeat and entrapment on sadness rumination controlling for gender differences.

<table>
<thead>
<tr>
<th>Step</th>
<th>Outcome</th>
<th>Predictor</th>
<th>Standardised $\beta$</th>
<th>$p$</th>
<th>$R^2$</th>
<th>$R^2$ change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sadness Rumination</td>
<td>Defeat &amp; Entrapment</td>
<td>.394</td>
<td>&lt;.001</td>
<td>.15</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>Sadness Rumination</td>
<td>Defeat &amp; Entrapment</td>
<td>.389</td>
<td>&lt;.001</td>
<td>.15</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gender</td>
<td>.033</td>
<td>&gt;.05</td>
<td>.001</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
The current study supports suggestions that internalised perceptions of failure may lead to feelings of rumination being amplified (Traschel et al., 2010). This suggests that individuals' responses to events may lead to their defeat and entrapment perceptions, rather than the events themselves. Furthermore, evidence has suggested that internalised perceptions of failure may influence the development and maintenance of depression (Gilbert et al., 2004), suggesting that factors such as rumination may influence whether failure leads to symptoms related to mental health problems. However, whilst a basic relationship has been demonstrated between failure (conceptualised as perceptions of defeat and/or entrapment) and depression within undergraduate students on a cross-sectional basis (e.g. Gilbert & Allan, 1998; Lester, 2013) and clinical populations on a longitudinal basis (e.g. Rooke & Birchwood, 1998; Upthegrove et al., 2014) there has not yet been a direct test of the influence of rumination within this relationship.

Furthermore, a sample of undergraduate samples was recruited for the current study. Whilst a sample recruited from a clinical setting may have provided greater detail of whether this relationship is observed amongst individuals currently experiencing mental health problems, the research question was exploratory and aimed to establish whether a specific effect was observed. In such research, the use of student samples is common, to demonstrate initial evidence that can then be replicated amongst further samples recruited from specific populations. Secondly, it was expected that a wide variation in the experience of mental health problems would be present amongst participants, in terms of both type of problem and severity. This is beneficial as it helps to give a wider overview of whether a relationship existed amongst a sample more representative of the general population.

The findings of this study have implications for the treatment of mental health problems in therapeutic interventions. Altering individuals' perceptions of defeat and entrapment is likely to influence their behaviours and thoughts and should lead to improved well-being alongside reduced distress for individuals. Sturman (2011) suggested that encouraging clients to identify small challenges in their life that will result in victories that have potential to increase their confidence and mastery. This may occur if individuals enter into an adaptive cycle whereby victories increase self-efficacy and confidence, leading to an increased likelihood of further victories being experienced. Furthermore, ruminating on perceptions of defeat and the lack of escape options may be a key factor in the relationship between defeat and entrapment and mental health problems (Gilbert et al., 2004). Therefore, by targeting the underlying processes of mental health problems, clients may experience greater changes in observable symptoms. For example, this could be done within a CBT setting by providing clients with a contingency plan for a situation that they feel they would be unable to escape from: demonstrating that if the relevant situation arose, escape would be possible (Swallow, 2000). Additionally, highlighting ways in which individuals have control over the symptoms that they experience could be highlighted (Chadwick et al., 2000). This may be particularly relevant for individuals with psychosis, as the high amount of stigma attached to having a diagnosis of a psychotic disorder may act as a barrier to recovery (Link et al., 2001).

As this study was cross-sectional, no causality can be established; conclusions can only be drawn that a significant relationship exists between the variables studied. Further research collected over several time points, preferably studied within clinical and non-clinical populations would be able to confirm the direction of this relationship, and whether there is any variation in how it operates amongst different populations. By collecting information about the presence of symptoms related to mental health problems, such as depression or anxiety, the relationship could be examined in more detail.
Examining the relationship between combined defeat and entrapment and rumination

Conclusions
This preliminary study demonstrates an interesting relationship that has not previously been considered within the literature and suggests that rumination may act as a moderating or mediating factor in the longitudinal relationship between defeat and entrapment and psychopathology. However, no outcomes related to mental health problems were included. Future research should now examine the role of rumination as a moderating or mediating factor in the relationship between combined defeat and entrapment and subsequent mental health problems, on both a cross-sectional and longitudinal basis.

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References


OBSESSIVE COMPULSIVE DISORDER (OCD) is categorised as an anxiety disorder because the central factors are apprehension and discomfort, both of which are usually increased by obsessions and decreased by compulsions or rituals (Jenik, Baer & Minichiello, 1990). According to DSM-IV-TR (2000) a patient with OCD may have either obsessive thoughts or compulsive action, for example, impulses, images, ideas, doubts, fears, ruminations, or checking, cleaning, counting respectively or a combination of both.

Numerous psychological theories, for example, psychodynamics, behaviourism, and cognitivism explain those factors which may cause OCD. Among many other explanations of OCD family theory focuses on the mental health of relatives of OCD patients. However, there is no one ‘official’ definition of mental health. Cultural differences, subjective assessments and competing professional theories all affect how mental health is defined (Patel & Prince, 2010).

The literature (e.g. Jenik et al., 1990) suggests that first degree relatives of OCD patients have a higher than normal prevalence of psychiatric disorders including OCD. Similarly, Ramos-Cerqueira et al. (2008) reported 42 per cent of their studied caregivers of OCD have scored positively for common mental health disorders for example, depression. High prevalence rates for OCD in immediate relatives have led researchers to speculate about the mechanisms through which parents may influence the development and maintain OCD in the patient. Parents may model caution, avoidance or fearfulness that may cause obsessive compulsive symptoms to develop in a child (Barrett, Shott & Healy, 2002).

Therefore, it may be possible that a parent’s psychological state may influence a child’s mental health. It is important to involve parents of OCD patients in the psychological management plan because research (e.g. Pollack & Carter, 1999) reported that parents’ coping styles may play a significant role in the development and in the maintaining of this disorder throughout the child’s life.

Coping can be defined as continuous change in cognitive and behavioral efforts to manage specific external or internal demands that are assessed as physically and mentally demanding as well as beyond the resources of the person (Folkman & Lazarus, 1984). Lazarus and Folkman (1984) proposed two ways of coping as emotion-focused coping, for example, avoidance, minimisation, and distancing, and problem-focused coping, for example, strategies for altering environmental pressure, resources, procedures, and learning new skills. Derisley et al. (2005) reported that parents of children with obsessive compulsive disorder used significantly more cognitive and behavioral avoidance coping strategies than non-clinical parents. Similarly, Geffken et al. (2006) reported denial, disengagement, social support and religious coping in caregivers of patients with obsessive compulsive disorder.

In Pakistan, OCD is an under-researched area as there are only few published research evidence exist on OCD (e.g. Jabeen &
Kauser, 2010). There is a little literature on mental health and coping strategies in the parents of OCD patients. The estimated lifetime prevalence of OCD is generally in the range of 1.7 to 4 per cent in adults (DSM-IV-TR, 2000). It may indicate that the parents’ mental health and coping strategies possibly play a role in the development as well as in the maintenance of this disorder.

In the present study it was hypothesised that there is a difference in the mental health and coping strategies of the parents of OCD patients and the parents of individuals who have no psychological disorders. This research will provide research-based evidence on mental health and coping strategies of obsessive compulsive disorder in Lahore, Pakistan, which may highlight the importance of the active involvement of family in the treatment plan of the patient.

**Methodology**

**Sample**

Non-probability sampling was used, with the sample comprising two groups, clinical and non-clinical. The clinical group consisted of 25 mothers and 25 fathers of OCD patient(s), diagnosed without remission by at least one psychiatrist. The sample for the clinical group was collected from Mayo Hospital, Sir Ganga Ram Hospital and Services Hospital, Lahore. The non-clinical group consisted of 25 mothers and 25 fathers from the general population. The data for this group was collected from Mughal Pura, Baghban Pura, Misri Shah and Bund Road, Lahore, Pakistan.

**Instruments**

1. DSM-IV-TR criteria of OCD was used to confirm the diagnosis. Moreover, the same criteria were used to screen out the children of parents of non-clinical group.
2. Symptom Checklist-R was used to assess the mental health of the parents of the OCD patients. It consists of six subscales measuring six different psychological disorders, namely, depression, somatoform, anxiety, obsessive compulsive disorder, schizophrenia and level of frustration tolerance. Each subscale was validated against a related, translated and adapted test or inventory, measuring the same symptom. The reported validity was between \( r = 0.21 \) to \( 0.74 \), with test re-test reliability between \( r = 0.74 \) to \( 0.96 \) (Rehman et al., 2009).
3. Ways of Coping Questionnaire (WC-Q; Folkman et al., 1984) was used to measure the ways of coping of parents of OCD patients. It features 67 items, measuring two main coping strategies: emotion-focused coping and problem-focused coping. The emotion-focused coping was measured by six subscales: distancing, self-controlling, seeking social support, accepting responsibility, escape avoidance and positive reappraisal. Problem-focused coping was measured by two subscales: confrontive coping and planful problem solving. Internal consistency reliabilities were reported in between .56 to .85 (Folkman et al, 1984). In this study an Urdu translated version of the WC-Q was used (Sitwat, 2005).

**Procedure**

Diagnostic criteria for OCD in DSM-IV-TR were first translated into Urdu. Before collecting data official permission was taken from the Head of the Hospital Psychiatry Department. The researchers obtained written consent from patient and their parents independently. Moreover, participants were also provided with the brief description of the aims and objectives of the study. Data was then gathered for both groups simultaneously.

**Statistics**

The data was analysed through independent sample \( t \)-test, by using SPSS-10. An independent sample \( t \)-test was used to compare the means of the two groups.

**Results**

There was a significant mean difference in the scores for mental health between groups, clinical group (\( M=119.36, SD=52.78 \)) and non-clinical group (\( M=62.20, SD=29.68, \)...
Discussion

The results of the study revealed significant differences between clinical and non-clinical groups on mental health and on coping strategies. Analysis of the results showed that the parents of OCD patients reported psychiatric problems more than parents of individuals without OCD. There was a significant mean difference on the five subscales of symptom checklist, that is, depression, anxiety, OCD, LFT and Schizophrenia.

Similarly, on the ways of coping questionnaire both groups showed mean difference on emotion-focused coping, and problem-focused coping. The results showed that the clinical group was significantly different on self-controlling, escape avoidance and accepting responsibility from the non-clinical group. However, no significant mean difference was revealed on the subscales of problem-focused coping.

Similarly, Ahlstom and Wenneberg (2002) concluded that people under prolonged stress are more likely to use distancing and less likely to use accepting responsibility. Moreover, they also reported that people under prolonged stress were less likely to use problem-focused coping when compared with the control group. However, in the present study no significant difference was found between groups on the use of problem-focused coping. Parents of non-OCD children may have less stress to deal with.

The findings about the mental health of the parents of OCD patients are in line with previous literature (e.g. Nestadt et al., 2001; Ramos-Cerqueira et al., 2008) which suggested that all anxiety and affective disorders are more frequently reported by the relatives of OCD patients. It is interesting to note that both groups are not significantly different on somatoform disorder. The possible reason for presenting these physical symptoms might be that in Pakistan, culturally; physical problems get more attention than emotional or psychological problems. That is why people in non-clinical group also showed these symptoms as a tool to attain their secondary gains.
Limitations and recommendations
The present study is not free from methodological limitations. The study featured a small sample size; therefore, generalisability of the results was questionable. In addition, the sample was collected from Pakistani government hospitals featuring most people from lower socio-economic group. Moreover, at the time of testing local norms of the ways of coping questionnaire was not developed; therefore, Western norms were used. Also the researcher could not screen the whole family of the non-clinical group because all family members were not available at the time of testing. The researcher hence relied on the verbal account of the parent.

The results of the study indicate the need for Pakistani parents of OCD patients should be screened for mental disorders. It may possible that their mental health may not permit them to comply with the treatment of the OCD patient. Their involvement in pharmacological and psychological treatment may give the dual benefit. However, the results of the current study might not reveal that parental mental health contribute in the development and maintenance of the OCD in the patient. Moreover, clinical psychologists should include those strategies which help their parents to build up more problem-focused coping which may ultimately help them to resolve all problems more effectively.

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Coping and mental health in parents of Obsessive Compulsive Disorder (OCD) patients.

**Discussion paper:**

**Cricket, confidence and self-modelling: A QSEP trainee’s reflective case study**

Darren Britton

The following case study details my work with a collegiate cricketer over the course of almost a year-and-a-half, and the development and use of a self-modelling video: a collection of video clips of the client performing his skills in practice. This video was designed to provide him with sources of sport-confidence in preparation for his performances. It was also designed as an alternative to imagery. I reflect on the efficacy of my work, my characteristics as a consultant, the nature of the consultancy over an extended period of time (with varying levels of client-consultant contact), and the practicalities of making a self-modelling video (particularly for a trainee working at an amateur college level), along with its application to sports performance preparation.

**Nature of the consultancy**

I had just begun my supervised experience as a trainee sports psychologist and was volunteering for a sixth-form college’s cricket academy when I was approached by wicket-keeper batsman WK, who had just moved to a new cricket club. They played at a much higher standard, and he wanted to be more confident before he went out to bat. We agreed to discuss it further in a one-to-one meeting at the college. I would be unable to directly observe his club performances if that were required. However, I would be able to arrange one-to-one meetings with WK at the college and attend his matches and training sessions for the college. The consultation would be free of charge for WK as I was in the very early stages of my QSEP training.

I met with WK at the college and firstly asked him to read and sign a consent form, outlining the consultant-client agreement in line with the British Psychological Society’s *Code of Ethics and Conduct*, and the Health and Care Profession’s Council’s *Standards of Conduct, Performance and Ethics*. I then began asking him why he was seeking my help at this time. He explained that he had just left his local club to join a new club and play a higher standard of cricket. His current goal was to be the first team’s wicketkeeper by the end of the following season (17 months’ time). He felt that his biggest barrier was his lack of confidence before going out to bat.

**My initial plans**

I thought that WK’s confidence could be enhanced using a guided imagery script (Morris, 2010; Murphy, 2005). This would involve WK recalling a successful past performance, paying particular attention to details that comprise Holmes and Collins’s (2001) ‘PETTLEP’ model of imagery (Physical, Environment, Timing, Task, Learning, Emotion, and Perspective). WK’s recollection could be developed into an audio-recording, to be listened to as part of his match preparation. Imagery of physical movements shares many of the same neural networks as real movement (Sharma & Baron, 2013). Furthermore, it is widely used by athletes to mentally prepare for competition and aid learning, and is a skill associated with ‘mental toughness’ (Hardy et al., 2010; Wakefield & Smith, 2012). Using imagery also covers many ‘bases’ in line with Vealey et al.’s (1998) cognitive-behavioural model of sources of sport-confidence (notably: mastery, demonstration of ability, preparation, and vicarious experience) (Figure 1).
However, when it came to introducing guided imagery to WK, he wasn’t particularly keen. He appeared to be looking for a more ‘concrete’ technique to use rather than, in his mind, sitting with his eyes shut. Still being a neophyte practitioner at the time, this was something that I wasn’t really prepared for. I had to change my original plan for the consultancy. I suggested that we arrange for another one-to-one meeting a week later, while I considered an alternative strategy.

**A change of plan**

I sought advice from my supervisor and it was suggested that a self-modelling video be used (i.e. a video of WK demonstrating successful performance in practice and/or matches). Self-observation can provide cricketers with information regarding successful past experiences and mastery in practice sessions (Cotterill & Barker, 2013). Furthermore, a self-observation video would, hypothetically, tap into the same sources of sport-confidence as imagery, in line with Vealey et al.’s (1998) model. When I presented this idea to him at our next meeting (calling it a ‘personal highlights reel’), he seemed much more enthusiastic. He agreed that he could watch the video on his tablet computer in his changing room before matches. However, with the college’s cricket season drawing to a close, we would be unable to collect any footage until the beginning of the indoor winter training programme in four months’ time.

After the college’s summer break, where WK played his last few games of the season for his club, the cricket academy began its winter training programme from September through to March. Alongside my other commitments to the academy (running micro-workshops and other individual work), I would video-record WK practising his batting in the nets. WK would watch the footage back, and give me feedback on which shots, in his mind, demonstrated good technique. I would edit the video myself, and through a process of re-editing and refinement in collaboration with WK, a two-and-a-half minute video was produced consisting of his best shots.

**Monitoring the consultancy**

Once the next cricket season had started I was initially able to monitor WK’s progress though brief face-to-face contact through the club’s cricket academy. I was still unable to physically attend his club’s matches though. I would ask him how things were going at his club and whether he was using the video. He had begun the season well and was already in his club’s first team, but was now facing the challenge of still being there by the end of the season to achieve his goal.
When the college’s cricket season had finished, he still had three more months until the end of his club’s season, where I would have to monitor his progress without face-to-face contact. Through the local cricket league’s website I was able to keep track of his and his team’s performances in their league, and give him positive feedback on these performances via email. I would set myself reminders to ‘check-in’ on WK once every two weeks to ask him how he had been doing and whether he was using the video. With two weeks left of the season, I sought to arrange a meeting with him to evaluate our work together.

**Evaluating the consultancy**

Through an email exchange with WK, I was able to ask him questions in order to evaluate the effectiveness of the consultancy. He had established himself as his club’s first team wicketkeeper. He considered the personal video to have been very useful in achieving this goal. However, he found watching his video more effective the evening before a match, as he had struggled to fit it in to his pre-match preparation.

I also asked him to complete a copy of Partington and Orlick’s (1987) Sports Psychology Consultant Evaluation Form, asking him to rate my characteristics on a scale of one to 10, and my effectiveness from minus five to plus five. This was emailed to him in the form of a word-processing document for him to complete electronically and then send back to me (Figure 2). Ratings of my characteristics ranged between eight and 10, and my effectiveness was rated at plus four.

**Reflection**

Based upon the evaluation, it would appear that this consultancy was a success. WK’s goal was achieved, and he stated that the work we did together was significant in accomplishing it. Partington and Orlick (1987) suggest that scores of eight or below for characteristics on the consultant evaluation form should be seen as having room for improvement. Therefore, my openness, readiness and willingness to collaborate and co-operate with WK could have been improved upon (Figure 2). This may well be due to the nature of the consultancy itself, with my ability to keep in contact with him varying greatly throughout the consultancy. Being the college’s trainee sports psychologist and not his club’s, I was actually unable to observe him play in the environment in which the intervention was designed to address (his club environment). Furthermore, during the college’s summer break (where he would play the bulk of his club cricket) my contact with him would be limited to exchanges via email. I feel that this is possibly the reason why my readiness to collaborate and co-operate may have been rated as it was.

I feel that this aspect of the consultancy has given me valuable experience in dealing with clients where face-to-face contact and performance observation opportunities are sporadic and/or limited. In my future career as a consulting sports psychologist, it is highly likely that I will be approached by potential clients from team sports whose clubs or organisations I am not employed by. Perhaps these clients may want to keep the fact that they are seeking the consultancy of a sports psychologist confidential under a consultant-client agreement of consent. However, through negotiations with the client, in future I could make contact with coaches in order to gain their perspective. For example, I could have asked WK if I could make contact with his club coach (under a consultant-client agreement of consent). I therefore could have asked his club coach about his recent performances or even encouraged him to give WK positive feedback on his successful performances, in order to further add to his sources of sport-confidence (coach’s leadership) in line with Vealey et al.’s (1998) model (Figure 1).

It is difficult to say exactly how much the self-modelling video contributed to WK’s success though. He was part of the cricket academy I was running workshops for. Perhaps other psychological skills he picked
up during these workshops also contributed to his success (e.g. self-talk, goal-setting, arousal and emotional control). In other words, it is difficult to isolate the true effect the self-modelling video on WK’s performance, as other psychological skills he had learnt may have acted as confounding variables. At the beginning of the consultancy, perhaps my naivety as an inexperienced trainee was reflected in the fact that I saw the simple goal of WK making it into his club’s first team as sufficient. I perhaps should have used measures in order to assess the short-term effects of the observation video, such as Vealey’s (1986) state sport-confidence inventory (SSCI). However, this would have proven difficult with the little contact time I had with WK. This further highlights the
difficulties of working with clients where face-to-face contact and observation opportunities are limited. Future research could further examine the effects of self-observation on confidence in athletes, and its legitimacy as an alternative to imagery.

I may well continue to use videos such as this as an alternative to imagery when working with clients who are resistant to its use. However, developing it was not without its problems. WK found incorporating watching the video into his match-day preparation difficult. This is due to the nature of a cricket batsman’s preparation, which can be unpredictable based upon whether his team bats or fields first, and how long those above him in the order last out in the middle. WK couldn’t find a consistent time on match-day where watching the video wouldn’t be disrupted. Therefore, in future, I would advise clients to watch self-modelling videos before their match-day preparation (i.e. the night before a game or before their arrival at the venue) in the same way WK ended up doing.

Furthermore, recording and editing the footage proved to be a time consuming and laborious task, as the video was made up of approximately 200 different shots. Using imagery would certainly have been much quicker to implement if WK had been more open to its use. If working in an elite sport set-up, footage for a self-modelling video could be compiled and edited by a performance analysis team in little time at all. On the one hand, it felt satisfying working closely with a client and developing a ‘cutting-edge’ and ‘tech-savvy’ intervention. On the other hand, the reality of many hours spent cutting and editing the footage did make me wonder whether it was really worth all of the time and effort. However, I have learnt that putting in these types of hours is one of the many realities of being a trainee sports psychologist working within amateur sport.

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References

Discussion paper:
Autism through the years
Leah Derham-Boyce

In recent years, recognition of Autism Spectrum Disorders (or ASDs) has increased dramatically. Despite awareness of its existence, many do not know what the disorder actually involves or what causes it, though many mistakenly believe it’s due to vaccine poisoning (Wakefield et al., 1998). Often it is written off as a fraud and a label for someone who displays anti-social behaviours which haven’t been beaten out of them by their parents (Michael Savage on Larry King Live, 2008). Looking back on the origins of autism may help to abolish misconceptions and increase understanding of what having an ASD really means.

Onset
In 1980, the first set of diagnostic criteria for ASD was published in the third edition of the Diagnostic and Statistics Manual (or DSM) by the American Psychological Association. Prior to this, autism did not exist officially. The previous two editions of the DSM had not included autism as a diagnosis. The only mention of autism in the DSM-I and DSM-II was to describe the psychotic reactions and cognitions of childhood and paranoid schizophrenia as ‘autistic’ (APA, 1952, 1968). Psychotic reactions generally refer to delusions, hallucinations, impaired affect, behaviour, intellect and contact with reality. Impairments to affect and behaviour might include the typically autistic impairments to social behaviour and emotional-reactions to change, and impairments to intellect might refer to absent or deficient language. Thus, while inaccurate, it is easy to see how autism may in some ways have been mistaken for schizophrenia.

Since being mentioned under the childhood type of schizophrenia, autism has always been associated with childhood onset (APA 1952, 1968). Indeed, when autism was classified as its own disorder, it was as Infantile Autism in 1980 (APA, 1980). Following that, the DSM always stated that onset was during early childhood, typically around age 3. By the DSM-5 (APA, 2013), however, the description of onset has become much more sophisticated, allowing for belated emergence based on social demands exceeding capacities or learning compensatory (or ‘masking’) strategies.

Furthermore, the description of onset is non-specific regarding duration (APA, 1980, 1994, 2000, 2013). Both this and the acknowledgement of masking strategies demonstrate that ASD has the potential to last into adulthood. This seems to be accurate, as there is ample evidence for lifelong neurological differences between those with and without ASDs. For example, Piven and colleagues (1997) found that many individuals with ASDs have a larger head circumference than controls, due to an abnormally large cerebellum and cerebral cortex, particularly in the right hemisphere. Other cerebellar anomalies have also been found (Bauman & Kemper, 1985). Thus, ASDs may be congenital.

Restricted patterns of interest
From the outset, autism has always been associated with unusual intensities or topics of interest. The DSM-III describes it as a ‘bizarre’ response to the environment, or ‘peculiar interest in or attachments to animate or inanimate objects’. The move away from using words such as ‘bizarre’ and peculiar in following editions may be less of a reflection of increased understanding and more of a reflection on advancements in political correctness.
By the *DSM-IV*, ‘restricted, repetitive and stereotyped patterns of behaviour, interests and activities’ had an entire four-trait section (*DSM-III*), covering similar topics to the *DSM-III*. The main difference in the revision was that the language became less vague—for instance, the number of words used to describe the nature of the unusual interests doubled. The most notable change was the removal of the ‘marked distress over changes’.

It is interesting that restricted interests had a large section, yet there is no mention of anxiety. Recent studies make it clear that those with autism, particularly high-functioning autism, experience above average levels of anxiety, so it is surprising that such a characteristic was not deemed a diagnostic requirement (Kim et al., 2000). Especially since the *DSM-5* includes sensory sensitivity as a criterion, which is often linked to anxiety and distress (APA, 2013; White & Robertson-Nay, 2009). Little else about this section changes much between *DSM-IV* and *DSM-5*.

### Language, communication and interaction

#### Language and communication

By the arrival of the *DSM-III* (APA, 1980), researchers had begun to identify some of the traits we now associate with autism, such as language and communicative impairments. However, these ideas had not yet been fully developed and were at times overly specific (APA, 1980). For example, language was described as involving pronominal reversal as a dominant feature, which was replaced in the *DSM-III-Revised* by unusual speech production, idiosyncratic phrases and conversational conventions (APA, 1987). Before this, there was no mention of how language is used (APA, 1980).

From then on more specific and detailed descriptions of language irregularities and communication deficits were noted. For instance, the use and purpose of non-verbal communication, speech production (e.g. volume and pitch), speech content (e.g. repetition and irrelevant remarks), and conversational difficulties (*DSM-III-R*, APA, 1987). By the *DSM-IV* and *DSM-IV-Revised* (APA, 1994, 2000) the focus had slightly shifted from describing the communicative behaviours themselves to the use and purpose of social and communicative behaviours. For example, using gestures or mime to compensate for an impairment to verbal communication.

However, in the *DSM-5*, verbal language impairments were removed entirely from the diagnostic criteria for ASD, and instead given their own disorder: Social (Pragmatic) Communication Disorder (SCD). SCD includes many of the features of autistic language seen previously, such as difficulties adapting communications to different contexts. It also includes some of the features of communication which had not previously been stated to be absent or deficient, such as taking things literally, or difficulties with certain social rules and conventions.

As a result of removing linguistic impairments, the *DSM-5* criteria now resemble Asperger’s syndrome much more closely. Asperger’s syndrome in the *DSM-IV* only differed from ASD in the absence of verbal language and cognitive impairments, neither of which are criteria for the *DSM-5*’s ASD diagnosis (though cognitive or intellectual disabilities are listed as potentially comorbid; APA, 2013). It would appear that making the diagnostic criteria more similar to Asperger’s syndrome may be a result of observing that many autistic individuals have no problem using language when talking to themselves, but struggle to use it for communicating with others.

#### Interaction

The closest to describing social behaviour that the *DSM-III* comes is mentioning unresponsiveness to others (APA, 1980). Since then, this comment has been exchanged for an entire four-trait section on social reciprocity (APA, 1987). For example, impaired non-verbal skills, peer relationships inappro-
ropriate to developmental level, a lack of seeking to share experiences, and a lack of social or emotional reciprocity.

Following the DSM-III-R, yet more changes were made: more attention was given to non-verbal behavioural impairments, and other features of social interaction (APA, 1994). Emotional reciprocity was added (DSM-IV, APA, 1994) and merged with social reciprocity (DSM-5, APA, 2013). This entire section from the DSM-IV onwards was of major importance, as two of the four traits were a requirement for diagnosis, while the other sections only required one trait in four. Clearly, in time, autism has become more weighted towards reciprocity and social interaction as criteria.

Other ASDs
In the DSM-IV (APA, 1994), three new disorders were added or the Autism Spectrum Disorders section: Childhood Disintegrative Disorder, Rett’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Childhood Disintegrative Disorder (CDD) and Rett’s Syndrome (RS) are both degenerative disorders involving typical development up to the age of onset, followed by regression and the unlearning of social and communicative skills, and other skills. RD shows fewer similarities to typical autistic disorders, for instance it involves decelerated head growth, loss of purposeful motor skills and poor coordination of the torso. It does involve the development of the stereotyped hand movements, decreased social engagement and impaired language, though CDD is far more similar to traditional ASDs. CDD has three sections in common with traditional ASDs: impaired social interaction and communication and restricted, repetitive interests. However, CDD also has unique features of its own, though less than RS: loss of play, motor skills and bowel control. Both show a similar age of onset to ASD. While the APA have not specified the reason for the removal of CDD from the DSM, they have stated that the reason for removal of RS is because it was recently associated with mutations to a protein encoding gene (MeCP2; Amir et al., 1999) and thus is a genetic disorder, not a psychological one.

Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS) was also removed from the DSM as it was basically just an ‘other’ category. Those with this diagnosis are able to gain a diagnosis of ASD in the DSM-5 though.

Discussion
Where autistic diagnoses used to be more like using a ‘pick and mix’ method, it’s now a ‘satisfy all criteria’ method. One might think that this would result in the Disorder no longer reflecting the Spectrum nature of the condition. On the contrary, three severity levels have been included to allow for more descriptive differentiation between the diagnosed. Moreover, the DSM-5 no longer includes the other ASD (seen in the DSM-IV), so some of these are now merged into this single Disorder. Thus this is now aptly renamed Autism Spectrum Disorder, which still allows for variation. It needs to, since the other ASDs seen in the DSM-IV are now merged under this umbrella term.

Unfortunately, the removal of RS due to the genetic link has left some dissatisfied. However, some, such as Huda Zoghbi, one of the researchers who discovered the genetic mutation, argue that genetic mutations like this are going to be found to account for all ASDs. So what will the APA do? Remove these too? Instead of removing disorders from the DSM every time a genetic basis is found, Zoghbi (2014) recommends an alternative method of inclusion for ASDs, involving two subcategories account for syndromic and non-syndromic autism. Whether this would be more accurate or not is unclear, as it has yet to be concluded beyond a shadow of a doubt that autism is a solely genetic disorder. There is some evidence for heritability, such as family studies (Hallmayer et al., 2011; Hoekstra et al., 2007), but there have also been sugges-
tions for other explanations. One such example being ‘Extreme Male Brain’ theory (Baron-Cohen, 2002) – the theory that autistic traits are the result of a hyper-masculinised brain geared toward systemising rather than the more feminine trait of empathising. This hyper-masculinisation is thought to possibly result from unusual testosterone exposure during pregnancy (Baron-Cohen et al., 2009). Only time will tell us the true cause.

Conclusion
In summary, diagnostic criteria for ASDs have developed over the years and become more complex and sophisticated. What started as behaviour thought to be part of schizophrenia has become a unique developmental disorder, with very different features and traits. Controversy has arisen upon publication of each edition of the DSM, from concerns over terminology, to adding and removing traits and even entire related disorders. But, a few things remain generally the same: onset is still during childhood (with the potential for later emergence), impaired communication and interaction are still included, as are unusual interests. What remains is for the general public to be better informed, to the point that misconceptions like ‘it’s a fraud… [autism is] the illness du jour’ (Savage, 2008) are nowhere to be seen.

But my final question is: ‘What do these changes mean for those on the Autism Spectrum?’

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References


Discussion paper:
Hoarding – more than just an obsession with collecting?
Katy Jones

My experience

We ALWAYS KNEW my grandmother was a little eccentric. She liked to collect ornaments and fill every available space with them. She loved buying cushions and piling them on the sofa making it almost impossible to sit on it. She adored books and filled the hallway with them. She always made herself look glamorous before leaving the house and was very popular with her neighbours and family. We would meet most weekends either at her house or in town for lunch, but during my teenage years these visits became less frequently at her house and more often in town. From what I can recall, the ever growing pile of newspapers next to her fire had been questioned by another family member which (we assumed) had then led to her preferring to take our company outside the house. We never questioned it with her – as my grandmother was an incredibly independent woman and had been ever since her husband had passed away. She rarely accepted help from anyone and valued her privacy.

In December 2010, my aunt and her husband delivered an almighty blow. My grandmother had passed away in her sleep, found amongst her things in the front room. After the funeral, we decided to start the process of sorting through her belongings. As I walked through the door into her home, in what must have been the first time in at least seven years, I had the biggest shock. This wasn’t the cute, eccentric home full of collectables that I remembered. The rooms were barely recognisable and there was little room to move. There were piles of magazines and newspapers in the living room along with teddies, cushions, ornaments and bags full of bric-a-brac. The kitchen was full of foods dating back years and the bathroom contained a bath which had been used as a storage box for yet more toys, clothes and ornaments. Then there was the bedroom, full of clothes and shoes which littered the floor, the bed, everywhere. Some looked as though they had never been worn, and the bed, had not been slept in. We could barely even get over to it. How could it of ever got like this? My grandmother had always presented herself so well to the outside world, but inside her home was complete chaos.

An introduction to Hoarding

So what had gone on? This wasn’t just an ‘untidy’ or messy’ house, this was different. Her ability to carry out simple everyday tasks such as cooking and washing had been comprised. It was then that I came across the term ‘compulsive hoarding’ – now referred to as ‘Hoarding Disorder’ (HD) in the Diagnostic and Statistical Manual of Mental Disorders (5th ed. – DSM-5) where for the first time it has been recognised as a separate diagnostic entity (American Psychiatric Association, 2013).

Hoarding was previously considered as a symptom of Obsessive Compulsive Disorder (OCD; American Psychiatric Association, 2000) due to the fact that the fears of losing valuable or personally important things experienced by individuals who hoard, resembled ‘obsessions’ and the urges to save or collect items resembling ‘compulsions’ (Clark et al., 2010). Often, however, many people presented with hoarding symptoms
but without any of the common symptoms of OCD and the thoughts experienced by ‘Hoarders’ were rarely intrusive or unpleasant. Conventional treatments for OCD were found to be unsuccessful for those presenting with hoarding symptoms (Clark et al., 2010; Frost, Steketee & Tolin, 2003). More recently, the DSM-5 presented hoarding as its own discrete disorder within the ‘Obsessive Compulsive and Related Disorders’ chapter and has been characterised as the ‘persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions… for individuals who hoard, the quantity of the collected item sets them apart from other people with normal collecting behaviours… and the behaviour usually has harmful effects – emotional, physical, social, financial and even legal for the person suffering from the disorder and family members’ (American Psychiatric Association, 2013).

So how does it happen?
I’d seen documentaries on TV about people who were ‘hoarders’ – usually outcasts of society that had ruined the reputation of the village living in dirty, messy houses. Adults (usually 50+) who had been living amongst dangerously high piles of objects, clothes and books, alarming both friends and family, were then set up to meet with professional de-clutterers: people brought in to clear the clutter and sort their lives out by helping the hoarder to organise their belongings into ‘keep’, ‘sell’ and ‘throw’ boxes. But was it really that simple?

It was distressing and upsetting for these people to see their belongings touched, sorted through and potentially thrown away. Nothing was discarded without their permission, but the mere thought of it was distressing enough. These people had developed sentimental attachments to these objects and couldn’t bear to throw them away or see them passed on. Even pieces of rubbish that no longer served an obvious purpose were clung on to with no explanation. Watching these programmes made me almost glad in a way that my grandmother had passed away peacefully amongst all her belongings, had we known the extent of the clutter, would we of tried to do something about it and would this in turn have traumatised her? I’m glad she never had to experience that kind of distress and upset.

So what is it that brings a person to get to the stage where they can no longer discard or throw away an object?

There is some interesting research that suggests that trauma plays a vital part in future hoarding behaviours (Allen et al., 2005; Cromer, Murphy & Schmidt, 2007; Frost et al., 2010; Iervolino, 2011). A study by Iervolino et al. (2011) which looked retrospectively at past trauma using semi-structured interviews found that across four groups of participants, hoarding disorder without co-morbid OCD, hoarding with co-morbid OCD, OCD without hoarding symptoms, and non-clinical controls, was found that hoarders (regardless of the presence of co-morbid OCD) reported greater exposure to a range of traumatic and stressful experiences compared to the two non-hoarding groups and around half of the hoarding group (52 per cent) linked the onset of their hoarding behaviours with stressful life experiences.

A study looking at the relationship between hoarding, trauma and attention-deficit/hyperactivity disorder found that compared to a sample of controls, hoarders reported a significantly greater number of traumatic or stressful experiences as well as symptoms of inattention and hyperactivity (Allen et al., 2005). Further, a study that looked at whether trauma influenced the expression of hoarding in individuals with OCD found that compared with those individuals with OCD who did not hoard, a significantly greater number of hoarders reported at least one significant traumatic life event (Cromer, Murphy & Schmidt, 2007).

My grandmother had been placed in a foster home from an early age. Her last
recollection of her mother was at the age of 5, when she had been given a doll and a promise that she would see her again, which she never did. Over the years it became apparent how much this had affected her and also the impact it had on her relationship with her husband. My grandmother was loved by so many people and was always trying her best to help others, but inside she was always the little girl who had been left at the door by her mother.

A cognitive behavioural model of hoarding (Frost & Hartl, 1996) suggests that individuals who hoard have three main areas of dysfunction: information processing, maladaptive beliefs about possessions and emotional distress and avoidance. Firstly; individuals who hoard exhibit substantial problems with focusing and sustaining attention (Allen et al., 2005) and greater response latencies for decision-making about their own possessions (Book et al., 2009). Secondly; maladaptive beliefs about, and emotional attachment to possessions, which research suggests falls into four basic subtypes (emotional attachment to possessions, poor memory confidence, exaggerated sense of responsibility for possessions and desire for control over possessions) and thirdly; emotional distress and avoidance – the maladaptive beliefs that exist are thought to lead to intense emotional experiences (e.g. anxiety, grief) about the prospect of losing an object. This then leads to avoidance and escape in the form of saving and acquiring objects (Christian et al., 1995). Tolin and Villavicencio (2011) found that inattentiveness in particular was a key predictor of hoarding behaviours which may also serve as a barrier to effective treatment.

**Treatments**
Quite recently, a documentary was aired on Channel 4, *The Hoarder next door*, which introduced us to a group of individuals who had all developed serious problems with hoarding but who all shared a common theme- they had all experienced some kind of loss in their lives. The professional de-clutterers sent in to divide and conquer were still there – but before this happened, a psychotherapist named Dr Stelios Kiosses visited the hoarders to offer them the opportunity to look into their pasts and make the connection between their hoarding behaviours and their past trauma. The hoarders underwent six weeks of psychotherapy with Dr Kiosses before any de-cluttering took place. In one episode, a lady who had suffered a lifetime of misfortune and loss including her husband, child and job, was treated using Eye Movement De-sensitisation and Reprocessing (EMDR) to help her come to terms with the loss she had experienced and move forward with her life.

The most common treatment available for hoarders is based around the CBT model and involves office and home visits, motivational interviews, exposure treatment, cognitive restructuring, decision-making training and efforts to reduce acquisition and have shown some promising results in treating hoarding symptoms. In a study by Frost, Tolin and Steketee (2007) 40 per cent of patients receiving 26 individual CBT sessions including frequent home visits have showed ‘much improved’ or ‘very much improved’ ratings on the Clinicians’ Global Impression (CGI) scale mid-treatment and 50 per cent at post-treatment. Another study last year, also looking at the outcomes of cognitive behavioural therapy in treating Hoarding Disorder (Frost et al., 2013) found that ratings provided by patients and clinicians using the CGI scale showed that 62 per cent of patients were rated as ‘much improved’ and 79 per cent as ‘very much improved’ at follow-up. Interestingly, perfectionism and social anxiety were significant predictors associated with a ‘worse outcome’ for patients. Results such as these are encouraging as previous attempts to treat hoarding behaviours using different methods e.g. using medication and behavioural therapy have in the past not been as successful (Collier et al., 2009).

Perhaps my grandmother’s hoarding behaviours could have been explained by a
number of things, such as difficulties with information processing, decision making, and maladaptive beliefs about possessions but also because of her past emotional trauma, feelings of abandonment and loss. Now that we know more about the possible causes of hoarding, there is hope that we can help raise the profile of this disorder so that others can recognise the behaviours as more than just ‘collecting’ or ‘being a bit eccentric’ and help these people to gain control, before it’s too late.

References

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Here is no doubt that our contemporary commercialised culture is rendering children more materialistic than ever before (Schor, 2004). One significant concern is that the media is encouraging children to believe that consumer culture ‘ideals’ (CCIs) of materialism and appearance (i.e. excessive affluence, the latest material possessions, and the ‘right’ image and body-type), are essential for optimal well-being, and a viable way to compensate for social and emotional difficulties (Opree et al., 2011, 2012). Nevertheless, it remains unclear whether children turn to consumerism when they are feeling upset or experiencing stress, and what effect this has upon their overall well-being. My Master’s dissertation is the first study to explore relations between media exposure, consumer-focused coping strategies and well-being among preadolescent children.

CCIs and well-being
Despite the pervasiveness of consumerism throughout Westernised culture, a number of correlational studies have now demonstrated that adults who strongly endorse these CCIs, tend to exhibit lower levels of subjective well-being and life satisfaction (e.g. Kasser & Ryan, 1993, 1996). There is now a growing evidence base of the same negative link among adolescents and children, whereby preoccupation with CCIs has been found to be associated with conduct disorder, lower societal adaptation, commodity-based bullying, body dissatisfaction and disordered eating behaviour (e.g. Harrison & Hefner, 2006; Kasser, 2002, 2005). But where do such values emerge from?

The media’s grip
One pathway to explaining the development of materialistic values is via the mass media; a powerful socialisation agent which routinely accentuates the importance of CCIs. In fact, it is estimated that the average child will now be exposed to over 40,000 commercials annually through sources such as the television, internet and magazines (Kunkel, 2001). Such advertisements incorporate an array of persuasive techniques that encourage individuals to invest in CCIs. Clever marketing strategies, for instance, promote products as salient routes to happiness. This results in a common misconception throughout society, which assumes that CCIs have the ability to essentially remove negative emotions, and elicit well-being. In this regard, it seems plausible that excessive exposure to such messages may encourage impressionable children to turn to CCIs as a form of coping mechanism.

CCIs as a coping mechanism
Just as CCIs may lead to lower well-being, research has suggested that lower well-being may also reciprocally lead individuals to seek consolation in CCIs in their attempts for coping. It is habitually believed that these ideals have the ability to regulate mood, provide psychological and identity-related benefits, offer status, and provide security.
and normative value (Elliot & Leonard, 2004; Furby, 1991; Garðarsdóttir & Dittmar, 2012; Isaksen & Roper, 2008; Kasser et al., 2004). For example, researchers Chang and Arkin (2002) primed participants with either self-doubt or societal doubt (anomie). Results illustrated that following both of these primes, participants were more likely to adopt materialistic values in an attempt to overcome the experimentally-induced adversity. Another study by Kasser et al. (1995), found that teenagers of cold and punitive parents, were more likely to develop materialistic orientations in an attempt to satisfy psychological needs neglected by their care-givers.

But does this actually work? Do CCIs equate to an adaptive coping response?

**Does it work?**

Going by the intuitions provided by Ryan and Deci’s (2000) Self-Determination Theory (SDT), we guess not. This is because CCIs are extrinsic in nature and are in line with rewards, contingent evaluations of others and social status. These motives are thought to be paradoxical to more intrinsic psychological needs for things like close relationships, self-acceptance, competence and autonomy.

However, despite consistent correlational evidence outlining negative associations between the endorsement of CCIs and lower well-being, and the insights provided by SDT, the direct link between consumer coping strategies and well-being was yet to be examined within the psychological literature; particularly among children. It is likely that children utilise consumer-focused coping strategies in response to stress, as they are more susceptible to the unrealistic hedonic messages highlighted within the media (Valkenburg, 2000). This may be reflected in increased demands on parents for advertised products, or through greater investment in physical appearance.

With this in mind, our study set out to explore associations between media exposure, consumer coping strategies and well-being among children aged between 9 and 11 years. The primary focus of the research was to examine the role of consumer coping strategies as a potential mediator of the link between media exposure and well-being. Our three hypotheses were:

1. Children who regularly engage with the media will be more likely to use CCIs as coping mechanisms.
2. Consumer-focused coping strategies will predict lower well-being in children.
3. Consumer-focused coping strategies will mediate the association between media exposure and well-being.

**Method**

School children aged between 9 and 11 years were recruited from two suburban primary schools in Sussex (N=79). The children were given a booklet of five self-completion measures.

The first measure looked at children’s coping behaviour and was adapted from Wright and colleagues’ (2010) original paper. Here, children are asked to state what they usually do when they feel upset. The questionnaire then lists a number of different coping strategies which fall within the domains of problem-solving, social support, distraction and trivialisation. The measure was extended to include consumer-focused coping behaviour, which included both materialistic and appearance-focused strategies such as ‘When I am feeling upset…I ask my parents to buy me something new to make me feel better’ and ‘I spend time making myself look better’.

The second measure looked at how long children spent watching television, surfing the internet and reading magazines on a daily basis (Harrison & Hefner, 2006).

Lastly, well-being was measured using three different indicators: loneliness and peer rejection (Asher & Wheeler, 1985); life satisfaction (Huebner, 1991); and depression (Kovacs, 1992).
Results

Firstly, a correlation analysis was run on all variables in the study. In line with expectations, consumer coping strategies demonstrated a negative relationship with life satisfaction ($r=-.37$, $p<.01$) and a positive relationship with depression ($r=.35$, $p<.01$). There was a positive correlation between the number of hours children spent watching television, and levels of depression ($r=.40$, $p<.001$) (correlations for internet and magazine exposure were non-significant). There was also a positive correlation between television-viewing hours and consumer coping strategies ($r=.21$, $p<.10$).

Next, we conducted multiple regression analyses to examine the hypothesis that consumer coping would predict lower well-being in children. We carried out three separate analyses on loneliness, life satisfaction and depression as the outcome variables. Problem-solving, social support, trivialisation, distraction and consumer-focused coping were entered into the analyses as predictor variables (Table 1).

In support of our hypothesis, consumer coping was a significant negative predictor of life satisfaction, and a significant positive predictor of depression.

We conducted mediation analysis in order to test the a priori hypothesis that consumer coping would mediate the link between media exposure and well-being, and to follow up evidence of significant associations between consumer coping strategies, television-viewing time and depression.

After running the Sobel test, no mediation was found in this model. In contrast to our original expectations, this suggests that consumer-focused coping does not mediate the relationship between television exposure and depression. Instead, the independent variable (television hours) and the mediator (consumer-focused coping) exert independent effects on the outcome variable (depression) (Figure 1).

We decided to explore the data further and so tested an alternative mediating model. In this model depression was entered as the mediating mechanism through which television exposure influences consumer coping. The Sobel test indicated that the indirect pathway from television-viewing time to consumer coping strategies, via depression, was indeed significant (Figure 2).

| Table 1: Results of multiple linear regression analyses of Consumer Coping, Problem Solving, Social Support, Trivialisation and Distraction on Loneliness, Life Satisfaction and Depression. |
|---------------------------------|----------------|----------------|----------------|
|                                 | Loneliness | Life Satisfaction | Depression |
| Consumer Coping                | .24+       | -.46***           | .49***       |
| Problem Solving                | -.13       | .08              | -.14         |
| Social Support                 | -.10       | .04              | -.17         |
| Trivialisation                 | -.16       | .24+             | -.14         |
| Distraction                    | .05        | .04              | 0.2          |
| $R^2$                          | .08        | .22**            | .21**        |

Note: $^+p<.10$, $^*p<.05$, $^**p<.01$, $^***p<.001$
Discussion

This study was the first, to our knowledge, to examine correlations between media exposure, consumer-focused coping strategies and well-being in preadolescent children. Specifically, we designed the study to explore how consumer coping strategies might mediate the relationship between media exposure and well-being.

Results imply that the utopian nature of the media may encourage heavy viewers to seek fulfilment in CCIs as a form of coping response. Additionally, in line with the intuitions provided by Self-Determination Theory, internalisation of consumer-focused coping strategies was found to predict lower levels of life satisfaction, and higher levels of depression in children. Hence, turning to extrinsic sources of comfort when distressed (image, money or possessions) is likely to have a reverberating effect, as these sources do not provide the right conditions to satisfy intrinsic psychological needs.

However, there was no mediation found in our original hypothesised model, suggesting that consumer coping and hours spent watching the television exert independent effects on depression. Instead, an alternative mediating model identified depression as a possible mechanism for explaining why children who watch more television, are more likely to turn to consumer coping strategies. Although further longitudinal evidence is required to evaluate temporal
sequences, this suggests that watching hours of television may leave children feeling unhappy and disappointed, which may in turn encourage the endorsement of consumerist behaviours in an attempt to cope with said discontentment.

Despite typical limitations of the correlational design and use of self-report measures; overall our results build upon limited knowledge on how children interact with our contemporary commercialised culture. They have direct theoretical implications for SDT with regard to consumer coping mechanisms that undermine children’s well-being.

Our results also call for greater restrictions on advertising and marketing campaigns aimed at children. With a relentless stream of media messages suggesting that consumerism leads to happiness, it is unsurprising that unhappy or insecure children may use this ‘knowledge’ in an attempt to better their lives and assuage negative emotions. It may be challenging, but society needs to instead promote non-materialistic sources of comfort to deal with stress, and focus on more intrinsic forms of coping mechanism (Ryan & Deci, 2000). This lends itself to a productive avenue for interventions designed to reduce materialistic orientations within young people.

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**References**


HE PsyPAG Annual Conference 2014 took place from 23–25 July at Cardiff Metropolitan University. Building upon the success of previous PsyPAG conferences, over 100 delegates filled the lecture theatres to present their research or to learn about their peers. A total of nine organised symposia were held, including Research Methods, Forensic Psychology, Developmental, Health and Transpersonal Psychology. General talk sessions were also part of the programme and included research on conspiracy theories, social punishment, moral dilemmas as well as disengagement and stereotype threat. The conference, therefore, provided a source of networking for like-minded, motivated postgraduate students across a range of fields in psychology.

The conference hosted four excellent keynote speakers across the three days. First, Dr Paul Hutchings offered advice regarding postgraduate study and disseminating research into society. He explained how research could make an impact to individuals in the general public, offering the layman an opportunity to understand what psychologists do and the research that we undertake. I and many other students found this talk particularly beneficial. Indeed, we all know that our research should make an impact, but it is sometimes difficult to understand how we can go about this; where do we go to publicise our research? Will the general public accept it? What are the benefits (and limitations) of disseminating our research? Paul explained that you have to be confident in your research; explore different outlets in which your research can be published. If you find the time, it will sure be worth it.

Professor Patrick Leman led the second talk. Although Patrick’s research focuses around social identities and how they can influence children’s development, Patrick took a different stance with his keynote speech through which he explored another research interest: the psychological nature of conspiracy theories such as those surrounding the 9/11 disaster, Princess Diana’s death and the JFK assassination. Patrick’s keynote was fascinating. He further highlighted why we should all strive to have extra research interests and taught us that we do not have to be guided by only one research area. Patrick ended his talk by playing Led Zeppelin’s Stairway to Heaven backwards; he stated, ‘Humans can attribute meaning to anything’.

In another keynote, Occupational Psychologist Dr Almuth McDowall discussed ‘What is work-life balance and how can you manage your own?’, a topic that resonates with all of our lives. As such, I found it extremely beneficial to explore the importance of managing our workload and social life, and strategies to do so in an ever-growing and competitive psychology discipline.

Professor Paul Bennett led the last keynote talk. Offering yet another psychological perspective, Paul drew upon his previous experience working in the NHS and universities such as Cardiff, Bristol and Birmingham. Now a Professor at Swansea University (and the current chair of the British Psychological Society’s Division of Health Psychology) Paul discussed his research interests in psychological interventions and the challenges and coping strategies associated to the threat of illness. Here,
Paul focused on the requirement to shift from individual to systemic psychosocial interventions.

As well as four fascinating keynote speakers, we were also presented with an exciting social programme across the three days. This social aspect of the conference was organised to provide postgraduates with further chance to discuss their research interests and network with students’ from over 20 different universities. Here, students came together from universities as far as Naples and Milan. This was a great (and cultural) experience in itself, as students’ offered many different perspectives about undertaking postgraduate study outside of the UK. The social programme included a BBQ by the River Taff in Llandaff and a three-course meal in the impressive Cardiff City Hall.

As well as the conference presentations, the PsyPAG Annual General Meeting was hosted to elect new committee members and to thank those stepping down from the committee. The committee received numerous applications for each post, making it the most competitive year yet. New committee members were voted in for various posts, including the representatives for the Developmental, Psychobiology, Social, Cognitive, Health and Sports sections, a vice-chair and two Quarterly editors. There are still a few committee positions available so if anyone is interested, please go to the PsyPAG website where all information regarding the vacant positions (and the application process) can be found.

Overall, the PsyPAG Annual Conference 2014 was a huge success, welcoming delegates from near and far. Yet, it wouldn’t have been such a success without the hard working, dedicated and organised members of the PsyPAG committee, including the lead organiser and conference chair Hamish Cox. Thank you to all, and I look forward to next year’s PsyPAG Annual Conference (and 30th anniversary celebrations), in Glasgow!

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**Health Psychology symposium review:**

**Showcasing Health Psychology postgraduate research: Contemporary theory and methods**

Kimberley Hill

PsyPAG Annual Conference 2014, Cardiff Metropolitan University, 23–25 July

Health psychology is a relatively novel field which brings together a wide range of approaches, methodologies and theories. The field has previously been dominated by theory-driven quantitative research, but important contributions have been made to the field by research using qualitative or mixed methods (O’Cathain, 2009). It is important to showcase the breadth of current health-related research conducted by postgraduates, as this research has very practical implications on policy, health care and prevention. In addition to this, there are a diverse range of postgraduates involved in this type of research, including Master’s and Doctorate students, as well as trainees on courses accredited by the British Psychological Society (BPS).

Each year, the Psychology Postgraduate Affairs Group (PsyPAG) Conference Committee receives increasing numbers of submissions from postgraduates who are interested in the psychological processes of health, illness and health care. As the PsyPAG Division of Health Psychology representative for 2012–2014, I wanted to bring together these research interests and expertise by hosting a Health Psychology Symposium and a Health Psychology Keynote at the PsyPAG Annual Conference 2014. I was delighted that the Division of Health Psychology (DHP) recognised the value of showcasing Health Psychology postgraduate research and kindly agreed to sponsor the symposium and the keynote.

This year, the 29th PsyPAG Annual Conference 2014 was held at Cardiff Metropolitan University. Delegate demographics suggested that many were a member of the DHP. This was also demonstrated by accepted poster abstracts. For example, many of the posters presented at the conference were health-related, with research on blood transfusions, autism, osteoarthritis, alcohol misuse, chronic pain, sexual health, depression, learning disabilities and multiple sclerosis. I was also very grateful to the chair of the DHP, Professor Paul Bennett, for providing such an engaging and popular Psychology keynote at the conference. Professor Bennett’s presentation focused on the need to shift from individual to systemic psychosocial interventions, with a very relevant focus on improving health in Wales.

Following the call for abstracts for the Health Psychology symposia, I received many excellent submissions from postgraduates studying a range of health-related topics. This led me to host two Health Psychology symposia at the conference, both of which proved very popular for delegates. Speakers in these sessions included those completing Master’s and Doctorates, including those on BPS accredited courses, with a diverse range of health-related research interests. Within each symposia, speakers appeared to be using contemporary approaches and methods in their research to address real-world, health-related problems. For example, in her presentation, Emilia Trapasso from Liverpool John Moores University described how she is using semi-structured focused groups and grounded theory to explore children’s perceptions of
obesity and healthy lifestyle choices. In her Master’s research, Emilia is asking children to draw pictures of healthy and unhealthy meals and to describe why these are perceived in this way. Emilia’s research will provide a greater understanding of young children’s perceptions of healthy lifestyles and the lifestyle choices that they make.

The methods used by speakers in their research were not only innovative, but challenging. For example, Kayleigh Nelson from Swansea University described how she is using joint interviewing in the context of prostate cancer. In her presentation, Kayleigh explained how joint interviewing is not only a relatively under-used method of data collection, but it is also difficult to implement. Kayleigh gave an interesting insight into the factors researchers should consider before conducting individual or joint interviews. Kayleigh’s Doctoral research will provide a valuable perspective into how couples co-construct meaning and share their illness experience. Martine Robson from Aberystwyth University is also focusing on couples’ experiences, but as they make lifestyle changes following diagnosis with coronary heart disease. In her presentation, Martine provided a fascinating insight into how couples manage these changes. For example, Martine explained how couples create changes that they can live with, such as reducing the intake of unhealthy foods rather than prohibiting them completely. Martine’s Doctoral research will inform future support for those making lifestyle changes following diagnosis.

Many speakers were using contemporary theories to study the psychology of health and illness. For example, Salvatore Di Martino from the University of Naples Federico II, proposed that researchers need to take an inter-disciplinary approach to understand health and well-being. In his presentation, Salvatore suggested that this requires a combination of both top down and bottom up factors, including contributions from a number of disciplines. Salvatore’s Doctoral research will provide a new outlook on happiness and well-being, with a focus on the role of context, justice and morality. Jin Zhou from Edge Hill University also provided an innovative view on understanding alcohol consumption in terms of identity and group membership. In her presentation, Jin gave an engaging insight into the social influences and group-level processes that regulate drinking behaviour. Jin’s Doctoral research will uncover how social identity shapes alcohol consumption in certain social groups, including the implications this has for well-being and development (Zhou, O’Brien & Heim, 2014).

I was fortunate to be able to present my own research in one of these sessions. My Doctoral research also takes an inter-disciplinary approach to investigate drinking behaviour. In my presentation, I suggested that taking behaviour which occurs in an external world back to be explained in terms of internal, psychological determinants overlooks the unmediated and direct transactions between brain, body and environment. Instead, researchers should engage in conceptual and methodological re-tooling in order to overcome prevailing dichotomies between what is deemed to be qualitative-quantitative, objective-subjective and psychological-environmental. For example, I proposed that subjectivity could actually be re-defined and used as a tool to investigate how an individual’s relationship with their environment promotes and inhibits opportunity to consume alcohol. In turn, I proposed that these ideas could have important implications for how researchers understand health and prevent harms in society.

I was also very impressed with the discussions that were generated after each presentation between delegates and speakers. This included specialist topics, such as therapy-genetics. For example, Moritz Herle from King’s College London highlighted the importance of looking at individual and environmental influences. In his fascinating presentation, Moritz described how therapy-
genetics can identify genetic markers associated with responses to psychological interventions, such as exposure-based cognitive behavioural therapy. Moritz explained that, by focusing on these gene-environment interactions, researchers could better explain anxiety disorders. Moritz’s Master’s research will have implications for understanding the causes and treatment of common mental health problems.

The research presented in these sessions also had important practical implications. For example, Daniel Herron from Keele University explained how he is focusing on the experiences of those with intellectual disabilities that are living with dementia. In his engaging presentation, Daniel explained how little research explores the experiences of living with dementia, particularly for those with intellectual disabilities. Daniel’s Doctoral research provides an insight into these experiences, with unique contributions from family members and carers. This research will provide implications for how existing support systems can best be utilised to provide holistic care and support (Herron & Priest, 2013).

Yvonne Whelan from Birkbeck, University of London, also provided an interesting overview of her research, which focuses on distinct developmental pathways from maternal to adolescent depression. In her presentation, Yvonne focused on the unique contribution of irritability and the potential that this research has for prevention. Yvonne’s Doctoral research will also be crucial in informing both future research and evidence-informed treatment approaches.

Overall, the Health Psychology symposia enabled a diverse range of postgraduate research to be showcased and brought together under one broad theme. This research was of exceptionally high-quality, with many speakers using innovative theories and methods. I hope that future conferences and events will be able to showcase the valuable work that postgraduates do in this area. Sadly, I have now completed my two-year tenure as the DHP PsyPAG representative. However, I know that the PsyPAG Annual Conference will continue to be an encouraging and supportive platform for all postgraduate research and particularly that conducted by postgraduates interested in the psychological processes of health, illness and health care.

Acknowledgement
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References
Conference review:

BPS Cognitive Psychology Section Annual Conference

Harriet Smith

Nottingham Trent University, 3–5 September 2014

The BPS Cognitive Psychology Section Annual Conference took place at Nottingham Trent University this year (from the 3–5 September), with a jam-packed programme of prominent keynotes, symposia, presentations and a pre-conference (2 September) workshop. The conference was topped off with free lunch, tea and coffee, and (most importantly!) biscuits – what wasn’t there to like?

The proceedings began with a pre-conference Python programming workshop, organised for postgraduates, and run by Dr Mark Andrews (Nottingham Trent University). As a programming language, Python is highly versatile, free, and ideal for psychological experiments. We were all keen to get to grips with the syntax, not least because experience of computer programming is a much sought-after skill in the academic job market, and elsewhere. Most of us who took part had no prior experience with programming, so the workshop was a great opportunity to begin our Python-orientation and to embark on the journey of gaining greater control over our experiments. We must have all looked a bit shell-shocked at the outset, but luckily Dr Andrews was very gentle and patient with us.

As the new Cognitive Section Representative for PsyPAG, I was up at the crack of dawn the next day to get the PsyPAG stand ready for all the lovely postgraduate students. (I’m hoping the free sweets on the stand had nothing to do with the number of visitors we received!) There were a good number of students attending the conference, most of whom arrived suffering from bouts of pre-presentation nerves. Many of us were attending an academic conference for the first time, but we certainly needn’t have worried. Fellow students were available for moral support, and even with 160 delegates overall, the conference was a relatively intimate environment. That’s not to say that it didn’t feature its fair share of academic heavyweights, but from post-docs to professors, everyone was encouraging and constructive.

The conference organisers, Dr Andrew Dunn and Dr Duncan Guest from Nottingham Trent, secured some great keynotes from well-known, well-respected academics, who delivered talks to a packed auditorium. The opening keynote address was from Professor Simon Liversedge, on ‘Binocular processing during reading’, and the Broadbent Lecture this year was given by Professor Graham Hitch, of working-memory model fame. Professor Hitch was actually supervised by Donald Broadbent for his PhD, and rounded off the talk, ‘Working memory and attention’, by drawing links between his current work, Broadbent’s original insights into attention processes, and broader issues now current in Psychology. The timing of his talk couldn’t have been better, as this year is the 40th anniversary of the working memory model. The final keynote address came from the Cognitive Section Award Winners for best paper: Harris, Young and Andrews, ‘Neural representation of facial expression’, a fascinating talk jointly delivered by the second and third
authors, which emphasised the importance of a multi-methodological approach, in this case behavioural, neuropsychological and imaging.

Three parallel sessions of talks ran on each day, covering a spectrum of cognitive topics: face processing, thinking and reasoning, attention, language, memory… the list goes on! There were some fantastic talks covering budding areas of research, new insights, and cutting-edge methodologies. There was a good balance of big names and new faces, as well as both theoretical and applied topics covered in symposia such as ‘Face processing in the forensic context’ and ‘Learning and memory in visual search’. I definitely took home lots of new ideas to apply to my own research in face and voice perception. As well as talks there were two poster sessions, each featuring around twenty posters. This was a really nice number for the presenters because it meant they weren’t confronted by rushing delegates trying to get round everyone. The first session took place as part of a wine reception in the Old Chemistry Theatre, a lovely Victorian building and a great venue. Congratulations go to Nicholas Shipp from the University of Hertfordshire who won the Postgraduate Poster Prize for his brilliantly colourful poster on, ‘Looking at hands, objects or words? Tracking eye-movements in an action-based categorisation task’.

On the Thursday night there was a conference dinner, a chance for those of us who had already delivered presentations and posters to let our hair down. After-dinner entertainment was provided by a Derren Brown-esque illusionist (Duncan William http://tinyurl.com/kkksqny), who successfully used cognitive psychology against a room full of cognitive psychologists. No mean feat!

This was the first time I had been to the BPS Cognitive Psychology Section Conference, and I found attending to be an extremely worthwhile experience. It was an invaluable opportunity to meet experts in my field and pick up some pearls of wisdom at an early stage in my academic career. Have a look at #CogSec2014 on Twitter to read other people’s thoughts about the conference, and see some pictures.

I’d like to take this opportunity to recommend BPS Cognitive Section membership to everyone. At a cost of only £5 per year to postgraduate students, this is definitely money well spent. Not only does it look good on your CV, but you’ll get member rates for future Cognitive Section conferences, and the opportunity to apply for a postgraduate bursary for conference attendance. This year the bursaries for the conference were actually undersubscribed, so be sure not to miss out next year! Visit the Cognitive Section website for more details about how to apply to become a member.

The 2015 Conference will be held at the University of Kent, and promises to be another great event. So if you’re looking for a postgrad-friendly, supportive environment in which to make your ‘grown-up’ conference debut, look no further. I hope to see lots of you there!

In the meantime, make sure you follow the BPS Cognitive Section on Twitter (@BPS Cognitive), and ‘like’ them on Facebook to keep up-to-date with all things Cognitive!

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Conference review:
7th European Conference on Positive Psychology
Sara Dunne

Amsterdam, 1–4 July 2014

This year the 7th European Conference on Positive Psychology (ECPP) took place in the opulent setting of the Beurs van Berlage in the centre of Amsterdam. It was hosted by the Trimbos Institute in a consortium with the University of Twente and The Netherlands Institute for Social Research. It was an event I was eagerly anticipating and I was delighted to have the opportunity to attend and immerse myself in the most up-to-date positive psychology research and practice.

The four-day conference opened with an explosion of sound as a group of drummers took to the stage to launch the welcome ceremony. This was followed by an engaging keynote speech by one of the key figures in positive psychology, Barbara Fredrickson, who gave a charismatic lecture on ‘Love and Health’. Building on her recent book, Love 2.0 (Fredrickson, 2013) and her previous work on the theory of positive emotions, Fredrickson challenged standard perceptions of love. She suggested that love can be defined as *positivity resonance*. From this perspective, love is not merely an emotion felt by one individual. Instead it is an experience which unfolds when people share positive emotions with one another, when their behaviours and actions are in synchrony with each other and when they mutually invest in each other’s well-being. Although I found the lecture very inspiring and thought-provoking, some delegates expressed their regret that Fredrickson did not address the controversy surrounding her ‘magic ratio for human flourishing’ (Brown, Sokal & Friedman, 2013; Fredrickson, 2009). Other delegates even went so far as to say that the scientific credibility of positive psychology was undermined by inviting Fredrickson provide the opening keynote speech. Although I do not agree with this viewpoint, I do think that addressing the controversy could have sparked some very interesting discussion.

John Helliwell’s keynote lecture on the World Happiness Report (Helliwell, Layard & Sachs, 2013) set the stage for the second day of the conference. The lecture examined actual versus predicted trends in well-being across the globe, in response to the recent economic crisis. Being from Ireland I was particularly interested to learn that well-being levels in Ireland were higher than predicted over the period 2010–2012; a period which coincides with the peak of the recession. Helliwell explained that this may be due to the quality of social connections in Ireland, which serve as a protective mechanism in the face of adversity.

With approximately 16 symposia, workshops and paper sessions to choose from in each session, it was always a difficult task to decide which one to attend. In the morning I opted for a paper session chaired by Antonella Delle Fave, in which three researchers presented their studies related to the psychological aspects of dealing with physical and chronic illnesses. Following this introduction to Health Psychology, I then joined a large number of delegates who attended an invited symposium looking at the biological aspects of well-being and resilience. One of the main points that I took
from this set of presentations is that across populations, over one-third of variability in well-being seems to be genetically determined. However, understanding the heritability of well-being within individuals is not quite so straightforward. Of particular interest to me was a study by Claire Haworth from the University of Warwick who looked at ‘Gene by well-being intervention effects’ (Haworth, 2014). Using results from the Twins Well-being Intervention Study (TWIST), she highlighted that within individuals, genetic components of well-being are probabilistic, not deterministic. Therefore, environmental factors, as well as intentional activities such as positive psychological interventions, have a key role in shaping individuals’ levels of well-being.

During the lunch-break I presented a poster alongside some of the other members of my research group entitled ‘Can creative activity make you flourish?’ which investigates the role of creative activity in building autonomy and positive feelings (Bujacz, 2014). The poster attracted a considerable amount of attention and we received some valuable feedback from other delegates. I found that the poster sessions provided an excellent platform to network with people interested in similar topics and I exchanged contact details with a number of people who were interested in following up on our study.

The third day of the conference featured a special focus on how positive design can influence well-being. Many people who attended the keynote symposium on ‘Positive Design’ said that it was the most interesting and interactive symposium of the entire conference. An example of one such initiative was the TinyTask challenge, which was designed by Hans Ruitenberg for the Delft Institute of Positive Design (DIOPD) and was based on the work of one of the leading experts in positive psychological interventions, Sonja Lyubomirsky. All delegates were provided with key chain coins within their registration pack, each coin representing a tiny assignment aimed at enhancing well-being by developing an attitude of active experimentation and reflective observation. My registration pack contained two coins, one saying ‘New way home’ and the other saying ‘Acts of kindness.’ As I took a detour home through the streets of Amsterdam later that evening, I experienced first-hand how committing to such small concrete acts can have an impact, if only short-term, on building positive emotions and creating meaningful experiences.

Other highlights of the day included an engaging symposium on happiness tracking tools, where I learned about projects such as ‘Mappiness’ and the ‘Happiness Analyser’. These projects attempt to use smartphone technology to gather data in relation to where, when and why people experience positive emotions and subjective well-being. Having experience of using the day reconstruction method (DRM) (Kahneman et al., 2004), I was quite excited about the prospect of using smartphone apps to gather data using both the DRM and the experience sampling method. I was also pleased that most of the developing apps discussed intend to measure participants’ feelings and subjective well-being, as well as more functional, eudaimonic components of well-being.

On the last day I attended a workshop which looked at how positive psychology can play a role within an educational setting. ‘Zippy’s Friends’ is an evidence-based programme which is currently running in schools in over 30 countries worldwide (Clarke, O’Sullivan & Barry, 2010). Designed to be implemented by trained teachers, the course teaches primary school children to recognise and respond appropriately to their emotions, to develop social and coping skills and thus enhance their resilience. Through a series of experiential exercises, the facilitators provided us with an insight into how children can learn to identify their problems and feelings and how to resolve these issues with effective communication skills. I was quite impressed with the program and since returning, I have recommended it to a number of friends who are primary school teachers.
The conference closed with a final keynote lecture by the creator of the Theory of Flow, Mihaly Csikszentmihalyi, who discussed the future of positive psychology. Echoing many of the sentiments that had been expressed by Nic Marks and Dora Gudmundsdottir two days earlier, Csikszentmihalyi conveyed that the role of positive psychology, now and in the future, is to take responsibility to support the evolution of all life on the planet. He placed particular emphasis on the role of positive psychology in education. He made an appeal for children to be taught through cooperation, rather than competition; to acquire not only knowledge, but feeling and purpose; to emphasise personal development rather than conformity and to develop a love of learning for its own sake. As a mature student and one who seems doggedly determined to remain within academia, I was particularly consoled by Csikszentmihalyi’s statement that ‘Learning is not just a tool for life. It IS life’.

The value of the ECPP is that it caters for a wide audience, as positive psychology infiltrates so many different branches, from clinical, health, occupational and educational psychology. If I were asked to sum up the overarching message of the conference, it would be that well-being is important and should be prioritised. To achieve a sustainable future which supports the well-being of all living things, we need to develop our interconnectedness with each other and the planet as a whole. The 7th European Conference on Positive Psychology was a stimulating and inspiring experience. It was very well-organised and set in a superb location. Although it could hardly be construed as a negative, my biggest regret was that I was unable to attend all of the workshops and seminars I hoped to, as they often coincided with each other. However, I was fortunate to attend the conference with a number of fellow students and we were usually able to disperse into the different sessions and later swap notes.

One of the main points that resonated with me from the conference, was an issue raised by an audience member at the end of Csikszentmihalyi’s keynote speech. She asked to what extent do students, researchers and practitioners of positive psychology actually practice what we preach? I agree that often we do not reflect the values proposed by Csikszentmihalyi and are driven by competition rather than cooperation. However, I also know that I left Amsterdam feeling alive, inspired, engaged and very happy. If that is the aim of positive psychology then perhaps the ECPP is as good an intervention as any.

Acknowledgment
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References
August 2014 marked the 17th European Association of Social Psychology (EASP) summer school, which takes place every two years. The summer school comprised five workshops, each headed by two academic professionals who provided mentorship and supervision to attendees. This year I was lucky enough to secure a place and I therefore joined approximately 75 other eager PhD students from Europe, North America/Canada, and Australia to attend this year’s EASP summer school in Lisbon, Portugal.

The EASP summer school is a two-week research-intensive venture in which graduate students are given the opportunity to work alongside their international peers, under the supervision of some of the world’s leading academics in social psychology. This year, the EASP summer school was and organised by Dr Margarida Garrido and Dr Rui Costa-Lopes. The summer school was made up of five different workshops: ‘Socially Situated Cognition’; ‘Implicit Prejudice, Stereotypes, and Discrimination’; ‘Socially identify, influence, and Deviance in Groups’; ‘Social Psychology of Justice’; and ‘Epistemology and Methods in Social Psychology’. My PhD research considers how people make sense of victimisation and misfortune, so securing a place on the ‘Social Psychology of Justice’ workshop, led by Dr Robbie Sutton and Dr Hélder Alves, was a great academic fit for me.

Alongside the workshops, students also attended five keynote talks and two ‘Hot Topic’ sessions, led by the workshop tutors. As a student, I found the hot topic sessions, on Ethics and Publishing, extremely useful and inspiring in regards to my future career. A great deal of discussion was generated, in which students were able to directly ask the tutors about issues, questions, comments, or concerns surrounding these important areas of academic life.

The organisers also arranged several social activities, including a sightseeing tour of Lisbon, a visit to the coast, and a trip to the nearby beautiful village of Sintra. These social trips were an interesting and enjoyable break from the daily academic tasks, and also gave students and tutors the opportunity to appreciate our beautiful surroundings in Lisbon.

I found my time at the summer school to be a truly enjoyable experience. Over two weeks I made friends from all over the world, which I will undoubtedly keep in contact with. Further, as a function of collaborative ventures within my workshop, I have also left the summer school with two ongoing and independent research projects with several colleagues from my workshop. The summer school was, therefore, an excellent opportunity to network with my peers.

As I am currently finishing my PhD and writing my dissertation, I found the summer school also incredibly useful for my own research, especially in regards to gaining insight on topics for my general conclusion. As my PhD topic is closely related to the workshop topic of Social Psychology of Justice, I was able to discuss research within the area with motivated and interested intellectuals.
This was very enlightening in terms of evaluating my own research and in thinking about new directions and future research. I would, therefore, like to take this opportunity to thank everyone who was involved in this year’s summer school; it was a thoroughly enjoyable two weeks and I look forward to future research ventures, conferences, and meetings with my fellow attendees.

In summary, I would highly recommend current Doctoral students to consider applying for the next summer school. Not only are students given the opportunity to embark on innovative international collaborations and develop existing or new research, but can also spend an enjoyable two weeks working and socialising with their peers. The next EASP summer school is planned to be held in Exeter, England, in the summer of 2016. More information about the summer school can be found on the EASP website (www.easp.eu).

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Conference review:
International Congress of Applied Psychology
John P. Mills

Paris, 8–13 July 2014

WITH THE support of PsyPag’s International Conference Award, I was fortunate to be able to attend the International Congress of Applied Psychology (ICAP), which was held in Paris. ICAP is run by the International Association of Applied Psychology (IAAP) and is a vast international gathering of some of the highest profile names within applied psychology. This year’s event boasted over 4500 participants from 100 countries, with presentation topics ranging from Applied Cognitive Psychology through to Traffic and Transportation Psychology.

Due to the sheer volume of presentations, I found it somewhat tricky to navigate presentations and unfortunately, once a room was located, all too often only a fraction of the documented presenters were in attendance. The most notable of which, for myself, was Professor Bruce Avolio, who was due to deliver the Division 01 (Organisational Psychology) keynote on leadership, but failed to attend. That said, there were still a number of very interesting topics discussed over the six-days. A personal favourite was Dr Stewart Cotterill’s symposium discussing case studies within Applied Sport Psychology. As part of this symposium, Dr Cotterill (University of Winchester) discussed his applied experiences of working with sports teams to construct effective team environments. Joanne Batey (University of Winchester) also discussed her experiences of working with military teams and Mustafa Sarkar (University of Gloucestershire) his recent involvement with both paratriathletes and semi-professional rugby teams.

On the advice of a colleague, I also opportunistically attended Professor Joan Duda’s (University of Birmingham) keynote lecture on her recent project Promoting Adolescent Physical Activity (PAPA). The €3 million, four-year study is designed to use positive sporting experiences to enhance young people’s health and well-being. Using a network of coach educators across Europe (i.e. the UK, Norway, Spain, France, and Greece) Professor Duda explained how the project aimed to use theoretically grounded and evidence-based coach education to help grass roots coaches to foster motivation in their athletes and promote an empowering climate. Should the project be a success, it is hypothesised that the participating athletes will report an increase in physical activity, fitness, self-esteem and sporting enjoyment.

In addition to attending the presentations of others, I was also kindly asked to chair and present within a session entitled ‘Coaches, Managers, and Sport Psychologists’. Gokhan Caliskan (Dumlupinar Universitesi) opened proceedings by discussing his research on successful intelligence and coaching efficacy among football coaches in Turkey. Then it was my turn to discuss my recent research on exploring the impact of career transitions with currently unemployed English Premier League and international football (also known as soccer) managers. As this was my first time presenting at an international conference, I was keen to present myself as calm and composed. Although I was most definitely neither, I seemed to be successful in my
presentation, as on completion of the presentation, and the dreaded questions, I received overwhelmingly positive feedback from the audience.

Overall, the Congress was an excellent opportunity to meet new researchers and hear about recent developments in Applied Psychology. Due to the holistic nature of the conference, it offers a unique opportunity to explore a broad range of topics within the same event. As someone whose research straddles multiple disciplines, I found ICAP gave me the opportunity to cherry pick presentations that were relevant to me. However, I appreciate that such an approach is not for everyone. In sum, it was a good week, which afforded me the opportunity to keep up-to-date on a range of topics, while also offering time to strengthen some existing relationships and develop new ones.

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Conference review:
3rd Junior Researcher Programme Conference
Sara Dunne

Corpus Christi College, Cambridge, 14–15 August 2014

In August 2014 I was fortunate to attend the European Federation of Psychology Students’ Associations 3rd Junior Researcher Programme (JRP) conference which was held in the beautiful setting of Corpus Christi College in Cambridge. Each year the two-day conference marks the culmination of a 13-month research programme for over 36 psychology students from all around Europe. From its inception in 2012 the JRP annual conference has grown from strength to strength and this year featured a record number of attendees and an impressive line-up of keynote speakers.

For those who are not familiar with the Junior Researcher Programme, it provides psychology students with the opportunity to conduct high quality research projects with fellow students from across Europe. Each year the programme recruits approximately 36 undergraduate and postgraduate students to conduct six research projects within a specific theme. As the research theme was well-being, I was delighted to be selected as a participant of the 2013–2014 cohort as this is relevant to my own research interests in positive psychology.

The programme commenced in July 2013 with a week-long summer school in Belgium. This provided me with the opportunity to meet the other six members of my research team who had been selected to work on a project devised by our supervisor, Aleksandra Bujacz, a PhD student from the University of Stockholm. Geographically our team spanned over six countries, Italy, Sweden, Austria, UK, Poland and Ireland. During the course of the week we developed our project which aimed to investigate if engagement in creative activity could enhance well-being. Throughout the week we were privileged to receive support and advice from leaders within the field of well-being (Dr Felicia Huppert) and psychometrics (Dr Sam Norton).

Following a successful and productive week in Belgium we were officially initiated into the Junior Researcher Programme which provides a framework, guidance and academic support to students and supervisors throughout the duration of the programme. During this time I gained practical first-hand experience in completing formal ethical applications and methodological papers. I also had the opportunity to present our study at a number of academic conferences as well as submitting a work-in-progress report to the Journal of European Psychology Students, which was subsequently published in May 2014. Other members of my cohort also took advantage of the opportunity to participate in a five-week long internship in Cambridge in which they worked on a Global Health Initiative Policy with the Director of the Junior Researcher Programme, Dr Kai Ruggeri.

In August 2014 all six research groups met one week prior to the conference to continue developing their projects and to prepare oral presentations for the JRP conference. During this week we also had the opportunity to engage in a series of ‘Psychology and Policy’ seminars, which focused on the theme of well-being. Guest
speakers throughout the week included Dr Saba Hinrichs, of King’s College London, who highlighted the barriers involved in bridging the gap between research and policy. On the second night we heard from Dr Bóas Valdórsson, a clinical specialist and family mediator for the Reykjavík District Commissioner. Dr Valdórsson spoke about his experience of practicing mediation with families going through a divorce and the impact that this can have on the children involved. The following night’s seminar was led by Dr Dora Gudmundsdottir, the Director of Determinants of Health and Wellbeing in Iceland. Having being inspired by Dr Gudmundsdottir’s keynote speech at the 7th European Conference on Positive Psychology in Amsterdam the month previously, I was very grateful to have the opportunity to hear her speak again about the importance developing public policies which strengthen well-being. She suggested that the key to enhancing well-being across the entire spectrum of mental health is to focus on promoting well-being and flourishing, rather than just trying to ameliorate mental ill-health within a clinical population. This point really resonated with me as it is something which Dr Huppert had also mentioned when discussing her research at the summer school in Belgium the year previously.

The final night of the seminar series featured a Psychology and Policy Panel Discussion featuring Dr Suzanna Forwood from the Institute of Public Health in Cambridge, Dr Sam Norton from the Institute of Psychiatry in King’s College London, Dr Dora Gudmundsdottir, Dr Bóas Valdórsson and Mr Joe Galdstone, a PhD student from the University of Cambridge. This highly interactive discussion between audience members and panellists highlighted the issue of disseminating research findings in a timely manner so that public policies are evidenced-based and informed by the most up-to-date and relevant research. The discussion concluded with a reiteration of the importance of continuous policy evaluation. Following the Panel Discussion the conference was formally opened by the JRP conference chair, Ms Marike Deutz, from the University of Utrecht.

The official conference commenced with a poster presentation session which featured a broad range of topics from the ‘Confounding effects of cryptic relatedness: investigating their impact on genetic associations with continuous traits’ (Conrad, Papasotiropoulos & Vogler, 2014) to ‘Mindfulness versus health enhancement: how to improve emotional regulation among those with a history of non-suicidal self injury’ (Moltrecht et al., 2014). The majority of people presenting posters were affiliated with the Junior Researcher Programme and delegates included a number of alumni who returned to the conference to present the findings of their Master’s Degrees/PhDs or other independent research projects. I was delighted to present a poster of our JRP project which was also presented at the European Conference on Positive Psychology in Amsterdam and the European Conference on Personality in Lausanne in July 2014.

The following morning the main conference events commenced and my group presented our study ‘Can creative activity make you flourish?’ (Bujacz et al., 2014). Our research investigated the mechanisms through which creative activity can impact components of well-being. Conducted over five language samples, the results indicate that the cognitive processes underlying creativity can trigger an increase in emotional well-being through building autonomy and positive feelings of contentment and engagement. This was followed with a presentation led by Theodore Cosco (Cosco et al., 2014) which examined how young European adults conceptualise positive ageing. The morning session concluded with a presentation led by Sanne Lamers (Lamers et al., 2014) which examined conceptualisations of mental health across Europe, comparing psychology with science and engineering students.

Following a very special lunch, in which we were invited into the beautiful home and
gardens of the Master of Corpus Christi College Cambridge, Mr Stuart Laing, the afternoon session commenced with a presentation led by Praveetha Patalay and her group (Patalay et al., 2014). Their study examined mental health and well-being provision in schools in 10 countries across Europe. This provided an important backdrop to the next presentation which examined well-being in a school context by looking at the weekly experiences of pupils and teachers (Tadic et al., 2014). The final group to present their project were led by Lisa Wagner (Wagner et al., 2014). Their study examined adolescent’s well-being and how orientations to happiness relate to their leisure time activities. The depth and variety of the project topics illustrates how broad the concept of well-being is and how it plays a role in so many different contexts.

The presentation session concluded with a keynote speech by the new President Elect of the British Psychological Society, Professor Jamie Hacker Hughes, who spoke about the historical significance of psychology within the University of Cambridge. Professor Hacker Hughes later joined conference participants and keynote speakers at a formal dinner held in the stunning dining hall of Corpus Christi College, which marked the conclusion of the JRP programme for the 2013–2014 cohort. This important event provided all groups with an opportunity to reflect on the past year, to celebrate all that had been achieved and to reaffirm goals for the future.

The Junior Researcher Programme Conference provides a wonderful opportunity for psychology students and young researchers to gain valuable experience in conducting a large cross-cultural research project. The conference is an important focal point of the programme. For many participants it represents their first experience of presenting at an international academic conference. The calibre of guest speakers during the ‘Psychology and Policy’ lecture series this year really exceeded my expectations. My personal highlight was having the opportunity to talk to Dr Dora Gudmundsdottir and Dr Sam Norton who kindly offered advice regarding my future career direction. More than anything the conference enabled me to connect with a valuable network of psychologists and researchers throughout Europe and beyond. This network will hopefully be strengthened through the establishment of a JRP alumni initiative which is currently being formulated to guide future JRP cohorts as well to support current alumni in their professional development.

Acknowledgments
I would like to thank Dr Kai Ruggeri, Marike Deutz and Ladislav Záliš for their continued support throughout the year. I would like to thank my research group Aleksandra Bujacz, Ebba Karlsson, Alexandra Raluca Gatej, David Fink, Veronica Ruberti and Marta Wrońska for their hard work, inspiration and friendship. I would also like to thank PsyPAG for contributing towards my conference expenses.

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References


Dates for your Diary

7–9 January 2015  
BPS Division of Occupational Psychology Annual Conference  
*The Hilton Glasgow*  
http://www.bps.org.uk/events/conferences/dop-annual-conference

19 February 2015  
Midlands Health Psychology Network Conference  
*The University of Derby*  
http://mhpn.co.uk/page2.htm

6–8 May 2015  
BPS Annual Conference  
*ACC Liverpool*  
http://www.bps.org.uk/events/conferences/annual-conference-2015

1–3 July 2015  
Division of Forensic Psychology Annual Conference  
*Manchester Metropolitan University*  

10–11 July 2015  
Division of Counselling Psychology Annual Conference  
*The Majestic Hotel, Harrogate*  

22–24 July 2015  
PsyPAG 30th Annual Conference  
*University of Glasgow*  
www.psypag.co.uk/conference

9–11 September 2015  
Developmental Section & Social Section Annual Conference  
*The Palace Hotel, Manchester*  

16–18 September 2015  
Division of Health Psychology Annual Conference  
*Radisson Blu Portman Hotel, London*  

The BPS website lists a full list of BPS events: www.bps.org.uk/events
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‘The selection of papers suits my eclectic mind perfectly, and the quality and clarity of the synopses is uniformly excellent.’
Professor Guy Claxton, University of Bristol
PsyPAG Quarterly submissions guidelines

The PsyPAG Quarterly is a developing publication, which is distributed free of charge to all psychology postgraduates in the UK. It therefore receives wide readership. The PsyPAG Quarterly accepts articles on all areas of psychology.

Types of articles accepted:
Featured Articles and Discussion Papers: Articles can cover a wide range of topics. Articles may describe a piece of original research; provide an overview of a theory, area or issue.
Research in Brief: A short report of original research, often preliminary findings.
Big Interviews: An interview with anyone connected with psychology, usually written in a question-and-answer format.
Conference Reviews: Provide an overview of a conference, outlining the main themes of the conference.
Departmental Reviews: An overview of a department as well as research interests of the postgraduates.
Book and Software Reviews: A review of books or software relevant to psychologists.
Hints and Tips: Hints and tips that will be useful to postgraduates. For example, how to apply for funding.
Postgraduate Research in Brief: This is a reference list of research that has recently been published by postgraduates within a particular area or department.

Word limits:
The publication has a broad word limit of 500 to 2500 words excluding references.
The maximum word limit is flexible for in-depth discussion papers, longer interviews or hints and tips. The word count will differ depending on the type of article, for example, conference and book reviews should be shorter than featured articles.

Formatting:
Please submit all articles in Microsoft Word. The content, including tables, figures, and references, should all comply with the most recent APA guidelines. You should also include your contact details at the end of each article in the format of:

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If you have any further questions, please contact the editors at quarterly@psypag.co.uk, or send in your question via twitter: @PsyPAGQuarterly.
About PsyPAG

PsyPAG is a national organisation for all psychology postgraduates based at UK Institutions. Funded by the Research Board of the British Psychological Society, PsyPAG is run on a voluntary basis by postgraduates for postgraduates. Its aims are to provide support for postgraduate students in the UK, to act as a vehicle for communication between postgraduates, and represent postgraduates within the British Psychological Society. It also fulfills the vital role of bringing together postgraduates from around the country.

- PsyPAG has no official membership scheme; anyone involved in postgraduate study in psychology at a UK Institution is automatically a member.
- PsyPAG runs an annual workshop and conference and also produces a quarterly publication, which is delivered free of charge to all postgraduate psychology departments in the UK.
- PsyPAG is run by an elected committee, which any postgraduate student can be voted on to. Elections are held at the PsyPAG Annual Conference each year.
- The committee includes representatives for each Sub-Division within the British Psychological Society, their role being to represent postgraduate interests and problems within that Division or the British Psychological Society generally. We also liaise with the Student Group of the British Psychological Society to raise awareness of postgraduate issues in the undergraduate community.
- Committee members also include Practitioners-in-Training who are represented by PsyPAG.

Mailing list
PsyPAG maintains a JISCmail list open to ALL psychology postgraduate students. To join, visit www.psypag.co.uk and scroll down on the main page to find the link, or go to http://tinyurl.comPsyPAGjiscmail. This list is a fantastic resource for support and advice regarding your research, statistical advice or postgraduate issues.

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