The Impact of Expressive Writing on Work-Related Affective Rumination: An Experimental Study.

By

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Volume I

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Statement of Anonymity

To preserve anonymity all names, places and identifying information, directly relating to my client work, has been changed or omitted.
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'To what extent is membership of an ethnic minority group (in the UK) influential in the process of diagnosis and treatment of people experiencing depression?'

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1) Introduction

Research over the past decade has shown that mental illness in the U.K is more prevalent in ethnic minority groups than in the white majority population and this is especially true of depression (Weich & McManus, 2002). As a result studies have looked at how ethnic status influences diagnosis and treatment in a number of minority groups within the U.K (Nazroo & King, 2002). More recent health surveys have also reported a high prevalence of depression within the Irish community in Britain (National Institute for Mental Health in England, 2003). However the influence of Irish ethnic status on mental health has often been overlooked (Walls, 2006). A study looking at the effects of migration on depression (Ryan et al, 2006) is currently the only research that has attempted to explain the prevalence of depression in this ethnic group. I believe the reason for this is, within the paradigm of mental health and ethnicity, the Irish experience is still a marginalised discourse and this is perhaps explainable by the fact that the Irish have often been seen as part of a homogenous “white” group (Bracken & O'Sullivan, 2001).

Despite the lack of direct research in this area it is evident that assumptions concerning the influence that minority status has on diagnosis can be inferred by comparing demographic information and general theories of social and cognitive vulnerability factors for depression. Similarly assumptions concerning the need for a culturally sensitive approach to treatment can be inferred from more focused research (Comino et al, 2001) on the experience of depression in other ethnic minority groups, such as the African Caribbean group.

This subject is relevant to me as I am second generation Irish, living in London, with a family history of chronic depression. From this embedded position I would argue that my family’s ethnic status has exerted a varying influence on the process of diagnosis and treatment of relatives experiencing depression. Irish born members of the family clearly have health seeking behaviours and coping strategies, which are different to the general population. However I am not aware that my mother’s second generation minority status influenced her diagnosis and treatment of depression. I
believe this highlights the fact that Irish minority status is not a homogenous variable (Bracken & O'Sullivan, 2001).

2) To what extent does Irish minority status influence the process of diagnosis of people experiencing depression?

Definition of ethnic minority, depression and diagnosis

I have interpreted the term ethnic minority as “belonging to a group, with a shared ancestry, that has traits, such as language and culture that are different to the general population” (Heinemann English Dictionary, 1979. Pp 368). In discussing depression I have focused on major depression which is “a psychiatric disorder, where the sufferer experiences low mood, and a loss of interest and pleasure” (American Psychiatric Association, 1994). I have taken this focus as this is directly relevant in terms of my own practice as a trainee clinical psychologist working with clients with moderate to severe difficulties. For the purpose of this essay I have interpreted diagnosis as “the determination of the cause of a disease by studying the symptoms, signs and results of tests” (Heinemann English Dictionary, 1979. Pp294). I have also discussed the topic with the underlying assumption that generally a diagnosis of depression would be given by the GP in line with DSM IV (1994). This would be following a consultation in primary care, and would not involve a formal psychological evaluation.

Incidence of depression: Social factors

Direct research on the subject of Irish minority status and diagnosis of depression is limited and does not identify causal links (Walls, 2006). However informed assumptions concerning the reason for high incidence levels (Weich & McManus, 2002) can be made by linking general research on vulnerability factors for depression and the social factors that have been shown to often accompany Irish minority status.

Research has shown that Irish people in Britain suffer from discrimination and racism, which has been shown to affect socio-economic status and health (Bracken et al, 1998) This discrimination impacts on all areas of their life, affecting housing,
employment, education and health (Walls, 2006). Compared to the general population, the Irish in Britain are more likely to be homeless (Walls, 2006), to use emergency accommodation and to live in shared dwellings (Howes, 2004). At the other end of the spectrum, the Irish often experience isolation, and are more likely to live alone (Howes, 2004).

Again compared to the general population, in terms of employment, more Irish people are employed in manual jobs and are on low incomes (Howes, 2004). They also experience twice the level of unemployment compared to the general population (Bracken et al, 1998). In terms of health, the Irish have poorer levels of physical health and are more likely to be classed as permanently sick (Kelleher & Hillier, 1996). The Irish are also over-represented in the prison population in Britain (Howes, 2004). Thus it is clear that the Irish in Britain experience adverse social conditions, however the presence of socio-economic factors alone does not explain the increased incidence of depression in the Irish community. It is only through an examination of the social models of vulnerability for depression that the link is identified.

Incidence of depression: models of vulnerability
The social model of vulnerability for depression developed by Brown and Harris (1978) suggests that factors such as early maternal loss, lack of a close relationship, greater than three children under the age of 14 at home and unemployment can interact with "provoking agents" to increase the risk of depression. The provoking agents are primarily connected to stress. Thus it could be argued that Irish minority status promotes discrimination and racism, which in turn leads to adverse negative socio-economic conditions, such as unemployment and lack of support, and it is these conditions that explain the increased incidence of depression within the Irish community, as they have been shown to be direct vulnerability factors for depression (Brown & Harris, 1978).

In drawing these conclusions I have accepted the model offered by Brown and Harris, however this model is often disputed (Campbell et al, 1983). The original research was with female participants and a number of studies (Campbell et al, 1983:
Costello, 1982) have since tried to replicate the findings across ages and genders. The results of these later studies suggest that it is only the lack of a close relationship that holds as a stable vulnerability factor for depression. These qualifications to the original model suggest that if social factors are responsible for the increased incidence levels then it is the lack of a close relationship that is the primary cause. Further research on social factors of vulnerability for depression (Patten et al, 1997) support these conclusions by suggesting that lack of a close relationship is not only a vulnerability factor but also direct risk factor (Patten et al, 1997). The idea central to this work is that lack of support can lead to depression, and this is without the involvement of “provoking agents”. Thus by examining the fit between the Irish experience and vulnerability factors it could be argued that Irish ethnic minority status is indirectly associated with the risk factors for depression. For example Irish minority status may often lead to discrimination, which in turn leads to isolationism and the lack of a close relationship, and this could trigger a depressive episode.

It is evident, however, that Irish migrants may experience feelings of isolation without developing depression. I believe this variation is perhaps due to the mediating influence of cognitive processing styles. Again there is no direct research in this area; however I have made informed assumptions by drawing on general research looking at cognitive vulnerability factors for depression (Beck, 1967). The cognitive vulnerability model suggests that certain individuals have negative schemas, which are stored bodies of knowledge, organised as sets of dysfunctional beliefs. These negative schema develop as a consequence of various negative experiences in childhood, such as parental loss, rejection by peers or criticism from parents or authority figures. For example the loss of a family member during childhood could lead to the development of negative schema relating to abandonment, or the separation of the family could lead to beliefs about rejection. Theses schemas can then be activated when the individual encounters a situation similar to that in which the original schema was acquired. Once activated, they trigger a pattern of skewed information processing (Beck, 1967). Relating this to the Irish experience it is evident that the negative social consequences of migration, such as the loss of a close relationship and feelings of isolation, could trigger negative
schemas related to feelings of abandonment or rejection, and in turn prompt a depressive episode. Thus it could be argued that the high level of incidence of depression within the Irish community is a response to social factors experienced as a result of ethnic minority status and variations in response are explained through individual cognitive processing styles.

As mentioned the conclusions I have drawn are based on indirect research and rely on a number of assumptions; however they are partially supported by the only piece of direct research in the area. A study (Ryan et al, 2006) looked at social factors associated with migration from Ireland to England and sought to examine possible links between the levels of preparation and planning involved in migration and subsequent experiences of depression. Levels of preparation of migration were rated using an eight point scale, and levels of depression were rated using standardised measures. The results showed that levels of planning involved in migration negatively correlated with levels of depression. Results also showed that this negative effect was mediated by levels of social support experienced on arrival (Ryan et al, 2006). This again highlights the idea lack of a close relationship is a risk factor for depression. The article itself however offers no explanation as to why unplanned migration should negatively correlate with levels of depression, and why social support should then mediate levels of depression. In this way the findings of this research simply describe a negative relationship and therefore are essentially limited in furthering a causal understanding. The study itself also suffers from inherent weaknesses in it’s methodology. For example participants were selected on the basis of how Irish their name sounded. Obvious Irish names were selected from G.P registers. So at a basic level the findings of the study can only be found to apply to people with overtly Irish sounding names.

Number of diagnoses
Despite the lack of causal research in the area it is evident that there is a greater incidence of depression within in the Irish population (Ryan et al, 2006). This would imply that there should also be an increase in diagnosis, however research suggests that ethnic minority status may negatively impact on presentations and lead to a
disparity between incidence and presentation (Walls, 2006). Research shows the Irish, due to their minority status, have poorer access to health services (NIMHE, 2003). Also it has been shown that often ethnic minority service users lack confidence in the GP’s ability to provide a service that accounts for ethnicity (Shaw et al, 1999). Thus it could be argued that Irish people suffering depression may not seek help from the G.P, due to the perception that they may experience a poor service (Shaw et al, 1999).

Therefore it may be that, as mentioned, a lack of faith in the health service means that Irish people experiencing depression do not seek help from their GP. Research supports this idea, and suggests instead that Irish people in Britain experiencing depression may over use coping strategies, such as drugs and alcohol rather than seek help (Luce et al, 2000). I believe the use of alcohol as a coping strategy has a direct impact on the process of diagnosis of depression in the Irish community.

Incorrect diagnoses
Research suggests that given the overuse of alcohol as a coping strategy (Luce et al, 2000), an underlying depression may not be diagnosed (Walls, 2006). This is a good example of how perceptions held by the medical profession, concerning the Irish in Britain, influence the process of diagnosis. For example the stereotype of the Irish as “drinkers” may mean that GP’s fail to recognize that reliance on alcohol may be a coping strategy for an underlying depression (Greenslade et al, 1995). Research has identified that in general Irish in Britain are no more likely to abuse alcohol compared to the general population (Greenslade et al, 1995), however I believe this has done nothing to negate the stereotype that characteristically the Irish “like a drink” more than the English.

Summary
Taking an overview of the ideas presented above. I believe that Irish minority status does influence the process of diagnosis of depression in a number ways. The first being an increase in incidence, due to vulnerability factors inherent within the
community, however the same vulnerability factors may prevent access to health care and lead to a lack of correct diagnosis.

My own family experience, however, stands in contrast to this pattern of diagnosis, influenced by minority status. Family members suffering from depression appear to have vulnerability factors associated with depression, however these factors have not prevented them accessing health services and being correctly diagnosed. This discrepancy, I believe, is produced by the fact that the conclusions I have drawn have more relevance to certain subgroups within the Irish community, such as Irish travellers, and recent migrants, rather than the Irish community as a whole. This idea has been reported in work by Kenrick and Clark (1999), focusing on the Irish traveller community in Britain. Again this idea is supported by research that suggests that lack of support networks and close relationships will increase risk of depression (Patten et al, 1997).

3) To what extent does Irish minority status influence the process of treatment for people experiencing depression?

I have interpreted treatment for depression as “services, outlined by NICE guidelines for depression, offered within the NHS”. Thus I have not discussed the different drug treatments available or the varying processes involved in different types of therapy. Instead I have simply referred to general treatment, which can involve drug therapy, psychotherapy or therapies such as acupuncture or meditation. This focus has again been determined by the directly relevant research on the subject.

As far as I am aware there is no research focusing directly on treatment for Irish people in Britain, who suffer from depression. Therefore, to approximate the situation, again I have made indirect causal links between the influence Irish ethnic minority status has on health seeking behaviour, and the process of treatment, in light of research on other ethnic groups. For example culturally sensitive treatment approaches have been shown to be beneficial for other ethnic minority groups.
Access to treatment

I have, so far, discussed the fact that Irish people with depression may not receive a correct diagnosis, due to their avoidant health seeking behaviours (Walls, 2006), coping strategies and stereotyping by the medical profession (Luce et al, 2000). In terms of treatment, I believe the lack of a correct diagnosis will lead to a lack of appropriate treatment. This is supported by evidence of a trend in primary care, where GP’s may not refer ethnic minority groups for treatment and this is especially true of referrals for the “talking therapies” (Healthcare Commission, 2005).

However, again drawing from personal experience, this idea seems incongruent. My mother was correctly diagnosed and received treatment for depression for over 20 years, which involved the input of psychology, despite her ethnic minority status.

To explain this disparity I have tried to offer possible explanations for the lack of referrals for treatment for depression in the Irish community. Firstly I believe it is possible that sufferers of depression are being treated, but with the wrong diagnoses. For example Irish people in Britain have been shown to be over represented as users of alcohol services (Luce et al, 2000). Therefore it is arguable that GP’s are treating addictions rather than depression. (NIMHE, 2003).

Secondly, given my own experiences in primary care, I believe that in many cases GP’s may attempt to limit referrals for specialist treatment. Thus unless a treatment is specifically requested, a referral would not automatically be made. This is a situation apparently unrelated to ethnic minority status. However the reason I believe it impacts on the Irish in Britain is because Irish born sufferers, especially the older generation, may not know what treatments are available. This idea is drawn from my own experience accessing treatment and there is no specific research on the subject.

Treatment settings

I believe that if Irish people, suffering depression, initially fail to access treatment services, this will have an impact on the settings in which they are eventually treated. For example the avoidant health behaviour of Irish sufferers may mean they do not
seek, or receive, treatment prior to the condition becoming chronic. This idea is supported by research by Raleigh and Balarajan (1992), that shows an excess of depression related suicide attempts amongst the Irish community in Britain.

If this is the case, then for Irish people experiencing depression, treatment is more likely to happen in accident and emergency departments, community mental health teams and crisis centres (Walls, 2006). Similarly I believe, supported by research (Howes, 2004), that alcohol related coping strategies, amongst Irish people experiencing depression, could lead to higher levels of criminal behaviour. As a result treatment for this section of Irish people suffering depression will, perhaps, be more likely to occur in prison rather than in the community. These ideas show how ethnic minority status indirectly influences treatment setting, and they are backed up by research (Cochrane & Bal, 1989) that shows the that the Irish in Britain have greater overall admission to psychiatric hospitals.

Quality of treatment
Research has shown that, in general, clinical outcome and service satisfaction, following treatment for a mental health disorder, is worse for ethnic minority groups (Walls, 2006). Given the lack of treatment and setting in which treatment may be received, there is no reason to suppose that this would be any different for the Irish, and would not apply to depression.

Reflecting on why outcome, following treatment, could be worse for Irish people experiencing depression, I believe it may be connected to the lack of understanding surrounding the Irish situation. Research has shown that mental health services are often not appropriate to their needs of the Irish community (Walls, 2006). For example a recent survey (Erens et al, 2001), has shown that in Brent, the borough with the largest Irish population in London there were no approved Irish social workers, Irish psychiatrists, or Irish specific mental health resources.
Summary
Linking together the evidence surrounding lack of referrals for the Irish, health seeking behaviour and coping strategies, it could be argued that Irish minority status indirectly negatively influences the process of treatment of people experiencing depression. It does this by blocking access to services, shifting the focus to alcohol addiction rather than depression, and dictating the settings in which treatment occurs. However, unfortunately, Irish minority status does not appear to positively influence the process by directing culturally sensitive treatment approaches. The importance of culturally sensitive treatments has been identified through research conducted with people from other ethnic minority groups. For example research focusing on African Caribbean people suffering depression has shown a positive outcome to treatment when a culturally sensitive approach is utilised (Comino et al, 2001). For example research has identified that people from this ethnic minority group may present with symptoms of depression that are more somatic in nature, such as headache and treatments that are aware of this have better outcome (Comino et al, 2001).

This idea fits with the findings of studies that suggest that treatment outcome for depression is better when the interaction between client and patient is good (Cole & Mclean, 2003) and I would argue that the more the clinician or treatment accounts for cultural variations the more “understood” the patient will feel, and the more “understood” the patient feels the better the interaction between patient and clinician. Thus it could be argued that the promotion of this “understanding” through a culturally sensitive treatment approach is necessary for any ethnic minority group, if outcome is to be improved.

However from my own experience, it is clear that the negative factors, influenced by ethnic minority status, are prevalent within the NHS, however they did not prevent my mother accessing specialist treatment for depression. This idea suggests that Irish minority status is not uniform and in fact there are variations within the status.
4) Variations in Irish ethnic minority status, in terms of influence, on the process of diagnosis and treatment of people experiencing depression

One of the main issues I have encountered when attempting to examine the influence of Irish ethnic minority status on diagnosis and treatment of depression is that I find it misleading to talk about “the Irish”, as if it is a uniform group with identical shared experiences. This idea is exemplified by the fact that my immediate family’s experience, in terms of treatment for depression, is very different to that of my extended family.

I believe the reason for this discrepancy is that, in general, second or third generation Irish encounter less racism and discrimination, and thus are less likely to experience adverse conditions in housing, education, and employment, thus reducing risk factors. Similarly stereotypes of the Irish held by the medical profession may not be as pervasive for second and third generation Irish compared to Irish born service users (Greenslade et al, 1995). My immediate family, although still very much part of an Irish community, are second generation Irish, and therefore not subject to the same adverse conditions experienced by my grandfather, as an Irish born migrant in Britain. This idea is backed up by research looking at second generation in Britain. The conclusions of the research were that high levels of social mobility were shown in second and third generation Irish people living in Britain (Hickman et al, 2001)

Thus, one could conclude that an Irish service user’s ethnic status may influence the process of diagnosis and treatment of depression, but this influence will be moderated by generation and birthplace. However it is evident that, compared to the general population, second and third generation Irish still experience higher levels of mental health problems, especially depression (Walls, 2006).

This is perhaps explained by the fact that the vulnerability factors, attributed to first generation Irish migrants, also effect later generations, but not to the same extent. However, taking an overview of the situation, it could be argued that variations within the minority status are not enough to explain fundamental differences in the
process of diagnosis and treatment for people experiencing depression. To fully understand the influences that impact on the process, I believe it is important to consider the influence of Irish culture, as a variable, which is distinct to minority status.

5) The influence of Irish culture on the process of diagnosis and treatment of depression

Why are high levels of mental illness still being reported in second and third generation Irish people in Britain (Walls, 2006), given the apparent speed of social mobility across generations (Hickman et al., 2001)? And, why are second and third generation Irish still shown to use alcohol as a coping strategy for depression (Luce et al., 2000)?

I believe one answer to this situation lies within elements of Irish culture and vulnerability factors, associated with racism and discrimination. For example it appears that the general population’s attitude towards the Irish traveller community leads to increased racism and discrimination. Irish travellers in Britain are often regarded as a nuisance that people do not want near their homes. (Kenrick & Clark, 1999). I believe that this attitude is related to culture rather than Irish minority status and it could be argued that the discrimination they experience as a result of this attitude could impact on their health behaviours and coping strategies. It could also lead to feelings of isolationism and social exclusion, which have already been identified as risk factors (Walls, 2006).

Thus it appears that, it is the traveller culture, rather than ethnic minority status that is maintaining the vulnerability factors for depression. This impacts on the process of diagnosis and treatment of depression within this community. This distinction brings in the idea that ethnic minority status may be of influence in the process of diagnosis and treatment of depression, however it is evident that other variables also exert an influence.
Alternative variables

Again drawing from personal experience I would argue that ethnic minority status is not the only variable exerting an influence on the process of diagnosis and treatment of people experiencing depression. I believe factors such as geographical location, religion, age, gender and sex are all variables that have been reported to impact on the process, and this idea is backed up by current research (Walls, 2006).

At this point in the essay, however, I have not chosen to provide a detailed description of the differing variables and their influence on the process. This is because firstly I believe a discussion involving a number of these variables would become too extensive, and would distract from the ethnic minority focus of the essay. I believe that it is enough, in this situation, to simply acknowledge that these other variables exist and that they exert an influence on the process of diagnosis and treatment for people experiencing depression, and this influence is separate to the influence exerted by minority status.

8) Further research and government policy

The underlying theme of this essay is simply that the mental health of the Irish in Britain has not been researched enough, and without the research, government policy has failed to address the needs of the Irish community.

The need for action in this area was identified almost a decade ago (Bracken et al, 1998). At this time it was suggested that there was a need for more qualitative and quantitative evidence on the subject. However 10 years later the situation is still to be addressed (Walls, 2006). Following the Bracken article in 1998, there has been only one study attempting to uncover the reasons behind the prevalence of depression in the Irish community, which looked at the effect of unplanned migration (Ryan et al, 2006). Similarly there has been no work looking at treatment, in terms of outcome, from the perspective of the Irish in Britain.
This negative view of the situation is perhaps lightened by some improvements in related areas. These improvements appear to be influenced by the proposals outlined in the Race Relations act in 2000 (Walls, 2006). For example a separate Irish category was included in the National Census in 2001, and this also included a subdivision between Irish born and second generation Irish in Britain (Erens et al, 2001).

However at the moment I feel there is a lack of momentum in policy. Government reports like ‘Inside Outside’ (NIMHE, 2003) and ‘Count Me In’ (Healthcare Commission, 2005), have identified the need for action, however the reports themselves are yet to influence health care. Even the most recent article, (Walls, 2006) which has formed the basis for a lot of this essay, only reiterates previous findings.

Perhaps one of the reasons that this oversight, in terms of the mental health needs of the Irish community, is so clear is the fact that initiatives and research looking at the mental health needs of other ethnic minorities in Britain are happening. For example the prevalence of schizophrenia in the Black community is a subject that has been research and the research has led to formation of culturally sensitive treatments (Nazroo & King, 2002).

However, although the Irish needs have not yet been specifically addressed, I have noticed the emergence of new initiatives, relevant to other ethnic minorities, that will also be of benefit to the Irish in Britain, given their help seeking behaviours. These include new home treatment and early intervention teams. Thus despite the lack of awareness, in terms of Irish mental health, initiatives related to the recovery model and social inclusion will still benefit the Irish in Britain.

Conclusion
I believe that Irish ethnic minority status could exert a significant influence on the process of diagnosis and treatment of people experiencing depression. This influence is indirect and may generally rely on associations between discrimination and
vulnerability factors, especially in relation to Irish health seeking behaviour, and this in turn impacts on the process of diagnosis and treatment.

This impact occurs in a number of ways. Firstly minority status links to social vulnerability factors and these factors increase the incidence of depression within the Irish community, however in terms of diagnosis; they negatively influence the number of presentations and positively increase the chance of Irish people, experiencing depression, being misdiagnosed in primary care. Secondly, in terms of treatment, it limits access, and increases the chances of treatment occurring in secondary care and specialist services.

However it is evident that the influence is not uniform and is moderated by differences in the ethnic status itself, such as generation. It is also apparent that minority status alone does not explain the prevalence of depression in the Irish community. Instead it is one of the influences, along with variables such as culture.

This lack of research means health care policy has been slow to address the situation. However evidence, drawn from research focusing on diagnosis and treatment of other ethnic groups, has highlighted the need for a culturally sensitive approach. For this to happen I believe there needs to be more randomised control trials looking at outcome of treatment for depression, with Irish service users. This would be invaluable for furthering understanding around the issues that surround Irish ethnicity and treatment. I also believe that, in terms of formulation of a culturally sensitive approach, research needs to focus on potential risk factors and to identify more of the causal relationship between status, discrimination and isolationism, in the context of social vulnerability.
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Professional Issues Essay

"What are the strengths and limitations of the Improving Access to Psychological Therapy agenda for AMH service users? How might the agenda impact on service users relationships with either child and adolescent services or L.D services?"

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Introduction

The principal aim of the Improving Access to Psychological Therapies agenda (IAPT) is to assist primary care trusts in providing increased evidence based treatment for adults of working age, experiencing anxiety and depression, in line with the National Institute for Health and Clinical Excellence’s (NICE) guidelines (Department of Health (DH), 2008a). A secondary aim of the service is to reduce the number of people claiming incapacity benefit, due to mental health difficulties (Hague, 2008).

Due to the infancy of the service, there are relatively few articles discussing outcomes and practical application. This has meant that in addressing this question I have had to rely mainly on recent literature that refers primarily to the theoretical model of the service, rather than the practical application. However recent articles (Hague, 2008: Richards & Suckling, 2008), government publications (DH, 2008b), and a presentation from an IAPT conference in October 2008 (DH, 2008c), have proposed a number of strengths associated with the IAPT agenda for adult mental health (AMH) service users. These include improved access to treatment, increased engagement with black and minority ethnic (BME) groups, increased choice of treatment, reduced waiting times, improved quality of care through evidence based practice and stronger links to practical resources. Inversely the same research has identified a number of challenges, which if not met could become limitations. These include resourcing appropriate staff and ensuring delivery of a high standard of treatment. Relating theory to practice, I also believe the close link to government economic policy and emphasis on return to work (Hague, 2008) can be viewed as both a strength and a limitation, and I have drawn on the cognitive model of depression (Beck, 1967) to support this.

The literature regarding the emerging IAPT service also suggests that it will impact positively on the relationship service users have with child and adolescent services, with increased links to educational resources and emphasis on early intervention (Bury PCT, 2007). However views within child services suggest that there are concerns that it will be difficult to translate the adult IAPT model to child services.
effectively and that child services are not currently a priority within the agenda
(Gilliard, C. personal communication, 05/01/08).

I chose to answer this question regarding the IAPT agenda, as prior to researching
this essay, I felt that it was an emerging area within mental health that I did not know
enough about. As a second year clinical trainee I have worked in a Community
Mental Health Team (CMHT) and am currently on placement in a Child and
Adolescent Mental Health Service and Looked After Children (LAC) service. In both
placements the IAPT agenda appears to be regarded with a degree of negativity by
clinical psychologists working in these fields. Therefore as part of this essay I have
also considered the agenda in relation to the role of the clinical psychologist and my
own professional development, as failure to recruit competent professionals to the
service could impact on the quality of treatment received.

IAPT Agenda
In discussing the strengths and weaknesses of the IAPT agenda, and its possible
impact on child services, I think it is important to be aware of the origins and
development of the agenda.

Origins and rationale of the IAPT agenda
In 2004 Lord Layard, Professor of Economics at the London School of Economics
produced a report stating that mental health difficulties place a large financial burden
on the economy, with costs of about £4 billion a year resulting from time off due to
anxiety and depression (Layard, 2004). It also stated that mental health difficulties
account for 30% of G.P’s working time and that 60% of people experiencing
depression would be helped by medication or cognitive behavioural therapy, but the
relapse rate would be better with therapy (Layard, 2004). Therefore
recommendations from the report concluded that by reducing waiting times and
offering a choice of evidence based treatment, in line with NICE guidelines, this
would reduce the number of services users suffering from anxiety and depression,
and in turn benefit the economy (Layard, 2004). As a result of these
recommendations the IAPT agenda was formed (DH, 2008b).
Description of the IAPT service
The IAPT service is designed to offer increased access to psychological therapies in primary care for people experiencing depression and anxiety, as well as panic disorder, obsessive compulsive disorder, post traumatic stress disorder, social phobia, generalised anxiety disorder, and health anxiety (DH, 2008b). Treatments will allow for an alternative to medication, and will often involve a stepped care approach (NICE, 2004). There will be two levels of care, low and high. Low intensity therapy will be by telephone, guided self help with workbooks and computerised cognitive behavioural therapy (cCBT) (DH, 2008b). Patients that do not show signs of improvement will be stepped up to high intensity working with 20 sessions. Then patients will be stepped up to secondary care if required (Hughes, 2008).

Implementation
The first IAPT demonstration sites were commissioned in 2005 at Newham and Doncaster (DH, 2008b) and initial outcome information from Doncaster reported good clinical results (Richards & Suckling, 2008). Further funding, amounting to 173 million was then agreed, and it was proposed that IAPT sites should cover half of England by 2010/11 (DH, 2008b), the aim being that 900,000 more people will access treatment, and 25,000 fewer people will be on benefits by 2010/11 (Turpin & Wheeler, 2008).

Strengths of the IAPT agenda for AMH service users
Given the proposed nature of the service it is evident that in theory there are a number of strengths associated with expected improvements that will benefit adult service users.

Increased access to psychological treatment
It is evident that one of the main strengths for AMH service users will be the improved access to psychological treatments. The Department of health suggests that only 30% of people suffering from depression and less than 25% from anxiety are
currently receiving treatment (DH, 2008b). There are number of reasons cited for the low engagement with services, such as stigma and difficulty in accessing services (DH, 2008b). Therefore it is expected that by having the option to self refer and by locating treatment centres in convenient, but relatively anonymous locations, this will result in more people accessing treatment (DH, 2008a). Similarly reduced waiting times will be of benefit to AMH service users. The Layard report (2004) stated that the waiting time to see a psychologist for anxiety or depression is approximately six to nine months (Layard, 2004). Through the use of self help, cCBT and telephone therapy it is expected that waiting times will be reduced. For example the reported waiting times to access therapy in the Doncaster demonstration site was approximately 20 days (Richards & Suckling, 2008). It could be argued that this form of therapy is not as effective as a face to face intervention, and research shows that the relationship between the therapist and the service user has been shown to be a key indicator of outcome success (Waddington, 2002). However, drawing on the evidence base, I believe that increased access is still a strength, as the NICE guidelines endorse cCBT for mild and moderate depression and mild anxiety (DH, 2007).

Diversity
In line with the increased access to treatment it is evident that one of the agenda’s main priorities is to engage traditionally harder to reach groups, especially black and ethnic minorities (BME) (DH, 2008a). For example in the IAPT guidelines it is suggested that a local equality assessment needs to be conducted, in order to reduce discrimination (DH, 2008b). This is a clear strength as it has been shown that BME communities access healthcare less than the rest of the population (NIMHE, 2003). As part of the agenda Special Interests Groups (SIG) have also been commissioned, and, as a result, it is suggested that services should engage with local faith groups and that each service should be tailored to the culture and needs of the community it serves (DH, 2008a). For example translations of self help and cCBT packages are recommended (DH, 2008a). The effectiveness of this service is highlighted by the outcomes reported from the Doncaster demonstration site for BME service users (DH, 2008a).
Increased choice of treatments

A further aim of the IAPT agenda is that, by offering an available alternative to medication, AMH service users will benefit from a greater choice of treatment. I have included this as a strength, but I am aware that a current view, held by a number of clinicians working in the NHS, is that it will actually mean a reduction in choice, with CBT being the only treatment option. For example in 2007 a petition was sent to Downing Street urging the Prime Minister to

"consider other psychotherapy approaches, not only CBT, in the proposed expansion of psychotherapeutic services within the NHS, instead of restricting choice for members of the public to one only model of therapy." (Number 10, 2007, P1, L7-9).

In considering this view I have still labelled ‘choice’ as a strength because the strategic proposals suggest that IAPT only seeks to offer treatments recommended by the NICE guidelines, rather than to enforce CBT as the only treatment option (DH, 2008b). It also suggests that once enough CBT therapists have been recruited then other models of therapy, that show evidence of positive outcomes will be considered (DH, 2008b). I realise that this has further implications as ‘how can other models build an evidence base if CBT is the only treatment being commissioned?’ However I believe that within the IAPT service there is an understanding that CBT should not be the only model considered.

Holistic approach to mental illness and recovery

A further benefit of the IAPT agenda is that it proposes a holistic approach in treating people with anxiety and depression. For example IAPT services will have easy access to a G.P with a special interest in mental health, to provide advice on medication (Hague, 2008). As part of the service there will also be specialists available to advise on difficulties arising from debt, unemployment and housing (DH, 2008b). For example IAPT services are expected to integrate new employment advisors, which will increase links with employers, job centre plus and occupational
health services. Thus AMH service users will benefit from increased opportunity to find employment.

Evidence based practice
It can also be argued that the agenda’s emphasis on evidence based practice will be another strength for AMH service users. The routine recording of outcomes within the IAPT service will allow for assessment of the effectiveness of treatments on a regular basis (Hague, 2008). This form of evidence based practice is exemplified by the way in which the outcome results from the Doncaster demonstration site have been used to inform practice in the eleven pathfinder sites. However, there are perceived clinical limitations related to the over reliance on outcome measures which could impact on the quality of treatment.

Improvements to all services
The strengths I have discussed so far relate primarily to people suffering from anxiety and depression and therefore, given the agenda’s focus on these areas, it could be argued that AMH service users suffering from other difficulties, such as Schizophrenia and Personality Disorder, might not benefit from the implementation of this new service. However, reviewing the literature it is evident that in implementing IAPT a number of recommendations have been made that relate to all psychological services in primary care. For example;

"PCTs will need to demonstrate that there is no reduction in current funding of psychological therapies services and that they have considered the impact of new services on existing psychological therapies and other mental health services (DH, 2008b, P20, L15-18).

Therefore in theory it appears that the emerging IAPT services will not impact negatively on other services and in general AMH service users might benefit from the increased profile of psychological therapies within the NHS.
Limitations of the research

Taking a more critical view towards the research and literature used in support of possible strengths, it is evident that a number of the points are drawn form government publications. This raises issues concerning objectivity, and it could be argued that given that there may be an underlying invested interest in presenting the service in a positive light, an awareness of this should be employed when considering the conclusions drawn. For example, although the outcome data from the Doncaster site reports good clinical outcomes, it does not discuss how these outcomes compare to outcomes from other adult mental health services. Similarly the fact that the IAPT service has developed a number of its own outcome measures raises methodological issues, when comparing these results with outcome measures from existing adult mental health services.

Limitations of the IAPT agenda for AMH service users

Despite possible questions relating to objectivity, government proposals often refer to a number of challenges to be overcome, such as ensuring quality of care, which involves the recruitment of experienced staff (DH, 2008c). It also appears that these challenges could then become limitations for AMH service users if they are not adequately addressed. However, again due to the lack of reported outcome data, a discussion in this area relies on theory more than proven practice. Despite this qualification, it is my opinion that the IAPT service’s over reliance on outcome measures could impact on the quality of treatment received. Similarly although I have suggested that the service’s holistic approach, involving employment advisors, is a strength, I believe that the apparent emphasis on finding employment could actually be a fundamental limitation for AMH service users.

Recruitment of therapists

The majority discourse concerning the IAPT agenda at both of my placements, in terms of its impact on AMH service users, was that the psychological treatment provided would be of reduced quality. The reasoning behind this is that it is thought that the type of CBT being delivered would not be effective for a number of reasons. I have addressed a few of these previously, such as the fact that cCBT and telephone
therapy will not allow for the development of a therapeutic relationship. However another reason for this perceived reduction in the quality of treatment is that it is believed that it will be hard to recruit therapists to the profession. This idea, although not referred to as a limitation, is clearly recognised as a challenge by the Department of Health (DH, 2008b). In order to meet the proposed targets for 2010/11 3600 new therapists need to be recruited (DH, 2008b). If this target is not met it could would mean bigger caseloads and longer waiting times.

Outcome measures
At the IAPT National Overview Conference in October 2008 (DH, 2008c) resistance, on the part of therapists, to the collection of outcome measures was described as a challenge that needed to be overcome. As part of the agenda it is expected that outcome measures will routinely be used and therapeutic interventions will then be guided primarily by service users’ scores on these measures (DH, 2008b). Drawing from my own experience in clinical practice I would argue that the over reliance on outcome measures is a limitation in itself. For example in my practice routinely administering psychometric assessments at the start and end of therapy provided good points for discussion during sessions with clients during my adult placement. However if there had been an increased emphasis on demonstrating improved outcomes on these measures I believe this would have impacted negatively on the quality of treatment my clients received. Ethically it is also apparent that there are times when it is not appropriate to ask a client to complete an outcome measure. However the IAPT agenda seeks to obtain 95% compliance for pre and post measures (DH, 2008d). Thus, given this level of outcome monitoring, therapists may feel increased pressure to show improved outcomes, which might also impact negatively on the quality of treatment received.

Links to government economic policy.
The IAPT agenda’s emphasis on outcome measures and results appear to relate to its close link with government economic policy. For example it is evident that the high level of funding allocated to the service is influenced by a cost benefit analysis relating to incapacity benefits. For example the Layard report (2004) made the
suggestion that if it costs £1000 to deliver 16 sessions of CBT therapy and this results in only 3 months employment on the part of the service user then that has an economic gain of £2000 for the government, in unpaid benefit and taxes (Layard, 2004). Therefore, in order to secure further funding, it could be argued that the service needs to be able to show results that have an economic benefit, with increased numbers of service users finding employment. This could result in a policy where service users are encouraged to return to work despite their difficulties.

Thus I believe the focus on employment can be viewed as both a strength and a weakness for AMH service users, especially for people suffering from depression. To support this argument I have related theory to practice and employed the cognitive model of depression (Beck, 1967) to explain the different views. For example increased activity through employment could help to break the negative pattern maintaining feelings of low mood, leading to increased energy and a reduction in negative automatic thoughts (Beck, 1995). Inversely an inability to find work, given the emphasis on employment during the treatment, might lead to more negative thoughts about the future, and perceived usefulness within society. This in turn might maintain feelings of low mood. In this way the underlying employment agenda could be seen as both a strength and a limitation. However the reason I have chosen to include it under limitations relates to the current economic climate and the diminishing job market. It can be argued that currently it might be harder for service users to find employment compared to when the agenda was first implemented.

Thus reviewing the strengths and limitations it appears that there is evidence to support both sides of the argument. However it is hard to draw any firm conclusion as the ideas often relate to theory, rather than to proven outcomes.

Impact of the IAPT agenda on service users relationships with child and adolescent services.

The idea that it is hard to draw any firm conclusions about the IAPT agenda, due to its relative infancy, is also relevant to discussions concerning its impact on service users relationships with child and adolescent services. To date only one pathfinder
site has administered the IAPT agenda for a child service (Bury PCT, 2007). This ran from September 2007 to September 2008 and the results of the service are not yet available. However from the proposed nature of this service it has been possible to draw a number of conclusions relating to how the agenda might impact on child services in primary care. Through discussions on placement with clinical psychologists working in child and adolescent services, and drawing on my own practice, I have also been able to identify the ways in which it is often perceived that the agenda will impact on child services.

**Perceived Impact**

Following a discussion at the weekly psychology meeting, concerning the IAPT agenda and child services, it is evident that there is a belief that, as child services are not a priority with the IAPT agenda, it will not impact on services. Alternatively it is thought that if IAPT is applied to child and adolescent services it will be hard to translate the adult model and therefore service users will experience a less tailored service. In support of this my own perception is that it will be hard to translate the IAPT adult model of a single assessment to child assessments, especially with Looked after Children, where the assessments can be conducted over a number of sessions.

However in response to these ideas, although there is very limited research in this area, the literature does suggest that there is an intention to apply IAPT principals to child and adolescent services, without imposing an adult model of treatment. It is also evident that a number of the strengths associated with the adult model, such as the holistic approach and emphasis on engagement of disadvantaged groups, will also benefit service users accessing child and adolescent services. This is evidenced by the Bury Pathfiinder Site (2007).

**Bury PCT Pathfinder Site**

It is evident from the proposal for an IAPT service for child services from Bury PCT (2007) that the IAPT agenda is also being developed specifically for child services. The idea being that children who experience psychological difficulties also struggle
in education, and therefore fail to obtain the necessary skills to find employment in later life (Bury PCT, 2007). In this way the main emphasis for this service is on early intervention (Bury PCT, 2007) and it also incorporates the holistic principals of the IAPT adult service agenda by aiming to establish better links with schools to help service users to access education. In terms of diversity and reaching more disadvantaged groups, the IAPT service in Bury also emphasised the need to try and engage transitioning children that have been looked after by a CAMHS service but do not meet the requirements of an adult CMHT (Bury PCT, 2007). The Bury proposal (2007) also detailed the need to try and engage children from BME groups, especially asylum seekers suffering mental health difficulties (Bury PCT 2007).

However again taking a critical approach to the ideas presented in the Bury proposal (2007) it is evident that although the proposal states the intended aims, there are limited details actually describing how it will meet a number of these aims. For example there are no details describing how the service intends to engage BME groups in practice.

Further Initiatives within Child and Adolescent Services
The literature also indicates that alongside the Bury pathfinder site there are a number of other proposals from strategic health authorities and primary care trusts designed to apply the IAPT agenda to child and adolescent services. In considering these it is evident that they could mean improvement for users of child and adolescent services. For example the London strategic health authority has been involved in pilot projects to develop IAPT services for abused children (London Safe Guarding Children board, 2007). This service intends to improve links with all agencies offering services for abused children.

Link to Government Economic Agenda
Although there appears to be a number of benefits from the new IAPT initiatives in the area of child and adolescent services, it is evident that they are still closely linked with the government economic agenda, and this could have a negative impact on the relationship of service users to these services. For example in the proposal for Bury
PCT pathfinder site (2007) it was considered that new outcome measures should be developed to specifically relate to child outcomes in areas of education (Bury PCT, 2007). In this way it could be argued that therapists delivering interventions will be under pressure to provide results in order to justify the service, and clients receiving therapy might feel pressure to 'improve' and return to education despite their difficulties.

Thus considering the impact the IAPT agenda might have on service users’ relationships with child and adolescent services it is evident that it could impact positively through increased access to education, greater engagement of BME and under represented groups, and a more holistic approach to treatment. However there could be negative consequences with an over reliance on outcome measures and increased pressure to 'improve'. In this way it is difficult to draw firm conclusions as there is no outcome data to draw upon. However it is clear that in the future IAPT services will be available for both adult and child service users. As a result this has direct implications for the role of the clinical psychologist and my own clinical training. IAPT services will be under pressure to meet targets, in terms of recruitment of therapists, however recruitment could be hindered by the negative view of the service that seems to prevail amongst psychologists working in the NHS.

Role of clinical psychologists and implications for training
Thinking about the strengths and limitations of the IAPT agenda and impact on child services it is evident that, in order to ensure quality of treatment, the service will need to train and recruit experienced therapists. It is currently estimated that the service will need to recruit 3600 trained therapists by 2010/11 (DH, 2008b). However from my experience in the NHS it is evident that there appears to be a degree of negativity regarding the service on the part of clinical psychologists.

I believe one of the reasons for this negativity can be explained through the perception, held by a number of clinical psychologists, that IAPT services will only involve CBT therapy. Therefore if the agenda achieves its aim of
"offering a greater choice of NICE recommended evidence base therapies in addition to CBT" (Turpin & Wheeler, 2008, P8, L14-15)

such as Systemic Family Therapy, it may result in a reduction in this current negative perception. However I believe the main reason for the apparent reluctance on the part of clinical psychologists to work in IAPT services can perhaps be explained by a model of change, which suggests if the cost out weighs the benefit then change will not happen (Prochaska & DiClemente, 1986). For example for qualified clinical psychologists to currently work in IAPT services they need to be British Association for Behavioural and Cognitive Therapies (BABCP) accredited (BABCP, 2008), which might involve further training. However I believe that most clinical psychologists holding an 8A post or above would probably consider themselves qualified to work as a high intensity therapist. Similarly newly qualified clinical psychologists would automatically have to undergo further training to work as a high intensity therapist.

Considering my own professional development, this extra training would seem unnecessary given the three years training that I would have already completed, however my aim on completing the training course had been to work in primary care services. As a result I now feel I am being forced to consider training as an IAPT therapist. In this way I would argue that it might be easier to recruit newly qualified psychologists who want to work in primary care. However I believe it will be more difficult to recruit experienced clinical psychologists if they have to gain BABCP accreditation as the costs appear to out weigh the benefits.

This possible limitation in recruiting clinical psychologists to the service has direct implications for the quality of treatment received by both adult and child mental health service users. For example the IAPT agenda lists supervision by experienced therapists as one of the main strengths of the service (Turpin & Wheeler, 2008). It is planned that in supervision each client will be discussed individually and their treatment will be based on discussed outcome measures (Turpin & Wheeler, 2008). However if the service fails to attract enough qualified supervisors the service will
have to operate a less intensive approach in order to meeting its waiting time targets. In this way it can be argued that an inability to attract enough experienced clinical psychologists to the service will impact negatively on both adult and child services users accessing IAPT services. However, as with all elements of the new service, there are again few recorded outcomes so, although this could potentially become a limitation, at this stage I would argue that it is currently only a challenge.

Conclusion
Reviewing the points that I have discussed regarding the IAPT agenda, firstly it is evident that there are a number of strengths associated with this service for AMH service users, such as increased access to services and greater engagement with BME groups. Limited outcome data from the Doncaster demonstration site also supports a number of these ideas. However there are methodological issues relating to the interpretation of this data, such as the use of outcome measures that are not comparable to measures from existing services.

Inversely I have also discussed a number of challenges that could become limitations if not addressed adequately, primarily the over use of outcome measures and the need to recruit a high number of experienced therapists. The focus on employment can also be viewed as a limitation. For example, in line with the cognitive model for depression (Beck, 1967), pressure to find employment could maintain low mood in service users engaging with IAPT services. This idea is highlighted by the fact that it has been suggested that cCBT could be delivered in job centres (DH, 2007).

It is also evident that, although developing, IAPT services will soon impact on service users accessing child and adolescent services. This impact could be positive through a more holistic approach and increased engagement of BME groups, however it could, as with the adult service, increase the pressure on service users to show ‘improvements’ and it may also place an emphasis on therapists to achieve immediate and tangible results in a short time frame.
In drawing these conclusions I am aware that I have often relied on theory rather than practice, therefore, given the limited reported outcome data and innovative nature of the service, I believe that it would be important to wait to see how the service addresses the potential challenges before judging its effectiveness. Also taking a critical approach to the literature it is evident that I have drawn on ideas that are primarily presented in government publications where there might be an invested interest in presenting a positive image of the service.
References:


PROBLEM BASED LEARNING (PBL) REFLECTIVE ACCOUNTS
Problem Based Learning Reflective Account I

“The Relationship to Change”

March 2008

Year I
Introduction
This is a reflective account of the problem based learning exercise that that I undertook three months ago, during a six week induction programme at the start of clinical training. The exercise involved seven first year trainees and a facilitator. We were told as a group that we had to think about the phrase “the relationship to change” and create a presentation based on our thoughts and ideas. In structuring the account I have reflected on my involvement with the process, the group’s involvement, and how both of these relate to my learning needs and clinical practice. In doing this I have identified how uncertainty can produce anxiety and why it is important sometimes to be able to tolerate this anxiety when working with clients. I have similarly reflected on how a desire for harmony within a group can stifle open discussion and lead to false assumptions.

Reflections on my involvement with the process
Reflecting on my thoughts prior to starting the exercise, I believe the effort involved in acquiring a clinical training place had cognitively predetermined me to over-value any activity involved with the course. The dominant discourse on the first day of training was how difficult it had been to get onto training and how pleased people were now that they had “made it”. Similarly for me the application and interview process had been overwhelming and hard. Research on group membership (Aronson & Mills, 1959) and cognitive dissonance (Aronson, 1968) suggests that the more effort exerted in achieving membership, the more the membership will be valued. I believe this cognitive process directly raised my evaluation and willingness to engage with the exercise. This is relevant to clinical practice as clients can wait up to a year to see a psychologist and this may influence the extent to which they value the therapy and therapist. I am not suggesting that the longer a client has to wait for therapy the more they will engage with it, but I do believe a therapist should be aware of the amount of effort the client has had to make to access therapy.

Session 1
In the first session our first task was to elect a chair and scribe. At this time I was experiencing a small amount of anxiety connected to the fact that I felt that the
facilitator and other group members might have thought that I was not qualified enough to be on the course. I had not worked within the NHS and had limited experience with clients. I have found that in the past when I experience anxiety I try to tackle it straight on and thus, to reduce feelings of incompetence, I nominated myself as chair. The nomination itself was enough to reduce anxiety, as I felt it gave the impression of competence. However in the end I was elected as the chair.

Reflecting on this behaviour, in light of my current clinical work, I can see that in this situation I attempted to present a confident image to dispel doubts about my competence. Similarly initially in clinical work I suffered from anxiety related to perceived competence and as a result tried present an image to counter this idea. In therapy sessions I had a tendency to dictate the agenda, over use jargon and be too keen to offer advice. This learning need was addressed in supervision and as a result I have become comfortable sitting with the anxiety and letting a collaborative, open discussion unfold.

After we had elected a scribe and chair, still in the first session, we then discussed what the “relationship to change “meant to the group. This involved contributions from each trainee in the group. Following this conversation we then focused on the role that the media played in changing public opinion and finally the focus then narrowed to examine changes in terms of the media’s presentation of the “McCann story”1. At the end of the first session it was agreed that before the next session we would research our own area of interest. To reduce any residual anxiety connected with the task, between sessions I tried to find more concrete information concerning what was expected from us and how the task was to be evaluated.

Session 2
In the second session each member of the group discussed their preferred area of interest in relation to the title of the exercise. At the end of this discussion it was clear that there were a number of disjointed threads, such as how the media promotes change, how the “McCann” story has changed, and how cognitively we process

1 The McCann story refers to the disappearance of Madeline McCann in May 2007.
information. I believe my default reaction in situations where there are competing ideas is to feel anxiety related to “making the right choice” and being “in control”. However in the group we discussed that the presentation was not being formally evaluated and therefore I was able to tolerate the anxiety.

This idea relates to work looking at cognitive closure, which is the need for an answer, and how accountability can mediate this and in turn increase anxiety levels (Kruglanski & Webster, 1996). For example someone with a high need for cognitive closure will experience higher levels of anxiety when made accountable for their decisions. In clinical sessions I work from a collaborative stance and allow the client to explore ideas, however when I am being directly evaluated by my supervisor, I feel anxious and try to take control of the session. I have identified this as a learning need for now and the future.

Session 3-6
At the end of session two it was agreed that we would not focus on one idea, but include all relevant ideas under the general theme of change. In session three we then brainstormed how we would present these ideas. It was suggested that we should make the presentation engaging and perhaps create a news report. I was elected as the presenter and it was at this stage that I felt that the exercise became highly enjoyable, perhaps due to the shift from theoretical knowledge to a different set of skills. In session four we discussed how we would structure the news report and then in sessions five and six we practised it. Finally in session seven we presented it to our cohort and members of the course team.

I have not focused on my involvement in the final stages of the exercise as I believe these are not as relevant to my learning needs or clinical work. I come from a theatrical background and feel very comfortable presenting information in front of a large group, especially when the information is not being formally evaluated. I have, however, processed this information in terms of my learning needs and prioritised direct client work above presenting or teaching experience.
Reflections on the group’s involvement with the process

Thus far I have discussed my involvement with the exercise, now I would like to reflect on the group’s involvement. It was evident from the start that there was a desire to bond. Everyone was polite and considerate in the first session when discussing our varying thoughts and ideas, and this politeness continued throughout the exercise. I believe the reason for this is that, as mentioned previously, we identified at the beginning of the second session that producing an accomplished coherent presentation was not our main goal, as it was not being formally evaluated. Instead, outside the session, it was discussed how we should use the time to “get to know each other”. I believe this process is directly relevant to clinical work as it highlights, supported by research (Beck, 1995) how an identification of goals at the beginning of therapy can allow the client and therapist to collaboratively work together to achieve the same outcome.

In line with the group’s desire to form a strong bond it was evident that we also started to make “in group, out group” distinctions (Quattrone & Jones, 1980). For example we had heard about conflict in other groups and this was used to reinforce the idea that our group could function without conflict and thus strengthen our individual identity and the bond between the members.

The facilitator

The fact that the group of trainees identified a shared goal early on in the exercise had direct consequences for the facilitator within the group. The facilitator described himself as “liking to play devil’s advocate” and therefore often positioned himself in an adversarial role within the discussions and this conflicted with the principal goal of harmony. This I believe, supported by research on group processes (Quattrone & Jones, 1980), resulted in the facilitator being seen as distinct from the group. Reflecting on the role of the facilitator further, it was evident that, due to unforeseen circumstances he was late on one occasion, and this in turn increased the group’s willingness to distance themselves. I believe this last point should be reflected on, in relation to the fragility of the therapeutic alliance. For example it highlights the need for structure, clarity and reliability on the part of the therapist (Beck, 1995) as, in
terms of the views of the client, it can be easy to reject someone that is not helping you to achieve your goal. I found the distancing of the facilitator difficult as I was the only other male in the group and therefore felt positioned between the female group members and male facilitator.

**Strengths and Weaknesses**

Reflecting on the strengths and weaknesses of the approach taken by the group to the exercise I believe there were a few positive benefits, which are counter balanced by a number of negatives. Firstly, given the context of starting training, it enabled the group to bond and allowed the individual members to form strong relationships with other course members. Secondly it enabled us to achieve our main goal of creating harmony.

Inversely I feel the desire to create a strong bond and common identity led to a number of ill informed assumptions being generated about group members, in relation to difference and diversity. For example it was apparent that there were a number of shared characteristics within the group of trainees and I believe these shared characteristics, coupled with a desire to bond, led members of the group to make further assumptions about shared characteristics. For example when discussing the McCann story it was proposed that it was shocking to all of us because we were all middle class. This I feel identifies an important learning need for the group, which is to not make unsupported assumptions without considering available evidence.

The second negative factor related to the groups approach is that I feel a need for harmony stifled open discussion and led to a glossing over of important ethical issues to avoid conflict. For example when considering how to deliver our presentation the facilitator prompted us to think about ethical issues relating to the information concerning the McCanns. This mutated into a conversation about how it is difficult to maintain confidentiality within a community mental health team. There were opposing views within the group on this subject. However the group as a whole acted to alter the focus and divert back to the presentation in order to maintain
harmony. This behaviour is in line with research on the containment of aggression in animal groups (Bradley, 1999).

Conclusion
I believe the exercise highlighted important aspects of my behaviour in relation to clinical work, most importantly that I need to learn to tolerate anxiety produced through uncertainty. Similarly I believed the exercise highlighted how a need for harmony in a group can restrict discussion and lead to assumptions concerning similarities and differences. Reflecting on these criticisms of the approach taken by the group in this exercise, I believe the group will struggle to produce a balanced, coherent presentation if it adopts the same approach during the next exercise, which is formally evaluated.
References


Problem Based Learning Reflective Account II

Working with people in later life, their families, and the professional network

March 2009

Year II
Introduction

This is a reflective account of the problem based learning exercise that I undertook, as part of a group, at the start of my second year of clinical psychology training. Our group included four second year and three third year trainees. The task involved thinking about a client referred to the psychology department for an assessment of his short-term memory problems. We had approximately three weeks to engage with the task and we were then required to present our ideas.

In reflecting on the exercise I have considered the strengths and weaknesses of our approach to the task and the presentation, my involvement with the process, and the group’s involvement. I have also reflected how each of these might relate to my own clinical practice and inform future practice. I have also considered the service user perspective and possible ethical issues in relation to choice of therapy. Whilst engaged in the exercise I kept a reflective journal and I have been able to identify changes in my thinking over time.

In writing this account I have also been guided by feedback I received about a previous reflective account of a PBL exercise, which suggested that it was a good but ‘safe’ account. As a result, here I have attempted to discuss ideas that I am less comfortable presenting, such as my difficulty in tolerating other group members’ anxiety and the use of humour in presentations. The same feedback also suggested that I could take a narrower focus. Therefore I have tried to identify only the most salient ideas, and discuss them more in depth.

Task and presentation: Approach

In our first meeting it was discussed that the presentation should be ‘funny’. The third year trainees talked about presentations they had given in the past and how ‘funny’ they had been. Once we had read through the referral letter and background information we discussed that it was possible to formulate the client’s difficulties using more than one model. We also considered the ethical issues related to the extent to which the client has a choice over the form of therapy they receive. From
this it was suggested that we take a ‘Dragon’s Den’\(^2\) approach for the presentation. This involved pitching the benefits of either a neuropsychological or Cognitive Behavioural Therapy (CBT) assessment, a Systemic assessment, or a Psychodynamic assessment. The idea being that the ‘Dragon’s’ would decide which model would best address the client’s needs. We thought we would also make a ‘funny’ comment on the Government’s current emphasis on CBT, in line with the Improving Access to Psychological Therapies agenda (Department of Health, 2008), by suggesting that no matter which model the judges chose, it would still be a CBT model that was employed.

Reflecting on this approach it is evident that it was guided by a desire to deliver a ‘funny’ presentation. In order to critically evaluate if this was a strength or weakness, I think it is important to question whether a presentation on a clinical subject should be ‘funny’ and what kind of humour is appropriate. The idea of dressing up in a wig or costume to entertain the cohort could be seen as disrespectful to service users and to clinicians. Drawing on an example to support this, during my first year of training, I watched a presentation where a service user was depicted wearing a hat with an offensive label on the brim.

However I believe that humour can be of benefit in engaging an audience with a presentation and making the ideas accessible. Research suggests that if humour is directed at a situation, rather than a person or group, it can have a positive impact (Sultanoff, 1995). Therefore if the humour is drawn more from the identification of frustrations and assumptions, it can perhaps help the audience to reflect on challenges and difficulties.

Considering our presentation in relation to the use of humour, I believe we managed to avoid causing offense and were able to subtly communicate ideas in an entertaining way, which was a strength. However our drive to ensure that the presentation was ‘funny’ meant that we did not do justice to some of the ideas, which was a definite weakness. This idea is supported by our feedback, which suggested

\(^2\) ‘Dragons Den’ is a programme on BBC 2 where entrepreneurs pitch for investment for their inventions and ideas.
that the presentation failed to engage with the client’s difficulties in any real depth. Therefore in terms of future learning, perhaps the style of presentation should be determined by the ideas themselves rather than making the ideas fit with the style.

Reflecting further on how these ideas relate to my own clinical practice. As part of my placement with a Looked after Children service I presented to eleven female carers, of West Indian or African origin. Thinking about difference and diversity, I viewed this group as relatively homogenous, and myself as quite diverse compared to the group, in terms of age, gender and culture. Therefore I had to consider how best to engage the group. The presentation took place in a porta-cabin in a car park and the majority discourse amongst the group was that the distance to the toilets was too far. I picked up on this and by highlighting their shared frustration in a humorous manner, I was able to gain the trust and the attention of the group.

My involvement in the group process
My engagement with the group process was determined by the conflict that occurred between myself and another group member. Once it was agreed that we would present in the style of ‘Dragon’s Den’ we split into pairs to prepare the pitches. I elected to do the CBT and neuropsychological pitch, along with a group member that I had a close friendship with, on and off the course. However we had not worked in a pair before and conflict began to arise when it was evident that my partner was very anxious about presenting, and my enthusiasm for presenting seemed to cause her irritation. Research suggests a strong link between anxiety and hostility (Banyani, & Kocheki, 2007) and, possibly due to her anxiety, my partner often changed her mind about what she wished to present and tried to control and direct my input. Our relationship then deteriorated and during the practice session before the presentation we were openly hostile towards each other. This conflict impacted on my involvement with the wider group, as it meant that I then took more of a reserved stance, perhaps due to my partner’s feedback about my enthusiasm, but also because I started to disengage with the exercise.
In terms of my own learning I have examined my reaction to my partner’s hostility, and I have reflected on why I reacted negatively, allowing the conflict to escalate, rather than seeking to contain her anxiety and reduce the hostility. On placement I have often consulted to social workers who, at times, feel anxious about aspects of their client work, and as a result can be hostile to new ideas, however I do not react to this hostility. I think there are two reasons for my differing reactions. Firstly on placement the hostility is often focused towards my ideas, however during this exercise, the hostility was focused toward me. Secondly my relationship with my partner was not purely professional and I think I reacted from a position of being in conflict with a friend rather than a colleague. Therefore I have become aware that on occasions personal responses can impact on professional situations, especially when the boundaries around the relationship are not distinct.

Extrapolating this situation further, and considering the learning needs of others, it is evident that fear of presenting appears to be a common problem for a number of members of the cohort. In line with the cognitive model of generalised anxiety (Beck et al, 1985) it is apparent that subtle attempts to avoid presenting reinforce this fear. For example, hiding behind the content, or only reading from a set script, avoids opening up the presenter to the audience. I believe that this situation with my partner has identified how important it is for trainee psychologists to address fears of presenting, as the ability to communicate ideas effectively to a large group appears to be a key skill needed by clinical psychologists once qualified.

**The group’s involvement with the process**

I think the group’s involvement and development is another important area to reflect upon. During the conflict with my partner the other group members chose to ignore the friction, and, taking a critical view, I am not sure if this approach was a strength or weakness. Ignoring the behaviour meant that it was not brought into the open and worked through, but it kept the rest of the group homogenous and did not cause further divisions. However despite the conflict with my partner it as also evident that there was a further division in the group between the second and third year trainees and this division related to each trainee’s knowledge base. The second year trainees,
myself included, appeared more comfortable discussing CBT and neuropsychological ideas, and were more hesitant around Systemic and Psychodynamic formulations. The third year trainees appeared comfortable discussing all models. Therefore one half of the group engaged less with the ideas at the start. However once we split into groups, and researched areas we felt comfortable with, this divide reduced.

In terms of my own learning, in this instance it is evident that I took the ‘safe’ ‘comfortable’ option by choosing to research an area in which I am familiar. I believe this tendency towards working in areas that are ‘safe’, relates to my experience of failing an essay at the start of the course. However in my recent placement I have directly challenged this behaviour and purposely chosen the more challenging clients. I have also attempted to move away from the purely CBT model that I am familiar with, and in supervision I have tried to formulate each client from a Systemic and Psychodynamic perspective.

As a final reflection regarding the group process it appears that group membership can be transient. In line with self categorisation theory (Turner et al. 1987), during a previous PBL exercise I identified with my Case Discussion Group (CDG) and, as a group, we made in-group out-group distinctions (Hogg et al., 1990) to bolster our identity. For this exercise that previous group was split in two and as part of the new group we again made in-group out-group distinctions, suggesting that other groups would not be as ‘funny’. In doing this I moved away from my previous identity with my CDG group and instead identified with members of my new group. Thinking about my training and experience on placement, it appears that this ability to adapt group identity is a vital skill required when assimilating into new teams.

**Conclusion**

Taking a meta-cognitive approach to my thoughts expressed in this account I believe I have succeeded in offering, compared to previous reflective accounts, a more open and honest account of mine and other group members engagement with the process, detailing the conflict and learning needs identified from it. I also believe, to a certain
extent, I have been able to select the most relevant ideas and present them in more depth. However I feel that reflections on the use of humour could justify the use of the two thousand words on their own. I also avoided focusing heavily on the group process as I felt that I was simply repeating ideas from previous reflective accounts. Taking a final reflection on the process of writing this account it appears that I have employed language that distances me from the approach we adopted. This relates to the fact that it was not my idea to be ‘funny’ and that I believe our emphasis on humour was a weakness. My own personal belief is that humour in clinical work cannot be forced, it should only be used when it is appropriate, and its impact on service users should always be considered.
References


Problem Based Learning Reflective Account III

How do we know if IAPT is working?

February 2010

Year III
Introduction

This is a reflective account of a problem based learning exercise, which I participated in at the start of my third year of clinical training. The task involved engaging with the question ‘how can the effectiveness of IAPT’ be assessed’, and preparing a presentation based on our ideas about the Improving Access To Psychological Therapies agenda (IAPT)(DH, 2008). The group was composed of four second year and four third year trainees. We met on five occasions prior to the presentation.

In writing this account I am aware that it is the final piece of reflective writing that I am required to complete on the course, therefore I have tried to assimilate the feedback from previous reflective accounts to enhance my learning. Specifically it has been noted that my reflective writing often seeks to introduce a number of concepts and theories but fails to develop these ideas in significant depth.

Therefore for this account I have detailed our approach to the task, looking at strengths and weaknesses. I have then selected the two themes of ‘cognitive closure’ (Kruglanski, 1996) and ‘leadership’ to direct my reflections. Within these themes I have reflected on my involvement, the group’s involvement, specifically one group member’s disengagement, and implications for clinical practice, now and in the future. As part of my reflections I have also commented on the diversity of the group and examined individual differences, in terms of a need for cognitive closure (Webster & Kruglanski, 1994).

Approach to the task

It was agreed at the start of the exercise that we would consider the different approach stakeholders, specifically service users and financiers, might take when evaluating the IAPT programme. The group then unanimously decided that we should present our ideas in an ‘Apprentice’ style format, with two teams representing the views of the two different stakeholders and a chairman evaluating the work of each team. In researching the content of our presentation it was agreed that we would split into two teams, and then draw our ideas together at the end.

3 The apprentice is a BBC two reality television programme.
Decisions concerning the task were often unanimous and there was no conflict within the group.

Reflecting on this approach, in terms of its strengths and weaknesses, one of the key strengths was that it allowed for cross year working and incorporated the diverse experiences of each trainee. As a group we were ‘stereotypically’ more diverse than the two cohorts we were drawn from, with two male trainees, and two ‘British Asian’ trainees and this allowed for us to draw on a wide range of experience when considering service user perspectives. Our comparison of the service user and the financial perspective also allowed for a greater understanding of the ethical issues around providing a service, where the rationale underpinning it is based on a cost/benefit analysis (Layard, 2004).

Inversely reflecting on potential weaknesses it was evident that our approach to the task was led by a focus on the presentation, leaving less time for an in depth consideration of the issues surrounding IAPT, which raises ethical issues about negatively commenting on a service when the research could have been more thorough. For example much of our discussion in the first meeting centered on who would play the lead characters and whether the main character should grow a beard or buy one.

Returning to the idea of strengths I have commented that often our decisions were unanimous and the process was without conflict, resulting in no one taking a directorial role, and this implies that the group worked effectively together. However a key limitation, hidden by the focus on the final presentation, was the fact that one group member did not fully engage with the task and instead took an observer role. During the task I kept a reflective journal and, drawing on my reflections, it is evident that I found this experience frustrating. Subsequently my frustration has reduced and I have since sought to understand the behaviour, drawing on theories of cognitive closure and leadership.
Cognitive Closure

'The need for cognitive closure refers to individuals' desire for a firm answer to a question and an aversion toward ambiguity'. (Kruglanski & Webster, 1996, P264, L6-7).

Cognitive closure is an idea I have superficially drawn on in a previous account to support my reflections on group behaviour, however it is very salient to my observations on the group member’s disengagement, as well as having direct relevance for my own clinical practice, therefore I have examined it in more depth in this account.

Reflecting on why the group member disengaged with the task at the initial stage, it appears the trigger was a conversation about what the task involved. The group member had made the decision that the task involved presenting the strengths and weaknesses of an IAPT service, rather than focusing on how you would evaluate it. When the other group members directed them to the printed guidelines for the exercise, the group member, rather than reinterpreting the question or argue their position, appeared to disengage with the task.

Relating this behaviour to the idea of cognitive closure, it appears that in this instance the group member appeared to remain cognitively closed, and did not use the printed instructions to reinterpret their decision. This suggests that for them it was better to keep to their original decision than seek to alter it, and a possible benefit may have been the reduction of ambiguity (DeBacker & Crowson, 2008).

In making this reflection on why the group member disengaged I am aware that this is only a hypothesis. However since identifying the impact of cognitive closure during the PBL task, I have found comparable examples on placement at a chronic pain service. A recent example involved a client who described reading in a letter that her spine was ‘crumbling’ and then was unable to alter her opinion, despite re-reading the letter and finding evidence to the contrary.
In conversations with my supervisor relating to this situation we considered how you work with people that are more likely to be cognitively closed, and whether the use of a measure of cognitive closure would be relevant to the initial assessment. These conversations have since led to a possible avenue of research, given the lack of an evidence base in this area, looking at cognitive closure and outcomes for pain management programmes.

In terms of my own personal learning and its impact on my professional practice I have also sought to identify the situations in which I might be more inclined to be cognitively closed, and to assess if these situations could have an impact on my clinical practice. For example through my work on my major research project I have identified that when presented with complex information I might form a firm opinion which is resistant to alteration, due to the potential costs of reinterpreting it. I have also identified that the situation regarding my MRP is often comparable to the complex information presented by a client and therefore I will be aware of my own tendencies towards cognitive closure when formulating and reformulating with clients in the future.

Returning to the process of the PBL task, and the group member’s disengagement, I have used cognitive closure as an explanation for why they may have distanced themselves from the task, but I have also considered if any other factors facilitated or prompted their disengagement. Drawing on reflections, provided by the second year trainees in the group, I have considered whether the lack of a group leader facilitated their disengagement.

Leadership

One of the second years’ reflections on the PBL process was that there was no clear leader for the group, and this was perhaps a weakness. It was also noted that perhaps the two third year trainees with more knowledge on the topic could have taken more of a leadership role. In questioning why the second years may have wanted a ‘leader’, given that we did not encounter many stumbling blocks in completing the
task, I am interested in whether they felt a ‘leader’ would have been able to create a more cohesive group.

My own personal perspective is that a leader uses their experience and knowledge to direct and inform the group process, but does not seek to control it, which is the role that I and another trainee took within the group. We offered copies of our essays on IAPT as a starting point for the discussion and we highlighted key issues relating to the IAPT agenda. However we did not seek to direct the group.

Therefore I feel that the group did have leadership, but it was very much in line with the idea of clinical leadership (Millward & Bryan, 2005) where some of the key skills are listening, empathy, and sharing knowledge, rather than a more autocratic type of leadership.

Reflecting on why I chose to adopt a clinical leadership style, I have considered contingency theories of leadership (Fiedler & Garcia, 1987) which suggest that appropriate leadership style is contingent on the situation. In this instance there was no significant crisis, and therefore I viewed a clinical style of leadership as the most appropriate.

However it is evident that group members still saw the lack of a clear ‘leader’ in the group as a weakness. Drawing on my own feelings, I believe this may be due to the their experience of frustration at having to work harder than another group member, and perhaps they felt that a ‘leader’ would have been able to resolve the imbalance. Personally I do not feel that this should be the role of a leader, given that I believe that trainees should take personal responsibility for their own learning. This I also consider to be a learning point for the group, now and for the future, in terms of how much personal responsibility they take for their own learning.

In terms of my own learning and relevance to clinical practice, through my reflections on leadership, I feel I have been able to further define the type of leadership/consultancy role that I am prepared to take within a team. I do not feel
comfortable taking a dictatorial role and instead feel that my style of leadership involves using my knowledge and experience to direct the conversation and subsequent work.

**Discussion**

Reflecting on the overall process of creating this account, my primary aim, in terms of learning, had been to introduce fewer concepts or themes but to still be able to include reflections concerning my involvement, the group process and relevance to clinical practice. I feel I have achieved this, but perhaps I could have focused on only one theme, and this will direct my writing in the future.

Taking a critical view of my inclusion of the theme of leadership I believe it was prompted by a need to justify the role I took in the group. Therefore the leadership section of this account appears to be written from a defensive position. Taking a meta-reflective stance, and considering the context that informed my decision to include leadership, I am aware that at the time of writing the first draft I was experiencing considerable work pressure, and this feeling perhaps focused my reflections on the situation of being asked to do more during the task. At the time of writing the second draft the feeling of being overwhelmed had subsided and resulted in my reflections on the theme of leadership becoming less salient, thus emphasising the importance of context on reflection.

A final aim in writing this account had been to highlight the importance I place on the concept of cognitive closure in my work, looking both at the cognitive styles of the client and clinician, in terms of decision making. I believe I have achieved this and I intend to build on this concept by researching in the area of chronic pain and cognitive closure in the future.
References


CASE DISCUSSION GROUP (CDG) PROCESS ACCOUNTS: SUMMARIES
Case Discussion Group Process Account I

Summary

September 2008

Year II
Case Discussion Group Process Account I: Summary

During my first year of clinical training I was a member of a case discussion group that was composed of seven trainees and a facilitator, and met fortnightly to discuss all aspects of clinical work. This reflective account has examined my contribution to the group, the group process, and implications for mine, and other group members’, personal development and clinical practice. It is evident from my reflections that that my contribution to the group, and the impact of the group on my learning, changed over time. Initially I and the other group members had a sense of enthusiasm about the group, however over time this enthusiasm reduced and I believe the group failed to meet its potential, in terms of creating a free open forum to discuss clinical work safely. However I have also reflected that there were a number of strengths to the group, primarily in terms of my personal and professional development. For example the group enabled me to reflect on my behaviour in response to anxiety provoking situations and allowed me to adopt a more reflective stance during the group meetings. As a final reflection I have also noted, influenced by my year long adult placement, that the Cognitive Behavioural model underpins a number of my reflections. Therefore I have also recognised a need to broaden this to include further therapeutic models in subsequent reflective accounts.
Case Discussion Group Process Account II

Summary

July 2009

Year II
Case Discussion Group (CDG) Process Account II: Summary

This is a process account of the CDG group that met fortnightly during my second year of clinical training. The group was composed of seven trainees and a facilitator from the course team. The work of the group can be split into three sections. Firstly we completed a problem based learning exercise. Secondly we met, with the new facilitator, to discuss general issues concerning training and we considered the change in facilitation style from the first year. Thirdly the facilitator handed the facilitation over to the trainees. In this account I have reflected on what I learnt through my involvement in the group, and my learning through observation and understanding of the group process and, for both aspects, I have considered how this learning has informed or impacted on my clinical work. I have also supported my reflections with relevant research evidence and psychological theory. In this account I have identified confidence, resistance, frustration and conformity as key themes. I have considered the mediating role of emotional arousal in relation to my recall of the process. I have looked at how ‘theory of mind’ (Baron-Cohen et al, 2000) can be distorted and involve false assumptions. I have also considered how trainees might employ a ‘false identity’ or ‘false self’ (Winnicott, 1960). In conclusion to the account I have taken a meta-reflective stance and identified that I have, in part, used the account as a cathartic process.

References


Overview of Clinical Placements
Adult Mental Health Core Placement  
October 2007 – September 2008  
Community Mental Health Team (CMHT)

This placement was based in a CMHT, however due to the closure of my initial CMHT I was relocated mid-way through the placement to a different CMHT within the same Trust. I retained my original supervisor following the relocation.

During the placement I gained experience of assessment and interventions with a diverse set of clients with a range of moderate to severe mental health difficulties. I also gained considerable experience of managing risk.

Cognitive Behavioural Therapy (CBT) was the model that I primarily worked in, however I also incorporated Systemic and Psychodynamic theories into my practice. I gained considerable neuropsychological experience providing evidence to support diagnoses with clients with early onset dementia. During the placement I had the opportunity to run a ‘Mind Over Mood’ group, and to present to a carers group on theories of CBT.

During the placement I conducted a service-related research project (SRRP) evaluating staff attitudes, using a qualitative methodology, towards a pilot intentional peer support programme. The programme was run on an inpatient ward and the findings were fed back to the ward staff and service to enhance the programme.
Child and Young People Core Placement
October 2008 – March 2009
Child, Adolescent Mental Health Team (CAMHS)
&
Looked After Child service (LAC)

This placement was split between a CAMHS service and a LAC service. During the placement I worked with children and adolescents from age two to seventeen, as well as their families. In the CAMHS service I gained considerable experience of working with clients from a wide variety of ethnic backgrounds, often working with difficulties relating to culture and experience of racism. I also gained experience of working with clients whose difficulties were primarily psycho-social, such as housing difficulties. In the LAC service, which was based within a Social Services team, I gained experience of working both with children who were in care and with the foster carers. The primary remit of the service was to help maintain the foster placement. For example, one piece of work involved helping a foster family to work through the impact of the client stealing from the foster placement. Given the role of psychology in this service I also provided consultation to social workers within the team. A systemic approach underpinned the majority of the work on this placement, however I also incorporated attachment theories and cognitive behavioural tools, making my approach integrative. During the placement I contributed to service development by setting up an audit system for the LAC service to start to routinely monitor outcomes. Towards the end of the placement I ran a group for foster carers based on the Webster-Stratton principals of parenting.
In this service I gained considerable experience of assessing and providing therapeutic input to clients diagnosed with a learning disability, and experiencing a range of difficulties. I worked with clients with Autistic Spectrum Disorders, providing relationship advice / sex education, and CBT for social anxiety. The majority of my work in this area was underpinned by consideration of the Bio-Psycho-Social model, looking at all factors that could impact on the client’s difficulties. I then drew on Cognitive Behavioural tools for use in interventions. In this placement I also built on my knowledge of neuropsychological assessment and had experience of administering and interpreting a wide range of tests. I also had the opportunity to complete a number of functional assessments, and to develop my knowledge of dementia. Towards the end of the placement I presented on dementia to staff in a care home. In this placement an opportunity also arose for me to consider ethical issues around service delivery. For example I worked with one client who did not meet the criteria to be seen by the service, however it was felt that he would benefit from brief psychological input, and I was able to consider the ethical issues surrounding his access to the service in supervision.
On this placement I worked as part of an MDT team, providing a group pain management programme, for people experiencing chronic pain. The team included a Clinical Nurse specialist and specialist Physiotherapist. The ethos of the service is to reduce distress and improve quality of life despite the experience of chronic pain, and it is based on CBT principles. The service also provides one to one input for clients where there is a clear psychological component to their pain. In this role I was able to further my knowledge of third wave CBT approaches such as Acceptance and Commitment therapy (ACT) and Mindfulness. I was also able to incorporate Systemic and Psychodynamic theories to reduce the client’s distress. In this role I worked with clients from a range of ethnic backgrounds and with a variety of medical difficulties. As part of the placement I also took a strong lead in service delivery and sought to enhance the service’s information dissemination. I assessed the functionality of the service’s website and through consultation with the team, I re-designed the website to enhance the information available. I also took an active role in updating the pain management programme, highlighting aspects that could be changed or adapted. I also had the opportunity to present on theories of pain at a meeting of Multiple Sclerosis Nurses.
In this service I gained considerable experience of working with older adults in a therapeutic context, and I gained further specific experience in neuropsychological assessment. As part of my role I also facilitated a memory rehabilitation group for 13 people with a diagnosis of dementia. In order to enhance my learning in a model other than CBT, a systemic perspective often underpinned my work in this service. I worked with people experiencing anxiety and low mood, often relating to a sense of loss or relationship difficulties and I worked with a number of couples and family groups. In this placement I also sought to build on my experience of working with chronic pain and I saw a number of clients with long term health difficulties, again with the aim of improving quality of life despite these difficulties. Another important addition to my learning involved conducting assessments and providing therapeutic input on an in-patient ward. Towards the end of the placement I also had the opportunity to consider challenges around service provision, such as how an ongoing service such as a memory rehabilitation group, continues to meet the need of the members when there are increasing numbers of appropriate referrals, and limited resources.
Clinical Case Report Summaries and Summary of Oral Presentation of Clinical Activity Summary
Cognitive Behavioural Therapy (CBT) with a thirty two year old British woman presenting with chronic low mood and suicidal ideation.

April 2008
Year I
Summary

This case report describes the assessment and intervention of Sarah, a woman with chronic low mood and suicidal ideation. Sarah had been referred by her G.P following the end of her engagement to her fiance. The report draws on evidence regarding parental loss in childhood leading to depression in later life. It explains issues of risk, the development of the formulation, and it also highlights the effective use of CBT tools, such as activity scheduling, thought challenging and behavioural experiments. The use of a variety of outcome measures, both psychometric and goal driven, are also considered.

In terms of the basic formulation it appeared that the death of the Sarah’s mother when she was fourteen had led to beliefs about being abandoned, which were then triggered by the end of her relationship. This caused a period of low mood that was then maintained by her withdrawing behaviour and further negative beliefs about being disliked. The intervention sought to reverse her withdrawal and at the same time to challenge some of her negative beliefs about being liked. The outcome of the intervention showed improvements, both in terms of scores on a measure of depression, but also in terms of helping her to achieve the goals that she identified at the start of therapy.
Adult Mental Health Case Report II

A neuropsychological assessment of a sixty three year old man presenting with memory difficulties.

September 2008
Year I
Summary

This report describes the process and outcome of the neuropsychological assessment to determine the cause of Mr Green's memory difficulties. The referral had indicated that his difficulties could be caused early onset dementia. During the initial assessment interview a number of specific memory difficulties were highlighted, such as remembering directions, the day of the week, and the location of personal items. During the interview a number of possible risk factors were also indentified such as a history of boxing, significant use of alcohol, and the use of Simvastatin for high cholesterol. Following the interview a hypothesis was devised that Mr Green would have a neuropsychological profile consistent with dementia, and this might be Alzheimer's disease or Korsakoff's syndrome. A standard battery of neuropsychological tests, in line with the services protocol, were then administered and the results showed a cognitive profile consistent with early onset dementia, however it was not possible to determine the type of dementia from the initial neuropsychological testing. Therefore it was recommended that the client be referred to the older adult service for further testing, specifically around executive function. The results of the assessment were then fed back to the client and his wife. The report also recommended that any care plan should also consider the needs of Mrs Green, if Mr Green's condition were to deteriorate, as she was his sole carer.
This case report describes Daniel, a thirteen year old boy, referred by his G.P to see if psychological input could help to reduce his experience of insomnia. Daniel reported finding it difficult to go to sleep as well as experiencing early morning waking. I assessed Daniel over three sessions, this involved meeting with Daniel and his mother, Mrs Khan, individually and together. Following the assessment it was formulated that Daniel’s difficulties related to his experience of stress. It was hypothesised that his insomnia was maintained by ongoing negative thoughts about his lack of sleep indirectly impacting on his mother’s health. It was also formulated that the boundary between parent and child, in Daniel’s family system, had become blurred, and this was a further cause of stress. The intervention sought to address Daniel’s negative thoughts about sleep. It also incorporated an expressive writing intervention, designed to reduce rumination, and psycho-education about sleep hygiene. The permeation of the parent-child boundary was also addressed. In terms of outcome, at the end of therapy, Daniel and Mrs Khan reported that his sleep had significantly improved. However, in terms of reinforcing Daniel’s role as the child in the system, this work felt incomplete and I believe that Daniel would have benefitted from further input in this area.
Advanced Competencies Case Report

A pain management intervention with a Chinese woman in her early thirties, presenting with chronic abdominal and facial pain.

April 2010
Year III
Summary

This case report focuses on my work with Mrs Smith, a Chinese woman in her early thirties. She was referred for an assessment at the pain management service, to see if the service could help her to manage her chronic pain. The aim of the pain service is to improve quality of life and reduce distress. Following the assessment a formulation was developed, incorporating biological, social and psychological factors, to explain why Mrs Smith experiences chronic pain, attention was also paid to issues of difference and diversity, specifically Mrs Smith’s Chinese ethnic background. It was identified that her catastrophic thoughts about the pain could explain its cause and her ongoing experience of anxiety was a maintenance factor. Therefore, guided by Mrs Smith, a Cognitive-Behavioural intervention sought to reduce her experience of anxiety and distress, focusing on her difficulties in social situations and negative thoughts about parenting and returning to work. Mrs Smith’s reported outcomes suggest that the work successfully reduced her distress and improved her quality of life. However in the report I have also highlighted that at the initial assessment Mrs Smith identified other difficulties in her life that caused her to experience anxiety, and a later unwillingness to address these with a male therapist, may have prompted her disengagement from therapy. Finally in the report I have also considered ethical issues around the remit of specialist services, given that pain was not Mrs Smith’s primary difficulty, however she may not have accessed psychological therapy in a less medical setting.
Learning Disabilities Oral Presentation of Clinical Activity Summary

Building a collaborative case conceptualization with a young man with significant impairments to his working memory.

October 2009

Year III

This presentation focused on Sam, a man in his mid twenties, who had initially been referred to the team for an assessment of cognitive functioning. The results of the assessment conducted by a previous trainee clinical psychologist suggested that he did not meet the criteria of an Autistic Spectrum Disorder, however he did have specific difficulties with his working memory. During the assessment it was also identified that he may benefit from psychological input to help him manage his anxiety in social situations. Sam had been bullied at school due to his dyslexia and shyness, and had been the victim of violence on a number of occasions. Following one attack he had been admitted to hospital with severe facial injuries. As a result it appeared that Sam had developed the belief that other people could hurt him and that the world was not safe. This led to anxiety about speaking and being noticed in social situations, and it was this difficulty that we worked on together in therapy.

In the presentation I indentified how the piece of work fitted with my own personal and professional development as a clinical psychologist. I explained the rationale for choosing this piece of work, gave an overview of the case and presented the formulation. I then discussed issues of gender, given that Sam’s presentation appeared to vary, depending on whether he was seen by a male or female therapist. The presentation then focused on the practicalities of adapting CBT to make the ideas accessible to Sam, given his difficulty with working memory. This involved working more visually and recording the information. Throughout the presentation I was able to show how Sam and I had built a collaborative case conceptualization, which allowed for an in-depth exploration of his difficulties. Finally, in the presentation I discussed issues around service delivery. For example it was evident at the end of the therapy that Sam may have benefitted from ongoing support, however he did not officially meet the criteria to be seen by the service. Therefore it was
agreed in supervision that the service could offer consultation to other professionals involved with Sam’s care, but he would not continue to be seen directly by the service.
RESEARCH DOSSIER
## Research Log

<table>
<thead>
<tr>
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<th>Task</th>
<th>Completed</th>
</tr>
</thead>
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<tr>
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</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
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</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
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</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
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<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
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</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
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</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
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<td>9</td>
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<td>14</td>
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<td>15</td>
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<td>16</td>
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<td>17</td>
<td>Conducting statistical analyses</td>
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<td>18</td>
<td>Choosing appropriate statistical analyses</td>
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<td>19</td>
<td>Preparing quantitative data for analysis</td>
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<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
<td>✓</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
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</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
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</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
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</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
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</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
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</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
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</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
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<td>28</td>
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<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>✓</td>
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</tbody>
</table>
Qualitative Research Project Abstract

Exploring parents' understandings of differences in their children's personalities.

June 2008

Year I
Abstract

Research studies have provided evidence that both environmental factors and genetic factors contribute to the formation of individual personality differences (Beer & Horn, 2000). Environmental factors can be divided into shared or non-shared categories. Shared refer to being in the same home or same school, non-shared refer to a factor such as birth order (Borkenau et al, 2001). Birth order refers to the order in which a child is born into a family in relation to the order of their siblings (Ernst & Angst, 1983).

This study took a qualitative approach and sought to explore parental understanding of the individual differences in their children’s characteristics, with a particular focus on exploring the importance of birth order. Four participants were recruited as a target sample of parents with two or more children, aged between two to twelve years. The participants were known to the researchers. Four semi-structured interviews were conducted. The interviews initially asked about differences between the children and then asked about possible reasons for the differences. The results were analysed using Interpretive Phenomenological Analysis (IPA). The results indicate that birth order was identified as a possible explanation for personality differences between children in the same family, however this was viewed as being secondary to parenting style.

References


Service Related Research Project

An evaluation of staff attitudes towards a pilot intentional peer support programme run on an adult in-patient ward.

July 2008

Year I
Acknowledgements

I would like to thank the nursing staff that participated in the study, both for sharing their views about the programme and also for their assistance in planning and conducting the interviews. Despite often being under-staffed they were incredibly flexible and accommodating during the interview period. I would also like to thank the trust’s service user consultant, whose experience as an in-patient on the ward was highly valuable when designing the interview schedule. I would also like to thank my field supervisor for coordinating with the programme directors and clearly defining the parameters of the evaluation at the outset. Finally I would like to thank my research supervisor for her general advice, and guidance.
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   ‘Recovery steering group’
Abstract

**Title:** An evaluation of staff attitudes towards a pilot intentional peer support programme, run on an in-patient ward.

**Objective:** Intentional peer support, within the National Health Service, has built upon the framework of peer support, where people with similar experiences share knowledge for the specific purpose of promoting recovery. An intentional peer support programme started in January 2008. This evaluation sought to identify staff attitudes towards the programme, in terms of implementation, usefulness, and possible improvements.

**Design:** A non experimental qualitative evaluation.

**Setting:** An adult mental health in-patient ward.

**Participants:** Fourteen full time nursing staff and health care assistants, working on the ward.

**Main outcome measures:** The staff responses to a sixteen item, semi-structured interview, designed to identify staff attitudes towards the program at the start, asked retrospectively, and after four months.

**Results:** Initially staff expressed concerns about the implementation of the programme, however after four months staff reported no obstacles nor impact on daily working. The results also showed that the staff felt that the dissemination of information could be improved. Finally results concerning ‘usefulness’ were unclear. However thirteen out of fourteen staff endorsed running a full time programme.

**Conclusion:** The results indicate that the programme is of use, however there were a number of methodological weaknesses inherent in the evaluation and therefore when considering implications for service delivery, the findings need to be considered in relation to the wider evaluation of the programme, looking at the attitudes of service users and peer support workers.
**Introduction**

Peer support within mental health has been described as the process of “understanding another’s situation empathically through the shared experience of emotional and psychological pain.” (Mead *et al*, 2001, P6, L19-20). The proposed benefits of peer support are that it does not rely on diagnostic labels and it is not underpinned by the medical model (Mead *et al*, 2001), and thus allows for a reformulation of the image of the service user, from a person with a disease that needs treatment to a person striving for health and wellness. In this way peer support is a facet of the ‘recovery’ model in mental health, where the key concept is that hope and wellness are possible, despite serious mental illness (Goldstein, 2001).

Intentional peer support, within the National Health Service, has built upon the framework of peer support and identified the need for a directed practice, where people with similar experiences share knowledge for the specific purpose of promoting recovery (Mead *et al*, 2001). The Trust, which is committed to a ‘recovery’ approach and social inclusion (Perkins, 2007), has incorporated the model of intentional peer support developed by Sheryl Mead (Mead *et al*, 2001) into its user employment programme and constructed a practical programme, where recovering service users are employed to talk to current service users on an adult in-patient ward to help them promote their own recovery (Nurse & Perkins, 2007).

In January 2008 a six month pilot of this intentional peer support programme started on an adult in-patient ward. Five peer support workers were recruited for the project. In order to have been eligible for the post the peer support workers must have had a “recent direct experience of psychiatric inpatient treatment and/or been given a diagnosis of a major mental disorder” (Nurse & Perkins, 2007, P2, L6). They must also have been “working toward their own recovery” (Nurse & Perkins, 2007, P2, L9). Prior to the programme starting the peer support workers, programme directors and ward staff met to discuss possible obstacles to the implementation of the programme. Following the meeting it was agreed that, in rotation the peer support workers would run drop in clinics on the ward two afternoons a week (Wednesday and Sundays). The ‘recovery’ orientated aims and objectives of the drop in clinics
were to help service users to a) settle in to the ward, b) promote understanding about an admission to an inpatient ward c) discuss issues and concerns of the service users on the ward, and d) help service users to plan their own recovery (Nurse & Perkins, 2007).

The programme has been evaluated from five perspectives: the experiences of service users on the ward, the experience of peer support workers, the attitudes of ward staff, the experiences of the trust directors, and the experience of mental health foundation staff. One reason for this comprehensive evaluation was that research over the past thirty years has reported the beneficial impact of peer support on mental illness (Gordon et al, 1982) and more recent literature reviews (Solomon & Draine, 2001) have similarly indicated the effectiveness of peer support programs. However there is limited research regarding the usefulness of intentional peer support in the health service. Studies that have addressed this area have been criticised for being overly descriptive and using traditional medical measures, rather than ‘recovery’ based measures, to determine outcome (Anthony, 2003).

**Objectives**

The specific objective of this evaluation was to identify the attitudes of the ward staff towards the programme, in terms of implementation, and possible improvements. It also aimed to identify attitudes towards the ‘usefulness’ of the programme, using ‘recovery’ based measures. Thus the results therefore were expected to provide stakeholders with information regarding staff attitudes towards the pilot programme and, in conjunction with the results of the wider evaluation, to direct clinical practice and to add to the limited evidence base for intentional peer support (Anthony, 2003).

**Methods**

*Design:* A non-experimental qualitative evaluation run on an adult in-patient ward for service users with severe and enduring mental health difficulties.

*Participants:* The participants, selected on the basis of level of contact with the programme, were fourteen full time nursing staff and health care assistants, working
day shifts on the ward. Medical staff, night staff and bank nursing staff were not interviewed. Staff on permanent sick leave, and annual leave, were not interviewed.

**Ethical Considerations:** The study did not require ethical approval, however, ethical implications were considered when stakeholders wished the results to be reported according to staff role. It was felt that this could have compromised anonymity and therefore the results made no distinction between healthcare assistants and nurses. Also, in order to maintain anonymity, demographic details of the participants were not recorded.

**Measures:** Staff attitudes were evaluated using a sixteen item semi-structured interview schedule (Appendix 1a: Interview schedule). The schedule was adapted from the interview schedule used to evaluate service users’ attitudes towards the programme (Nurse & Perkins, 2007). It was then altered, in consultation with ward staff and a trust service user consultant, to identify the attitudes of staff towards the programme. This interview schedule was then piloted (Appendix 1b) and following this, modified to include only one closed question.

The interview schedule focused on a) awareness of the programme, b) involvement with the programme, c) impact on daily working, d) dissemination of information, e) obstacles to the implementation of the programme, f) improvements to the programme, g) thoughts about having the programme run on a full time basis, h) Usefulness of the programme. With the exception of ‘improvements to the program’ and ‘thoughts about having the programme run on a full time basis’, the interview aimed to identify attitudes at the start (asked retrospectively) and attitudes after four months.

**Procedure**
Initially a pilot study was run three months into the programme. Four months into the programme the main evaluation was conducted. The interviews were held over three days in a meeting room on the ward. The interviews lasted between ten to fifteen minutes. The participants were given an information sheet, which introduced the study and explained confidentially (Appendix 1c). It also included a personal
description of the trust’s service user consultant’s experience of being an in-patient on the ward. Informed consent was obtained (Appendix 1d) and the interview then conducted. The responses were recorded in the form of bullet points and direct quotations. At the end of the interview the interviewees were thanked for their cooperation.

Analysis
The interview data was analysed using content analysis, a technique for organising text into categories in order to identify and to group general themes. (Krippendorf, 2004). In this analysis ‘Directed’ qualitative content analysis (Hsieh & Shannon, 2005) was employed. The questions directed the themes, and the participant responses generated categories within each theme. Quotations were then recorded to illustrate attitudes within each category. This approach allowed the results to identify the participants’ attitudes towards the implementation, improvements and usefulness of the programme.

Results
Following the analysis of the data, a number of themes emerged from the participants’ responses to the fourteen interview questions. The full analysis has been included in the Appendix (Appendix 2, a-m); however the themes directly relevant to the objectives of the evaluation are detailed below (Tables 1-7). Each table lists the theme, time, category, responses within each category (N), and relevant quotes that support the theme.


<table>
<thead>
<tr>
<th>Theme</th>
<th>Impact on daily working</th>
<th>Time</th>
<th>At the start</th>
<th>After four months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Positive Impact</td>
<td>Negative Impact</td>
<td>No impact</td>
<td>Positive Impact</td>
</tr>
<tr>
<td>N</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Quotation</td>
<td>&quot;relieve the pressure on staff&quot;</td>
<td>&quot;thought it would mean more work&quot;</td>
<td>&quot;part of an integrated team approach&quot;</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Results of analysis on attitudes towards ‘impact on your daily working’
**Theme 2: ‘Dissemination of information’. Results presented in table 2.**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Dissemination of information regarding the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time point</td>
<td>At the start</td>
</tr>
<tr>
<td>Category</td>
<td>Enough</td>
</tr>
<tr>
<td>N</td>
<td>12</td>
</tr>
<tr>
<td>Quotation</td>
<td>“concerns adequately addressed”</td>
</tr>
</tbody>
</table>

**Theme 3: ‘Obstacles to the programme’. Results presented in table 3.**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Obstacles to the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time point</td>
<td>At the start</td>
</tr>
<tr>
<td>Category</td>
<td>More than 1 obstacle</td>
</tr>
<tr>
<td>N</td>
<td>5</td>
</tr>
<tr>
<td>Quotation</td>
<td>“challenging behaviour”</td>
</tr>
</tbody>
</table>

**Theme 4: ‘Improvements to the programme’. Results presented in table 4.**

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>feedback.</td>
<td>Feedback</td>
<td>Improvements to the programme</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>know what the peer support workers find out</td>
<td>Peer support workers to be well.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>To know what is said</td>
<td>Contact peer support out of clinics</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>handover with peer-support workers and staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>share information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1 of peer-support workers looked like they might relapse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>contact the peer-support workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>not from same ward</td>
<td>Not from same ward</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>- None really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>- No not really</td>
<td>No improvements</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>- not as far as I know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I would have to think about that one, nothing is jumping out.</td>
<td></td>
<td></td>
</tr>
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</table>
Theme 5: Usefulness of the programme at the start. Results presented in table 5.

Table 5: Results of analysis on attitudes towards ‘usefulness of the programme at the start’.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Usefulness of programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>At the start</td>
</tr>
<tr>
<td>Category</td>
<td>Useful</td>
</tr>
<tr>
<td>N</td>
<td>6</td>
</tr>
<tr>
<td>Quotation</td>
<td>“every patient to be heard and this helps.”</td>
</tr>
</tbody>
</table>

Four months into the programme staff were again asked about their ideas about the usefulness of the programme but specifically in terms

A) helping service users to settle into the ward.
B) promoting understanding about an admission to an inpatient ward.
C) discussing issues and concerns of the service users on the ward.
D) helping service users to plan their own recovery.

The results of the analysis involving these sub-themes are detailed in table 6.

Table 6: Results of analysis on attitudes towards ‘usefulness of the programme’ after four months.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Usefulness of programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>After four months</td>
</tr>
<tr>
<td>Sub theme</td>
<td>Helping to settle in</td>
</tr>
<tr>
<td>categories</td>
<td>Not useful;</td>
</tr>
<tr>
<td>N</td>
<td>9</td>
</tr>
<tr>
<td>Quotation</td>
<td>“tend not to ask to see a peer support worker at that time.”</td>
</tr>
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</table>
Theme 6: Attitudes towards a full time programme. Results presented in table 7.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Attitudes towards a full time programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>After four months</td>
</tr>
<tr>
<td>Category</td>
<td>Positive</td>
</tr>
<tr>
<td>N</td>
<td>13</td>
</tr>
<tr>
<td>Quotation</td>
<td>“Really good benefit all round”</td>
</tr>
</tbody>
</table>

**Discussion**

This evaluation aimed to identify staff attitudes towards the programme in terms of implementation, improvements and usefulness. From the results it is evident that staff attitudes towards the implementation of the programme at the start were primarily negative. Eleven staff reported thinking that there would be obstacles, such as under-staffing and inadequate training (table 3). Six staff reported that they thought it would impact negatively on their daily working. This initial reticence, connects with psychological theories of resistance to change which suggest that staff groups will often be resistant to new initiatives that are a perceived as a threat to the ‘status quo’ or their own status (Folger & Skarlicki, 1999).

However after four months the results show that the majority of staff attitudes towards the implementation of the programme were positive. Fourteen staff said that it did not impact on their daily working (table 1) and thirteen staff reported seeing no obstacles (table 3). This change can perhaps be explained through a model of change, which suggests if the benefit out weights the cost then acceptance will happen (Prochaska & DiClemente, 1986). For example the staff member that still reported a number of concerns after four months, also reported seeing no usefulness in the programme.

Inversely, in terms of improvements, responses to questions about the dissemination of information show that staff felt that the information had initially been good, but this standard had not been maintained (table 2), and there were concerns that new or returning staff would not be aware of the programme. This suggests an area of need for future programmes. At the same time as identifying the need for improvements in
this area of information and communication, the staff also suggested a number of other improvements (table 4), however the only improvement to be consistently reported was the idea that staff would like feedback from the drop in clinics. Ethically this has a number of implications, and could undermine the ethos of the programme, and therefore would not be a recommendation of this report.

Finally, in terms of usefulness, the results suggest attitudes were initially mixed (table 5), with six staff believing that it would be useful. Unfortunately, unlike other areas of the analysis, it is not possible to see if these attitudes changed over time, as at four months into the programme, usefulness was evaluated using ‘recovery’ measures that staff felt unable to comment on, due to a lack of feedback. For example out of the fifty-six possible responses to questions about current usefulness, such as does the programme help service users to promote their own recovery, forty responses fell in the “do not know” category.

When considering the results it is important to acknowledge that a number of weaknesses were inherent in the methodology. Firstly, in terms of social desirability bias (Crowne & Marlowe, 1960), it could be argued that a desire to present a positive opinion of the programme, may have positively skewed the results. However the study aimed to minimise this effect by using an introduction (Appendix 1C) from a former service user to emphasise anonymity and the importance of honesty. In considering the weakening impact of this effect, it is also important to consider that recent research (Mathews et al, 2003), on response bias in health care professionals when evaluating a new service, reported limited evidence for the effects of social desirability in an NHS evaluation.

Secondly, in terms of weaknesses, it appeared that the staff attitudes toward the programme at the start, reported retrospectively, appear to have been contaminated by their attitudes at the time of interview. For example a retrospective response to a question on impact on daily working at the start of the programme, appears to be clearly rooted in the participant’s experience at that time.

“*I do not think that it gets in the way.*” (*Table 1*)
Therefore further research might therefore wish to interview staff at varying time points rather than ask retrospectively.

A third weakness relates to the tool used for the analysis. Although the literature, (Krippendorf, 2004), details ‘qualitative content analysis’ as a structured analytic tool, in reality it appears that there are numerous approaches that could be used within the heading of ‘qualitative content analysis’. This is supported by research that suggests that there are at least three types of ‘qualitative content analysis’ (Heish & Shannon, 2005). It also appears that each article on content analysis attempts, unsuccessfully tries to standardise an ever altering, highly subjective, qualitative approach. The reason this is a weakness for the evaluation is that the findings were planned to be considered alongside other evaluations that have employed content analysis. However, given the nature of ‘content analysis’ a cross comparison can now not assume that the analytic techniques are the same.

Conclusion
It is evident that the evaluation succeeded in identifying staff attitudes towards the programme, in terms of implementation and improvements, and one of the strengths of the evaluation was that it identified that staff attitudes towards the implementation of the programme improved over time. Similarly it was also able to identify that staff thought that the dissemination of information regarding the programme needed to be improved. The results also implied that staff thought the programme was useful, even if they did not know what was discussed in the drop-in clinics. However in terms of limitations, it failed to clearly identify attitudes towards usefulness at the start, and usefulness, in terms of recovery based measures. Therefore on its own the evaluation failed to add the limited evidence base for intentional peer support (Anthony, 2003), using recovery based outcome measures.

Thus, given the limited results on usefulness and the weaknesses inherent in methodology, it would be beneficial to view these results in relation to the results of the wider evaluation, when considering service delivery. For example cross comparison of the attitudes of peer support workers, service users and ward staff
would hopefully clarify the usefulness of the programme, and identify whether similar programmes should be run on other wards.

In order to make sure this cross comparison is achieved, the results of this evaluation have been fed back to 1) A development worker from the mental health foundation, in a meeting on the 05/06/08. 2) A ‘Recovery Workshop’ with mental health staff from the borough, on the 12/06/08 (Appendix 3a) and the results are due to be fed back to The Associate Director of Therapies for the borough, at a ‘Recovery Steering Group’ on the 17/07/08 (Appendix 3b).

The amalgamation of the results of the evaluation will hopefully direct service implementation, by determining if intentional peer support is of benefit within an adult mental health in-patient setting, and at the same time, through publication, add to the limited evidence base for intentional peer support.
References:


Appendix 1
Appendix 1a
Interview schedule

ID:
Interview:

A) Are you aware of the peer-support programme running on the ward?

B1) Retrospective view of the programme (ask interviewee to think back to the start of the programme).
1) How involved in the programme did you think you would be?
2) How did you think the programme would impact on your daily working?
3) How much information were you given about the programme prior to it starting?
4) How useful did you think the programme would be?
5) Did you see any possible obstacles to the implementation of the programme?

B2) Attitudes towards the peer-support programme which is currently taking place on the ward. (Ask interviewee to think of the programme currently)
1) How involved in the programme are you currently?
2) How does the programme currently impact on your daily working?
3) How would you rate the amount of information you have been given concerning the running of the programme?
4) How useful/effective do you think the programme is currently in terms of
   - The extent to which the peer support workers help service users to settle in to the ward?
   - The extent to which the peer support workers promote understanding about admission to an inpatient ward?
   - The extent to which the peer support workers are used to discuss issues and concerns of the service users on the ward?
   - The extent to which the peer support workers help service users to plan their own recovery?
5) How do you think the programme might be improved?
6) Are there any obstacles impacting on the delivery of this programme?
7) What are your thoughts about having this service run on a permanent basis?
Appendix 1b
Pilot interview schedule

Interview:

A) Are you aware of the peer-support programme running on the ward?

Section 1
1) How involved in the programme did you think you would be?
2) Did you think the programme would impact on your daily working?
3) Were you given information about the programme prior to it starting?
4) Did you think the programme would be useful?
5) Did you see any possible obstacles to the implementation of the programme?

Section 2: Attitudes towards the peer-support programme which is currently taking place on the ward.
1) How involved in the programme are you currently?
2) Does the programme currently impact on your daily working?
3) Do you think you have been given enough information concerning the running of the programme?
4) How useful/effective do you think the programme is currently in terms of
   - The extent to which the peer support workers help service users to settle in to the ward?
   - The extent to which the peer support workers promote understanding about admission to an inpatient ward?
   - The extent to which the peer support workers are used to discuss issues and concerns of the service users on the ward?
   - The extent to which the peer support workers help service users to plan their own recovery?
5) Do you think there are ways the programme could be improved?
6) Are there any obstacles impacting on the delivery of this programme?
7) Do you think that it would be useful to have this service run on a permanent basis?
Appendix 1c
Information sheet

Study Title: An evaluation of staff attitudes towards a peer-support programme run on an inpatient ward.

Background:

This evaluation seeks to identify staff attitudes to the pilot peer support programme currently operating on x ward within x Hospital, with a view to identifying both positive and negative aspects of the programme, in terms of the impact on patients' recovery. It will be conducted by x. This programme is part of the Trust's wider recovery programme. Below is a description from a service user about the importance of recovery in mental health care.

"My name is x and I have twice been an in-patient in x ward, and I remember how difficult it was but how the people there helped me through it. In my life since leaving the ward I have gained strength from learning how the mental health services operate and taking more control and responsibility for my own progress. An idea that has become important to me in thinking about life is the concept of recovery. Clearly, this is something that means something different to each person whether they are employed as a provider of services or a service user themselves. I know that it is easy to get stuck in the way things are or to continually go in the wrong direction because it has always been that way. Whatever each person's own point of view I am hoping that by discussing these issues we can explore what works and what does not work, and what it is that really matters. To help the various people involved work together I have been helping in the development of some questions focusing specifically on the peer support programme. In answering these I would stress it is okay to be totally honest, as it is just as important to know what is bad as what is good. I would like to thank everyone who contributes and am sure that they will benefit at least something even if it is different to expectations."

What will participating in the research involve?
Staff from x ward will be interviewed about their attitudes toward the pilot intentional peer support programme. It is not anticipated that discussing this topic should cause you any distress. However, if we touch on something you feel uncomfortable discussing, please let the researcher know and we will move on in the interview.

Anonymity:
When writing up the research participants' comments will remain anonymous. All participants will be offered a summary of the results if they choose. All information collected from you will be confidential.

Your rights as a participant:
Participation in this study is voluntary. Once you have given your consent to be interviewed you can withdraw it at any time without giving a reason.
Appendix 1d
Consent form.

Consent Form

• All personal data relating to volunteers is held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).

• All information collected will remain anonymous

• You are free to withdraw from the study at any time, without having to explain your decision.

Name:

Date:

Do you consent to take part in this study yes / no
Appendix 2
Results of directed content analysis
Appendix 2a) Results of directed content analysis of fourteen sets of interview responses to the retrospective question “How did you think the programme would impact on your daily working?”

Table 1) Themes and categories produced through analysis of the responses to the question “How did you think the programme would impact on your daily working?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“thought it would mean more work and more worry”</td>
<td></td>
<td>Negative impact</td>
</tr>
<tr>
<td>4</td>
<td>I thought it may cause problems</td>
<td></td>
<td>Attitudes at the start towards the impact of the programme on daily working</td>
</tr>
<tr>
<td>7</td>
<td>Yes, a lot, because it is new, A lot of people on the ward do not like change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I was not happy about the extra work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Thought it might mean a bit more work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>No I did not think that it would impact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>No – not at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>No would not impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I didn’t think it would</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I did not think that it would</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>- I saw it as positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Because I knew some of them as patients they were pleased so see me and I was pleased to see them doing well.</td>
<td></td>
<td>Positive impact</td>
</tr>
<tr>
<td>5</td>
<td>I do not think that it gets in the way.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>by would relieve the pressure on staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2b) Results of directed content analysis of fourteen sets of interview responses to the question “How does the programme currently impact on your daily working?”

Table 1) Themes and categories produced through analysis of the responses to the question “How does the programme currently impact on your daily working?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>It doesn’t much, I do not really see them</td>
<td></td>
<td>No impact</td>
</tr>
<tr>
<td>13</td>
<td>It does not impact on me at all,</td>
<td></td>
<td>Attitudes after four months towards the impact of the programme on daily working</td>
</tr>
<tr>
<td>12</td>
<td>Only a bit, actually no it is good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I do not think it does</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>No it doesn’t</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Not at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I wouldn’t have said so, it is just part of an integrated team approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Not really,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>It doesn’t really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I do not think that it does.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>the programme does not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>It does not get in the way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Very little</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2c) Results of directed content analysis of fourteen sets of interview responses to the question “How much information were you given about the programme prior to it starting?”

Table 1) Themes and categories produced through analysis of the responses to the question “How much information were you given about the programme prior to it starting?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>any concerns were adequately addressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>- Enough:</td>
<td>Enough</td>
<td>Attitudes towards the amount of information received about the programme prior to it starting</td>
</tr>
<tr>
<td>4</td>
<td>Some information and meetings, a lot, yes I think</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>enough definitely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Yes, lots of information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>We were well prepared</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>A lot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Quite a lot, couple of meetings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Yes we were briefed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I think the right amount, a good amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>- A good amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Quite a bit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I was told very little</td>
<td>Not</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I was sick for a while so maybe I missed it.</td>
<td>enough</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2d) Results of directed content analysis of fourteen sets of interview responses to the question “How would you rate the amount of information you have been given concerning the running of the programme?”

Table 1) Themes and categories produced through analysis of the responses to the question “How would you rate the amount of information you have been given concerning the running of the programme?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not much really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have not really had any more information, could do with more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I haven’t been given any now..</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Have not been given that much. They just come and if I am on duty I will show them patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Really not much, Could have had more</td>
<td>Not</td>
<td>Attitudes towards the amount of information received about the programme after four months.</td>
</tr>
<tr>
<td>6</td>
<td>It was fine at start now not much.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Need more on going information; do not know when it is ending.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do not know too much currently,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Not good, would like to get feedback on how the programme is going.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Ok, Not one of our concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>since the training I have not had any further information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>ok, heard about it in the acute care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Ok, Not one of our concerns</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2e) Results of directed content analysis of fourteen sets of retrospective interview responses to the question “Did you see any possible obstacles to the implementation of the programme?”

Table 1) Themes and categories produced through analysis of the responses to the question “Did you see any possible obstacles to the implementation of the programme?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>- did not think they would have had training to deal with challenging behaviour</td>
<td>More than one obstacle</td>
<td>Attitudes towards obstacles, at the start of the programme.</td>
</tr>
<tr>
<td>2</td>
<td>Also could end up seeing volatile patients and this could be a risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Yes a few, ward busy, not enough training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>- boundaries could get complicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>- ward can be quite busy and might have been in way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>we are often understaffed and that could be a problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I did not know about it, which I suppose is an obstacle</td>
<td>One obstacle</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Only prob could have been if there was trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Overall we thought they might have come at a bad time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>but used for patients to air horrible views about staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>If they have been on the ward then saying too much or thinking they know best.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>No I didn’t see any</td>
<td>No obstacles</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>No: they came when expected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Not really</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2f) Results of directed content analysis of fourteen sets of interview responses to the question “Are there any obstacles impacting on the delivery of this programme?”

Table 1) Themes and categories produced through analysis of the responses to the question “Are there any obstacles impacting on the delivery of this programme?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td></td>
<td>No obstacles</td>
</tr>
<tr>
<td>2</td>
<td>Weekends are a good time to come</td>
<td></td>
<td>Attitudes towards obstacles to the programme, after four months.</td>
</tr>
<tr>
<td>3</td>
<td>No not really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I do not think so, they come on good days when there are no ward rounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>not really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Not that I am aware of.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>No</td>
<td></td>
<td>No obstacles</td>
</tr>
<tr>
<td>9</td>
<td>It was considered well at the beginning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>No there were no obstacles it clearly worked out well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>None really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>- not as far as I know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>No it is fine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>No obstacles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>They do not always understand the boundaries. Any concerns should be</td>
<td></td>
<td>1 obstacle</td>
</tr>
<tr>
<td></td>
<td>talked about with nursing staff and not dealt with by them.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2g) Results of directed content analysis of fourteen sets of interview responses to the question “How do you think the programme might be improved?”

Table 1) Themes and categories produced through analysis of the responses to the question “How do you think the programme might be improved?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Probably by asking for feedback.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Feedback book</td>
<td>Feedback</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Like when peer support workers come we do not get any feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Would be nice to know what the peer support workers find out</td>
<td>Feedback</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>To know what is said</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I think there could be more of a handover with peer-support workers and staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Work together, share information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1 of peer-support workers looked like they might relapse and should not be here, because that upsets the patient.</td>
<td>Peer support workers to be well.</td>
<td>improvements to the programme</td>
</tr>
<tr>
<td>11</td>
<td>If the patients could contact the peer-support workers if they needed them</td>
<td>Contact peer support out of clinics</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Peer-support workers not from same ward</td>
<td>Not from same ward</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>- None really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>- No not really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>- not as far as I know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I would have to think about that one, nothing is jumping out.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2h) Results of directed content analysis of fourteen sets of retrospective interview responses to the question “How useful did you think the programme would be?”

Table 1) Themes and categories produced through analysis of the responses to the question “How useful did you think the programme would be?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>My opinion was why an ex-patient should be able to help someone with a different problem.</td>
<td>Not useful</td>
<td>Attitudes at the start “towards the usefulness of the programme”</td>
</tr>
<tr>
<td>4</td>
<td>Did not know, not keen, thought it might just be another idea</td>
<td>Not sure</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>to start with I had mainly negative,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Apprehensive,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I thought it would not be useful, the ward is very busy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Not convinced.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I thought it might be useful, or may not be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I wasn’t sure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>It did not know because I did not know about it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>- I thought it would be useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>- some patients do not always have relatives to visit them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Sometimes it is impossible for every patient to be heard and this helps.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Thought it would be very useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I thought it was a fantastic idea</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2i) Results of directed content analysis of fourteen sets of interview responses to the question “How useful did you think the programme is, in terms of the extent to which the peer support workers help service users to settle in to the ward?”

Table 1) Themes and categories produced through analysis of the responses to the question “How useful did you think the programme is, in terms of the extent to which the peer support workers help service users to settle in to the ward?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not really, do not see new patients</td>
<td>Not useful</td>
<td>Usefulness of the programme, in helping service users to settle in to the ward.</td>
</tr>
<tr>
<td>14</td>
<td>Maybe not new patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Because patient often familiar to the ward they tend not to ask to see a peer support worker at that time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>They do not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>They only come on a Sunday, so unlikely to see a new patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I don’t think they see new patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I think so but each patient is different and some patients they see might not be appropriate so don’t help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>No not really settle in, they do not see the new patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>do not know what they are talking about</td>
<td>Do not know</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I can’t answer as we do not discuss what they talk about</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>This is very difficult to answer 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I would not know as we do not ask them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I only know from what I have seen but I think it is useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I would not know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2j) Results of directed content analysis of fourteen sets of interview responses to the question “How useful did you think the programme is, in terms of the extent to which the peer support workers promote understanding about admission to an in-patient ward?”

Table 1) Themes and categories produced through analysis of the responses to the question “How useful did you think the programme is, in terms of the extent to which the peer support workers promote understanding about admission to an inpatient ward?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>It is not useful. They tell them bad habits and bad things about the staff.</td>
<td>Not useful</td>
<td>Usefulness of the programme, in helping promote understanding about admission to an inpatient ward.</td>
</tr>
<tr>
<td>6</td>
<td>I can’t answer it is the same we do not discuss it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>No comment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>These are different questions which I would not know the answer to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I can’t really answer, I do not know enough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>It is helpful I assume, but I wouldn’t know anymore</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I don’t know</td>
<td>Do not know</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I don’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I think this was the main aim but I don’t know if it is doing what it set out to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I don’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I do not know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I think they do but as we don’t ask we don’t know, who knows what they are discussing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I would imagine that it is helpful, but do not know what advice is given</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>I don’t really know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2k) Results of directed content analysis of fourteen sets of interview responses to the question “How useful did you think the programme is, in terms of the extent to which peer support workers are used to discuss issues and concerns of the service users on the ward?”

Table 1) Themes and categories produced through analysis of the responses to the question “How useful did you think the programme is, in terms of the extent to which peer support workers are used to discuss issues and concerns of the service users on the ward?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“peer-support workers would be best to answer that”</td>
<td></td>
<td>Do not know</td>
</tr>
<tr>
<td>12</td>
<td>No comment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I do not know as we do not get feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Again can not answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Peer support workers do not say</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I do not know I suppose it addresses recover right away by having the “recovered” patient there</td>
<td></td>
<td>Usefulness of the programme, in terms of the extent to which peer support workers are used to discuss issues and concerns of the service users on the ward?</td>
</tr>
<tr>
<td>6</td>
<td>No I wouldn’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Don’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>No I wouldn’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I think they can talk more freely</td>
<td></td>
<td>Think it is useful</td>
</tr>
<tr>
<td>8</td>
<td>A patient told me he valued being able to explain his point of view to someone who was not staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>It may help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Patients like it as have someone to talk to,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I do not think they do.</td>
<td></td>
<td>Do not think it is useful</td>
</tr>
</tbody>
</table>
Appendix 21) Results of directed content analysis of fourteen sets of interview responses to the question “How useful did you think the programme is, in terms of the extent to which the peer support workers help service users to plan their own recovery?”

Table 1) Themes and categories produced through analysis of the responses to the question “How useful did you think the programme is, in terms of the extent to which the peer support workers help service users to plan their own recovery?”

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I wouldn’t know because we do not discuss what they talk about</td>
<td></td>
<td>Do not know - Usefulness of the programme, in terms of the extent to which peer support workers help service users to plan their own recovery.</td>
</tr>
<tr>
<td>2</td>
<td>I do not really know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>To be honest I wouldn’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I do not know, we do not ask and we do not talk to the patients about it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I would not know, I do not ask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I wouldn’t know, not sure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I do not ask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I couldn’t tell you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Again I wouldn’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I do not ask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>No comment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Again I do not get feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Again I have no idea, really no idea.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not at all, they are not fully recovered themselves.</td>
<td>Not useful</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2m) Results of directed content analysis of fourteen sets of interview responses to the question “What are your thoughts about having this service run on a permanent basis?”

Table 1) Themes and categories produced through analysis of the responses to the question “What are your thoughts about having this service run on a permanent basis”?

<table>
<thead>
<tr>
<th>N</th>
<th>Response</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>They do help to talk to the patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Well its just more time to talk to patients the ward is always too busy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I do not see any problems with this, maybe a good thing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I think it would be good, but more kind of helpful to the peer-support workers more than the patient. I think it is helping &quot;their own recovery&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Good idea to keep it running Good they can give a bit more time to talk to the patients.</td>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>7</td>
<td>Get a chance to talk to patients</td>
<td></td>
<td>Thoughts about having the service run on a permanent basis</td>
</tr>
<tr>
<td>8</td>
<td>Yes it should be a long term plan definitely as it does appear to help.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I think that would be a good idea.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Yes that would be good.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Good idea, can help, have seen improvements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Really good benefit all round, never heard anyone say they get in the way. Would be good to have on full time basis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I see it as a positive step forward Run it full time, I do not see a reason not to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I think it is a good idea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Probably not They talk about the staff and that is not helpful</td>
<td></td>
<td>Negative</td>
</tr>
</tbody>
</table>
Appendix 3a) Evidence of presentation of results at ‘Recovery Initiatives’ meeting.

Dear x...x

I am writing on behalf of myself and x (Chair of Recovery Steering Group) to say thank you for your presentations of your service related research projects. These were a very important contribution to the Recovery Initiatives in afternoon, which was part of the Postgraduate Academic Teaching Programme on 12th June.

All the presentations were of an extremely high standard and were very clear and informative. The results were very valuable and provoked a lot of interesting discussion.

I understand that you will all be meeting with x, and the rest of the Recovery Steering Group in mid-July to discuss how the results can be used to help staff within the local trust services work within a more recovery oriented framework. I know that the group really value the time and effort you have put into these projects and are looking forward to working with you all so the recommendations can be put into practice locally.

Many thanks again
x

Chartered Clinical Psychologist
CMHT
Appendix 3b) Letter from the Associate Director of Therapies regarding the dissemination of findings at the Recovery Steering Group.

Please put in your diary that the next Recovery Steering Group will be 11.30am on 17th July.
I will forward the minutes and agenda when I return from leave, but x and x and x will be feeding back on their research projects. I would like to spend some time together looking at learning/ action points from their findings. I also wish to look at the membership of this group as I am very aware of how busy every-one is.

Associate Director of Therapies
Doctorate in Clinical Psychology
Major Research Project

The Impact of Expressive Writing On Work-Related Affective Rumination: An Experimental Study.

Richard Doherty

Word Count: 19,073

Date of submission: 19th July 2010
Acknowledgements

I would like to thank all the participants for sharing their time and thoughts. I would also like to thank my supervisor, Mark Cropley, for his advice and direction, Alice Theadom for her advice on the application of the expressive writing paradigm, Chris Fife-Shaw for his advice regarding the use of G-Power, and Linda Morrison for her advice on the differing approaches to analysing the results. Finally I would like to thank my wife, Sophie, for the hours she spent helping me to make the writing packs.
ABSTRACT

Introduction: Ongoing work-related stress, caused by an inability to unwind from work, has been shown to have a negative impact on health (Suadiciani et al, 1993). Work-related affective rumination (WRAR) has been identified as one possible reason that workers fail to unwind (Cropley et al, 2009). This experimental study aimed to identify if an expressive writing intervention (Pennebaker, 1989) could impact positively on work-related affective rumination, and related health difficulties.

Participants: A target sample of 269 participants, primarily ‘white-collar’ workers, recruited via email and snowballing from companies in London, were initially screened. Of the participants screened, 149 were identified as work-related affective ruminators and invited to take part.

Method: The participants were assessed at baseline using the work-related affective rumination Scale (WRAR), and completed the Patient Health Questionnaire (PHQ8), Generalised Anxiety Disorder scale (GAD7), Pittsburg Sleep Quality Index (PSQI), The International Positive and Negative Affect Scale-Short Form (I-PANAS-SF), and the Emotional Approach Coping scale (EAC). Participants were then allocated to either the factual writing or expressive writing condition, and wrote for twenty minutes a day for three consecutive days. They were assessed again at one and three months. Assessments were completed online. Data from 48 participants was included in the final analysis.

Results: The results show that participants in the expressive writing group reported experiencing significantly less work-related affective rumination, compared to the factual writing group, three months after the intervention. The results also show that participants in the expressive writing group reported significantly lower scores, compared to the factual writing group, on measures of depression, anxiety, poor sleep and ‘negative affect’.

Conclusion: The results indicate that expressive writing is a valid intervention for reducing work-related affective rumination, and has a positive impact on related health difficulties.
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1) INTRODUCTION

1.1 Literature review
A systematic literature review (Appendix 1) was conducted to identify current research in the area of expressive writing and work-related affective rumination. Using databases Psychinfo, Web of Science, Pubmed, Medline and INGENTA, initial searches were conducted for 'work-related affective rumination', 'affective rumination', 'work and rumination', 'expressive writing' and 'emotional disclosure'. Secondary searches then cross-referenced 'expressive writing' with, 'work', 'job' and 'rumination'. The findings of the review, discussed in the introduction below, were then used to inform and direct the current study.

1.2 Overview
Work related stress, maintained by an inability to unwind from work, has been shown to cause a number of health difficulties (Cropley & Millward, 2003). Work-related rumination has been proposed as a reason why workers fail to unwind and 'switch off' from work (Cropley & Millward, 2009). Recent research has identified that it is specifically work-related affective rumination, that increases arousal and inhibits 'switching off' (Cropley et al, 2009). Currently there is no research into specific strategies for reducing work-related affective rumination. However the expressive writing paradigm (Pennebaker, 1989) has been reported to have a positive impact on work difficulties (Barclay & Skarlicki, 2009; Sexton et al, 2009; Spera et al, 1994). It has also been shown to be moderated by levels of rumination (Gotner et al, 2006; Sloan et al, 2008), and to reduce intrusive cognitions (Klein & Boals, 2001). There has been no research looking at the impact of expressive writing on the combination of work and rumination. Therefore the aim of the study was to examine if expressive writing could reduce work-related affective rumination.

1.3 Work-related stress
Work-related stress is a growing difficulty in Great Britain (Health and Safety Executive, 2007). In 2005 to 2006 approximately 500,000 workers reported that work-related stress was impacting negatively on their health (HSE, 2007). A
systematic literature review (Michie & Williams, 2003) identified a positive relationship between prolonged work stress and a number of psychological difficulties, such as anxiety and depression. Research has also identified the physiological difficulties associated with work stress, such as raised blood pressure (Schnall et al., 1990), and cardiovascular disease (Kuper & Marmot, 2003). For example, one study on the physiological impact of work stress measured participants’ ambulatory blood pressure in their work environment, and the findings report higher blood pressure levels in workers that experience high levels of work-related stress (Schnall et al., 1990).

a) ‘Switching off’ and unwinding

It has also been highlighted that the impact of work-related stress is not limited to the ‘nine to five’ work environment, but negatively affects workers during their leisure time as well (Cropley & Millward, 2003; Cropley et al., 2006; Cropley & Millward, 2009). For example studies looking at the physiological response to stress after work report that participants that experience high levels of stress at work, also have raised blood pressure levels after work, in their leisure time (Steptoe et al., 1999; Vrijkotte et al., 2000). It has been suggested that the reason ongoing stress is experienced after work is because the worker fails to unwind and ‘switch off’ (Suadiciani et al., 1993). The inability to ‘switch off’ keeps the worker in a permanent state of arousal, and has been identified as a possible cause of specific health difficulties such as cardiovascular disease (Vrijkotte et al., 2000).

The inability to disengage from work has been shown to be common within the British workforce, with a large proportion of the work force reporting finding it difficult to unwind after work. Research in this area (Cropley et al., 2009), refers to findings from the Employment in Britain Survey (1992) (Gaillie et al., 1998), which reports that of the 3000 workers interviewed, difficulty unwinding after work was reported in 70% of cases (Cropley et al., 2009).

It also appears that this is a growing difficulty caused by the increasing blurring of the boundaries between work and home (Hardill, 1997), and the growing use of
portable communication devices such as mobile phones and mobile internet connections, that compromise the divide between work and leisure time (Chesley, 2005). For example, it has been identified that this blurred boundary can prevent home workers switching off, due to the experiencing of constant work-related reminders (Dart, 2006).

In line with the theories about the workforce’s reduced ability to ‘switch off’, research has also identified that over the past 30 years work demands have changed. There has been a shift from manual work to work that is more diverse, cognitively demanding, and uncertain (Pravettoni et al, 2007), and it has been suggested that this new type of work is harder to ‘switch off’ from (Pravettoni et al, 2007). Therefore it has been recognised that the inability to ‘switch off’ from work is becoming a growing problem and recent research (Cropley & Millward, 2003; Cropley et al, 2006, Cropley & Millward, 2009) has sought to understand the mechanisms that inhibit ‘switching off’. This research proposes that a possible reason why workers fail to ‘switch off’ is because they continue to ruminate about work (Cropley & Millward, 2009).

1.4 Rumination
Rumination has been described as ‘a mode of responding to distress that involves repetitively and passively focusing on symptoms of distress and on the possible causes and consequences of these symptoms.’ (Nolen-Hoeksema et al, 2008, P1, L4-7). It is identified by the presence of preservative thinking, controlled and automatic processing, and its role in hindering the attainment of goals (Cropley & Millward, 2003).

Rumination has been linked to a number of physical and mental health difficulties such as anxiety and depression (Harrington & Blakenship, 2006), ‘negative affect’ (Feldner et al, 2006), which is described as the experience of a negative emotional state (Watson & Clark, 1984), and poor sleep (Guastella & Moulds, 2007). As a result it is a behaviour that has become highly researched, both in clinical and health psychology (Cropley & Millward, 2009).
This research has led to increased understanding about the content and trigger for ruminative thinking. Studies looking at people’s cognitive responses to the experience of stress have identified that rumination often occurs in response to a stressful or unresolved situation (Lyubomirsky & Tkach, 2003; Nolen-Hoeksema et al, 1997). This type of rumination has been labeled ‘stress-reactive rumination’ (Robinson & Alloy, 2003) and the findings of studies into this type of processing suggest that it will maintain arousal and delay recovery (Cropley et al, 2006).

Considering why this is relevant to the current study, it is evident that work could be seen as involving both stressful and unresolved situations, and therefore people could be expected to ruminate about work, increasing arousal and delaying recovery from work. For example, research has shown that work is a primary cause of stress for people. A recent poll conducted by the organisation MIND, found that 26% of workers reported experiencing stress and anxiety on a Sunday when thinking about returning to work on the Monday (McVeigh, 2010, 16th May). Therefore it has been suggested that it is this experience of work-related rumination that may prevent ‘switching off’ and inhibit unwinding (Cropley & Millward, 2009).

1.5 Work-Related Rumination

Initial research on work-related rumination focussed on occupations where employees had encountered trauma. There are studies looking at rumination in ambulance drivers (Clohessy & Ehlers, 1999), fire-fighters (Haslam & Mallon, 2003) and GPs that have been exposed to violence (Coles et al, 2007). Research has also looked at the more common place experience of work place bullying (Moreno-Jimenez et al, 2008). Constructed as a reaction to a stressful incident at work, rumination in these contexts is seen as a maladaptive coping strategy that can maintain stress (Coles et al, 2007).

Recently research (Cropley & Millward, 2003; Cropley et al, 2006, Cropley & Millward, 2009) has started to focus on work-related rumination in the context of more everyday work stresses and general job strain, not involving explicit trauma. In this series of research studies the role that work-related rumination plays in preventing ‘switching off’ and unwinding during leisure time was examined. The
first in this series of studies (Cropley & Millward, 2003) looked at job strain, and rumination about work-related issues. This was a diary study, focussing on how people cognitively ‘switch off’ from work. The aim was to see if people, classified as experiencing either high or low job strain differed in the length of time they took to unwind after work, based on their level of reported rumination. The participants were 69 primary and secondary school teachers, identified as experiencing either high or low job strain. As part of the study they were asked to keep a record of their work-related thoughts over an evening.

The results suggest that both high and low ruminators unwound and disengaged after work, however participants in the high job strain group took longer compared to the low group to unwind, and the high job strain group experienced more ruminative thoughts about work (Cropley & Millward, 2003). This research highlights that the increased level of work-related rumination in the high job strain group may account for their greater reported difficulty in unwinding. However, due to the correlational design, causality cannot be inferred and therefore the exact role rumination played in preventing unwinding cannot be determined (Cropley & Millward, 2003).

The study did, however, identify that distraction was a useful tool in limiting the effects of work-related rumination. Both groups reported experiencing more ruminative thoughts when they were alone, compared to when they were in the company of family and friends (Cropley & Millward, 2003). These findings fit with research that suggests that the type of activities people engage in after work can either promote or discourage disengagement (Sonnentag, 2001). However it is evident from the results that the group, identified as experiencing high job strain, experienced more ruminative thoughts and took longer to unwind, even when distracted and engaged in the same activity as the low job strain group. This suggests that there is a cognitive, as well as behavioural mechanism, underlying the disengagement process, and that distraction is only partially effective at reducing work-related rumination.
Work in this area led to a further study on work-related rumination, job strain and sleep (Cropley et al, 2006). This study again sought to identify if people that experience high job strain take longer to recover from work, and experience prolonged physiological and psychological arousal, due to engaging in work related rumination (Cropley et al, 2006). The study then sought to identify if higher levels of work related rumination correlated with poor sleep. The rationale for exploring the relationship between sleep and rumination is based on research that suggests that intrusive cognitions may contribute to sleep disturbance (Gross & Borkovec, 1982), and that cognitive arousal prior to going to bed may maintain insomnia (Harvey, 2000). Both of these causes have been indentified as symptoms of rumination and therefore it is evident that an inability to ‘switch off’, caused by rumination, might have a negative impact on sleep quality.

The 143 participants in this study were again either primary or secondary school teachers, who were instructed to keep an hourly record of their work-related thoughts during an evening and then to rate the quality of their sleep in the morning (Cropley et al, 2006). Participants were categorised as experiencing either high or low job strain. The results of this study showed that, in line with earlier findings (Cropley & Millward, 2003), work-related rumination was correlated with increased job strain and difficulty ‘switching off’ (Cropley et al, 2006).

In terms of the hypothesis that work-related rumination would then impact negatively on sleep quality, this study found that intrusive cognitions about work showed a positive correlation with poor sleep (Cropley et al, 2006). The results also suggest that ruminating about work before going to bed caused increased physiological arousal. However, unlike the findings of previous research on rumination and sleep (Akerstedt et al, 2002), levels of rumination in this study did not moderate the relationship between job strain and sleep quality. The authors comment on this, suggesting that the recorded relationship between job strain and sleep was perhaps too small, in this instance, to find a moderating influence of rumination (Cropley et al, 2006). It is evident that this study built on the previous research (Cropley & Millward, 2003), utilising a more robust methodology. For
example the sample size was larger (n = 143), and more information about work-
related thoughts were collected, as the participants recorded thoughts from 6 pm to
bedtime in their diaries. The proposed reason for the null finding regarding the
moderating effect of rumination on sleep in this study is supported by more recent
research that has again reported a negative relationship between sleep quality and
levels of rumination (Carney et al, 2010).

The final study in the series, looking at work-related rumination (Cropley &
Millward, 2009), again built on research in this area. This study had two aims. The
first was to again identify the effect of ruminative cognitions on a person’s ability to
‘switch off’ from work. The second was then to identify the type and content of the
ruminative cognitions, utilising a qualitative design. Initially 50 participants were
recruited via informal networks and screened for levels of work-related rumination,
using the work-related rumination scale (WRRS) (Cropley et al, 2009). A target
sample of four ‘high ruminators’ and four ‘low ruminators’ took part in the study. To
be included in the study participants had to be employed at a mid-managerial level
and their work had to be primarily office based.

The results of the study report that high ruminators described experiencing
involuntary work-related thoughts, which impacted negatively on their sleep,
exercise, and ability to relax (Cropley & Millward, 2009). The results of the study
also indicate reasons why the high ruminators failed to unwind. For example in the
interviews high ruminators often referred to a situation termed the ‘Zeigarnik’ effect
(Zeigarnik, 1927), where incomplete tasks played on their mind after work. The
findings also report that ‘high ruminators’ showed blurred boundaries between work
and leisure, and allowed work to monopolise their life’ (Cropley & Millward, 2009,
P343, L4). High ruminators also reported ‘a less active social life, compared to low
ruminators, and ruminating about work prevented them relaxing.’ (Cropley &
Millward, 2009, P 343, L3). The study also identified that high ruminators were
more likely to be ‘slaves to technology’ (Cropley & Millward, 2009, P345, L6),
meaning that the home/work boundary was less clearly defined. These results again
emphasize that work-related rumination may prevent ‘switching off’, and impact
negatively on a person’s health. Based on these findings the research article then highlights the need to identify interventions to reduce work related rumination, ‘in order to decrease the risk of workers becoming ill, fatigued or burnt out’ (Cropley & Millward, 2009, P345, L6).

a) Strategies for reducing work-related rumination.

The findings of the 2009 study by Cropley & Millward also comment on the activities of people identified as low work-related ruminators, looking at how participants in this group ‘switch off’ during their leisure time. For example in one interview, a participant, identified as a low ruminator, reported ‘actively steering a conversation away from work-related issues when socialising’ (Cropley & Millward, 2009, P344, L10-11). Therefore it would appear that a reduction in work-related rumination might require the employment of active strategies, and the research in this field has indicated a few possible techniques.

The Martin and Tesser (1996) model of rumination, suggests that rumination can be reduced through goal attainment, distraction techniques, and disengagement. Considering the relevance of this model to work-related rumination, it is evident that this form of rumination could benefit from these strategies. For example goal attainment, in relation to work-related rumination, could be achieved by breaking tasks down into manageable chunks. Similarly distraction techniques could be taught to staff that experience ongoing ruminative work related thoughts. In terms of disengagement it is evident that the practice of cognitive strategies, such as Mindfulness (Kabat-Zinn, 1990), might facilitate disengagement from work. This theory is in line with research that suggests that Mindfulness may counteract rumination (Borders et al, 2010). It is also evident that strategies that limit the use of portable communication devices and work-related tools in the home might also be of benefit in facilitating detachment.

These techniques are based on research that conceptualises work-related rumination as a homogenous variable, which is uniformly negative. However it is possible that work-related rumination could be subdivided into both positive and negative
components. For example work rumination could be positive in nature, when it is employed as a problem solving technique. Research in this area (Cropley et al, 2009), although limited, has identified a three-factor model of work-related rumination where it is only work-related ‘affective’ rumination that has a negative impact on ’switching off’ and health.

1.6 Work-Related Affective Rumination

Although commonly seen as a homogenous variable, research has identified different factors within the concept of ‘rumination’. Initially, in terms of general rumination, a two-factor model, composed of ‘brooding’ and ‘reflective pondering’ was proposed (Treynor et al, 2003). This model was applied specifically in terms of depressive rumination and did not look at work-related rumination. In this model ‘reflective pondering’ was viewed as an adaptive strategy for problem solving and ‘brooding’ was seen as a maladaptive negative response (Traynor et al, 2003). This model was followed, specifically in terms of work-related rumination, with a three factor model composed of affective rumination, problem solving, and detachment, assessed using a 15 item measure (Cropley et al, 2009).

The work-related rumination scale (WRRS) (Cropley et al, 2009) used to assess rumination according to these three factors was produced from focus groups and interviews with 110 full time workers, from ‘white-collar’ occupations. It was assessed for clarity, relevance and comprehensibility (Cropley, et al, 2009). The results of the focus groups and pilot studies suggest that the items have good reliability and validity. Studies employing the measure have reported good internal consistency, with a cronbach alpha coefficient of .9 for work related affective rumination, .78 for work-related problem solving, and .84 for detachment (Cropley et al, 2009).

According to this three-factor concept of rumination, work-related affective rumination is described as a cognitive state characterised by the presence of intrusive, pervasive, recurrent thoughts about work, which are negative in affective terms. (Cropley et al, 2009). It resembles the concept of ‘brooding’ rumination
proposed by Treynor et al (2003) however it also emphasises an affective/emotional element to the rumination. For example on the WRRS it is assessed with questions such as 'do you become annoyed when you think about work related issues in your spare time' (Cropley et al, 2009).

Work-related problem solving, part of the three-factor model, is conceptualised as an adaptive strategy to finding solutions to work-related problems. It resembles the concept of ‘reflective pondering’ (Treynor et al, 2003), and it is measured with questions such as ‘I find solutions to work related problems in my free time’, (Cropley et al, 2009). It is clearly distinguished from affective rumination, by the fact that it does not lead to increased ‘negative affect’ or arousal.

Work-related detachment, the final part of the three-factor model, relates to the ease that people leave work thoughts and issues behind and are able to disengage from work-related thoughts in their leisure time. This is measured by items such as ‘do you leave work issues behind when you leave work?’ (Cropley et al, 2009). Detachment from work has been shown to have positive health effects (Sonnentag & Bayer, 2005), such as lowered levels of fatigue. It has also been argued that the ability to ‘switch off’ promotes a positive work/life balance. (Cropley & Millward, 2009)

Therefore, based on the underlying concepts of this three-factor model of rumination (Cropley et al, 2009), it would appear that it is only work-related ‘affective’ rumination that is negative, causes arousal, and impacts on a person’s ability to ‘switch off’ from work. For example, in line with the Martin and Tesser model (1996) of rumination, work-related problem solving may actually reduce rumination by allowing for tasks to be solved in manageable chunks and result in goal attainment. However work-related affective rumination does not allow for goal attainment, detachment or disengagement (Cropley & Millward, 2009), due to heightened arousal levels caused by the ‘affective’ component of the rumination. Therefore, given the negative health consequences associated with an inability to ‘switch off’, it is evident that it would be useful to identify interventions to reduce
this specific type of work-related affective rumination. One such strategy could be
the Expressive Writing Paradigm (Pennebaker, 1989), which has already been
applied to the areas of work (Barclay & Skarlicki, 2009; Sexton et al, 2009; Spera et
al, 1994) and rumination (Gotner et al, 2006; Sloan et al, 2008), but not to the
combination of work and rumination.

1.7 Expressive Writing
Description
Expressive writing is described as the process of emotional expression through
writing (Lepore & Smyth, 2002) and it has been developed into a standard paradigm,
which involves writing expressively on a topic that has caused upset or distress, for
fifteen to twenty minutes, over three to four consecutive days (Pennebaker, 1989).
Expressive writing has been shown to be beneficial for a range of difficulties, in a
variety of populations (Smyth, 1998). In terms of the focus for the current study,
expressive writing has been shown to reduce the amount of intrusive cognitions
people experience about troubling events (Klein and Boals, 2001), to reduce the
symptoms of anxiety and depression (Lepore, 1997), lower blood pressure (McGuire
et al, 2005), impact positively on trauma and affect (Fernandez, & Paez, 2008;
Smyth & Helm, 2003;), as well as improve sleep (de Moor et al, 2002).

Thus it would appear that expressive writing would be an appropriate intervention
for work-related affective rumination, as a number of the reported health benefits
associated with expressive writing match the reported symptoms of ongoing work-
related stress and rumination, such as anxiety and depression (Harrington &
Blakenship, 2006), increased ‘negative affect’ (Feldner, 2006), and poor sleep
(Guastella & Moulds, 2007). Similarly the underlying mechanism thought to account
for the positive health benefits of expressive writing (Pennebaker & Chung, 2007)
indicates that it is appropriate for work-related rumination.

b) Underlying mechanisms of expressive writing
The initial expressive writing paradigm was formed out of theories of trauma
(Pennebaker, 1985), where the adaptive coping mechanism in response to trauma is
to talk about the event (Pennebaker, 1985). Research suggests that by re-experiencing and verbalising the traumatic experience a form of habituation occurs and the memory of the event then becomes integrated and stored as part of the autobiographical memory (Elhers et al, 2004). However, when vocalised to another person, the addressee's response to the disclosure, if negative, can generate feelings of shame, and worries about ridicule and rejection. (Mogk et al, 2006). This experience may then cause people to inhibit their thoughts and feelings about a traumatic event, which has a negative impact on the person's health. The suppression of emotion over time has been shown to be maladaptive and involve increased cognitive 'work', maintaining arousal (Pennebaker, 1989).

Therefore it has been identified that expressive writing is a strategy that can facilitate emotional disinhibition, but circumvent the potential negative evaluation from another person (Pennebaker, 1993), and result in positive health outcomes, in situations where verbal disclosure might not be effective.

More recently research on expressive writing has sought to further understand the underlying cognitive process responsible for the reported health benefits (Lu & Stanton, 2010), given that the literature suggests that 'no single theory or theoretical perspective has convincingly explained its effectiveness' (Pennebaker, 2004, P1, L7-9). This research has added to theories of emotional disinhibition, (Pennebaker, 1993), by suggested that expressive writing also allows for cognitive restructuring (Lu & Stanton, 2010), and increased social integration (Pennebaker & Chung, 2007). The literature in this area suggests that expressive writing allows the memory of a traumatic experience to be converted into a coherent linguistic structure (Pennebaker & Chung, 2007). This then results in improved comprehension of the stressful experience and allows for the information to be stored and processed. In turn, this increased understanding and processing ability reduces the 'negative affect' associated with the experience (Pennebaker & Chung, 2007).

This theory is supported by research that also highlights the importance of linguistic and cognitive processes in terms of the underlying mechanisms involved with
expressive writing (Lu & Stanton, 2009). This research suggests that through expressive writing a coherent narrative about the traumatic event is created, which is then stored and processed more easily. Thus the memory can be more easily removed from the working memory (Lu & Stanton, 2010).

An additional process has also been identified to explain the reported benefits of expressive writing. It has been suggested that expressive writing results in enhanced social processing, leading to increased social integration (Pennebaker & Chung, 2007). For example it is thought 'writing may also encourage people to talk more openly with others about the secrets that they have been keeping.' (Pennebaker & Chung, 2007, P22, p3, L7-8).

Therefore it is clear that the research and existing literature indicates that expressive writing might reduce physiological and psychological distress, through allowing emotional expression, cognitive restructuring and facilitating social integration.

c) Emotional Approach Coping (EAC).

In line with the research that has attempted to understand the underlying mechanisms behind the benefits of expressive writing, other research (Gortner et al, 2006; Kraft et al, 2008) has also sought to identify the personality differences that may enhance the benefits of the expressive writing paradigm. These studies are based on theories of emotional expression (Pennebaker, 1989), and examine if individual trait levels of emotional expression and emotional processing, moderate the effects of the expressive writing paradigm. It has been identified that a person’s existing level of emotional expression and trait emotional coping may moderate the effects of expressive writing (Gortner et al, 2006; Kraft et al, 2008). However there are conflicting findings as to whether pre-existing levels of emotional expression and emotional coping enhance or reduce the benefits of emotional disclosure interventions. For example in a study by Gortner et al, (2006) looking at depression-vulnerable college students, participants completed the Emotion Regulation Questionnaire (Gross & John, 2003) and were then given the expressive writing intervention. The findings show that participants with scores above average on the Emotion Suppression Scale reported fewer depressive symptoms when assessed at
six months (Gortner et al, 2006). This suggests that lower levels of emotional expression enhance the benefits of the paradigm. This idea is supported by research that suggests that people who are less emotionally open benefit more from expressive writing (Soper & Von Bergen, 2001).

However studies looking at expressive writing in relation to Emotional Approach Coping (EAC) (Kraft et al, 2008), which is defined as use of emotional processing and emotional expression to cope (Stanton et al, 2000), found that low levels of Emotional Approach Coping reduced the effects of the expressive writing paradigm. This idea is supported by research on Alexithymia and expressive writing (Lumley, 2004). Alexithymia is described as a difficulty identifying, distinguishing and communicating one’s feelings (Lumley, 2004), and research in this area suggests that Alexithymia negates the benefits of expressive writing. Considering these different findings and contradictions, it is evident that a pre-disposition to use emotional expression as a coping strategy, might reduce the impact of the expressive writing paradigm, given that it is a strategy already being employed. However an inability to employ coping strategies based on emotional expression may also reduce the impact of the paradigm.

d) Meta-analytic studies of the benefits of expressive writing
In addition to this research that highlights variations in the impact of expressive writing based on personality traits and pre-existing coping strategies, there is also a suggestion that the population and the type of difficulty will also cause variations in the effectiveness of the paradigm. It has been highlighted that ‘We still don’t know for whom it works best, when it should be used, or when other techniques should be used in its place.’ (Pennebaker & Chung, 2007, P23, P4, L2-3). A number of meta-analytic studies of expressive writing (Frattaroli, 2006; Frisina et al, 2004; Harris, 2006; Mogk et al, 2006; Smyth, 1998), conducted over the past 13 years, have reported a range of effect sizes, from a medium effect (Smyth, 1998) to no effect (Mogk et al, 2006). The findings of these reviews are summarised in Table 1.1
Table 1.1: Summary of five meta-analytic studies of expressive writing

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Date</th>
<th>N</th>
<th>Pop</th>
<th>Design of studies</th>
<th>Effect size Physical</th>
<th>Effect size Psychological</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smyth</td>
<td>1998</td>
<td>14</td>
<td>Healthy</td>
<td>Experimental</td>
<td>d=.03</td>
<td>d=.66</td>
<td>d=.47</td>
</tr>
<tr>
<td>Frisina et al</td>
<td>2004</td>
<td>9</td>
<td>Clinical</td>
<td>RCT</td>
<td>d=.21</td>
<td>d=.07</td>
<td>d=.19</td>
</tr>
<tr>
<td>Frattaroli</td>
<td>2006</td>
<td>146</td>
<td>Clinical/ Healthy</td>
<td>RCT</td>
<td>n/a</td>
<td>n/a</td>
<td>d=.15</td>
</tr>
<tr>
<td>Harris</td>
<td>2006</td>
<td>30</td>
<td>Clinical/ Healthy</td>
<td>RCT</td>
<td>n/a</td>
<td>n/a</td>
<td>'Small' g=.16, but only for healthy populations</td>
</tr>
<tr>
<td>Mogk et al</td>
<td>2006</td>
<td>30</td>
<td>Healthy/ Clinical</td>
<td>RCT</td>
<td>Non Significant</td>
<td>Non significant</td>
<td>Non Significant</td>
</tr>
</tbody>
</table>

Taking a critical overview of the findings it is evident that the inclusion criteria varies, in terms of design, size and population, between studies, which may then account for the variations in effect size. For example the studies (Frisina et al, 2004; Frattaroli, 2006; Harris, 2006; Mogk et al, 2006) that report small effect sizes only included randomised control trials (RCT’s). Thus highlighting the fact that when a more stringent methodology was employed the expressive writing paradigm was shown not to be as effective as initially reported (Smyth, 1998). Similarly it is also evident that studies that employed Hedge’s g to calculate effect sizes also reported small or non-significant effect sizes, perhaps due to the employment of this more conservative methodology (Mogk, 2006).

Taking a further critical examination of the inclusion criteria for the meta-analytic studies that only used RCT’s, it is evident that there are further variations in the stringency of these designs. For example comprehensive guidelines (CONSORT) (Schulz et al, 2010) have been published regarding the transparent reporting of randomised control trials, and in the guidelines it is advised that for ‘gold standard’ designs the control group should receive ‘no treatment’ (Moher et al, 2010) and remain unchanged. However it is evident that studies which did not meet this standard were still included as RCT’s in two of the meta-analytic reviews (Frattaroli, 2006; Mogk et al, 2006) For example in these reviews studies were included as
RCT’s if the control group wrote on a factual or neutral topic, which is not in line with recommendation that the control group should remain unaffected (Moher et al, 2010). However this distinction only partially qualifies the findings of these studies as a rigorous randomisation procedure still had to be employed for the studies to be included in the analyses, and even if the findings could not be compared to a ‘no treatment’ group they could still be compared to a non-emotional factual writing group.

Considering further variations in the findings of the meta-analytic studies, it is also evident from the above table that expressive writing is more effective for physical rather than psychological difficulties in studies with clinical populations (Frisna et al, 2004), however in studies with non-clinical populations it is more effective for psychological difficulties (Smyth, 1998, Harris, 2006). This is perhaps due to non-clinical samples having experienced less exposure to therapies and interventions that encourage emotional expression. It is also evident that findings of meta-analytic studies often average both physical and psychological difficulties when reporting an overall effect size. For example the Smyth study (1998), which has been widely cited, reported an overall effect size of Cohen’s d=.47, which averaged physical health (Cohen’s d=.03) and psychological health (Cohen’s d=.66) (Pennebaker & Chung, 2007). However given the extent of the difference between these two effect sizes, it could be argued that reporting of an overall combined effect size may not present a true picture of the effects of expressive writing for specific types of difficulties.

Thus it is evident that the results of the meta-analytic studies present a differing picture of the potential effect sizes, and although this may relate to variations in methodological inclusion criteria, it also suggests that the effects of expressive writing might be population and difficulty specific (Mogk et al, 2006). Considering whether work-related affective rumination would be a difficulty that could benefit from expressive writing it is evident that there is no specific research in this area. However the expressive writing paradigm (Pennebaker, 1989) has been reported to have a positive impact on work difficulties (Barclay & Skarlicki, 2009; Sexton et al,
It has also been shown to be moderated by levels of rumination (Gotner et al., 2006; Sloan et al., 2008). Therefore, combining this research, it would appear that work-related affective rumination is a specific difficulty that might benefit from expressive writing.

1.8 Expressive Writing and Work

Research suggests that expressive writing impacts positively on work-related difficulties and a number of studies have applied expressive writing in this context. For example, one study (Sexton et al., 2009) looked at the benefit of expressive writing for nurses in the United States, who were experiencing difficulties sleeping and reported depressive symptoms. The results of this study indicate that the nurses benefitted from completion of the intervention. In line with theories of cognitive restructuring, Sexton suggests that the reason for this is that the intervention allowed for a cognitive reappraisal of the distressing situation they encountered at work (Sexton et al., 2009).

Studies have also looked specifically at job loss as a cause of stress (Spera et al., 1994). In this study, sixty-three professionals, who had become recently unemployed, completed either the expressive writing intervention or a control writing task. The participants were monitored over time and it was reported that participants in the expressive group were more likely to find re-employment (Spera et al., 1994). This research adapted the traditional expressive writing paradigm by asking the participants in the expressive writing group to focus their writing on the specific difficulty and trauma relating to job loss. Expressive writing studies have often adapted the paradigm to be context and difficulty specific, and the results of these studies have reported good effect sizes and indicate that the paradigm can be adapted without limiting its effectiveness (Pennebaker & Chung, 2007).

Further research, in the context of expressive writing and work, has looked at the impact of the expressive writing intervention on workers’ sense of organisational injustice (Barclay & Skarlicki, 2009). This study employed a large sample (n=100) and participants wrote about their thoughts, emotions, a combination of thoughts and
emotions, or a trivial subject. The findings report that in the ‘thoughts and emotions’
condition, participants experienced improved psychological well being, as well as
increased personal resolution and they also reported that they experienced fewer
thoughts of retaliation (Barclay & Skarlicki, 2009). This finding is in line with
theories concerning the underlying mechanisms behind expressive writing, which
identify the role of emotional expression and cognitive restructuring (Pennebaker &
Chung, 2007).

Taking an overview of these studies, which relate to expressive writing and work
difficulties, it is evident that work is a context in which expressive writing has been
shown to be beneficial, and therefore indicates that work-related affective rumination
may also be positively impacted by the intervention.

1.9 Expressive Writing and Rumination

It is evident that, along with studies that report the benefits of expressive writing on
work difficulties, there are also studies that indicate that expressive writing is
moderated by levels of rumination. An initial study looking at expressive writing and
rumination (Gotner et al, 2006), reported that the impact of the expressive writing
intervention was moderated by levels of ‘brooding’ rumination (Treynor et al, 2003),

A further study (Sloan et al, 2008), again reported similar findings, in that
‘brooding’ rumination moderated the impact of the expressive writing. In this study
69 participants, who were college students in their first semester, were assessed for
depression. The study was designed as a randomised control trail and therefore the
participants were allocated to either the expressive or control group. Outcome
measures were then recorded at two, four and six months. The results identify that
for people with a ‘brooding’ ruminative style (Treynor et al, 2003), expressive
writing reduced incidents of depression (Nolen-Hoeksema et al, 2008; Sloan et al,
2008). However a ‘reflective pondering’ ruminative style (Treynor et al, 2003) did
not moderate the effects of expressive writing on depressive symptoms (Sloan et al,
2008). Interestingly, a separate study (Sloan et al, 2009), again looking at the impact
of expressive writing on depression, reports that a significant effect was only found at the two month follow up, suggesting limited durability of the effects of the intervention (Sloan et al, 2009).

Having reviewed these studies on expressive writing and rumination, it is apparent that the effects of the expressive writing intervention can be moderated by a 'brooding' ruminative style, but not a 'reflective pondering' style. This is directly relevant to the current study, as 'affective' rumination (Cropley et al, 2009) closely resembles the concept of 'brooding' (Treynor et al, 2003) rumination, thus suggesting that the intervention would also be relevant for 'work-related affective rumination'.

However it is also evident that there are no studies that have directly examined the impact of expressive writing on rumination, using measures to assess rumination post intervention. A study in 2001 (Klein & Boals, 2001), examined the impact of expressive writing on working memory, and identified that expressive writing reduced intrusive cognitions and improved working memory (Klein & Boals, 2001). However, although intrusive cognitions can be an aspect of rumination, rumination was not the focus of this study.

Similarly, in terms of the literature on expressive writing and work-related rumination, research (Soper & Von Bergen, 2001) suggests that expressive writing about work could break the 'negative loop of avoidance and negative rumination' (Soper & Von Bergen, 2001, P 151, p3 L5-6). However this work only comments on the potential of expressive writing to reduce work-related rumination, and did not directly measuring it.

1.9.1 Current study

a) Rationale
It is evident that failure to 'switch off' from work, leads to a number of health difficulties (Cropley & Millward, 2003). Work-related affective rumination has been identified as a possible reason why people fail to 'switch off'. Therefore if reduced, it
may impact positively on a person's ability to disengage from work (Cropley & Millward, 2009). As already discussed there is currently no research looking at expressive writing and work-related affective rumination. However, combining the research and literature presented in this introduction on expressive writing in relation to work, expressive writing in relation to rumination, rumination and work-related rumination, it is evident that it could be argued that expressive writing could also have a positive impact on work-related affective rumination.

The underlying premise for this assumption is that expressive writing about work might facilitate the emotional expression of distressing work-related incidents, which people may feel unable to express in a work setting. It could also facilitate the development of a coherent narrative, thus allowing the incident to be stored and processed more effectively, which may lead to a reduction in arousal levels. It may also then lead to improved social integration and enhanced social functioning in the work environment. The research also supports the use of expressive writing with this type of non-clinical population, as the findings of a number of the meta-analytic studies (Harris, 2006; Smyth, 1998) suggest that expressive writing is more effective on 'healthy' populations. Therefore, the current study aimed to contribute to research in this area by identifying the impact of the expressive writing paradigm on work-related affective rumination.

Given that research indicates a connection between rumination and a number of health difficulties, such as anxiety and depression (Harrington & Blakenship, 2006), increased 'negative affect' (Feldner, 2006), and poor sleep (Guastella & Moulds, 2007), if expressive writing was shown to be effective in reducing work-related affective rumination, it would be a cost-effective, easy to administer intervention that could facilitate 'switching off', promote recovery from work, and impact positively on these related health symptoms.

b) Aims of the study

Therefore, the study aimed to examine the impact of expressive writing on work-related affective rumination by focussing the expressive writing paradigm on work-
related difficulties. It also aimed to identify if writing about work impacted positively on somatic and psychological health difficulties such as anxiety, depression, ‘negative affect’ and poor sleep. In line with an increasing emphasis on the need to add to the evidence base of expressive writing (Frattaroli, 2006; Mogk et al, 2006), the study utilised a rigorous experimental design, with two intervention groups, expressive writing and factual writing. On account of variations regarding the durability of the expressive writing paradigm (Pennebaker & Chung, 2007), outcome measures were collected at one and three months.

As research suggests that work-related rumination impacts on ‘knowledge’ workers more than ‘manual’ workers (Pravettoni et al, 2007) the study focussed primarily on ‘white-collar’ professionals. However, given that a majority of the research on work-related rumination has been conducted on school teachers (Cropley & Millward, 2003; Cropley et al, 2006), the study also sought to recruit a diverse sample, in terms of occupation, within the ‘white-collar’ professions.

Current research indicates a moderating role of pre-existing levels of emotional expression and emotional coping (Gortner et al, 2006; Kraft et al, 2008). Therefore this study also sought to measure pre-existing levels of Emotional Approach Coping (EAC), and to identify if this moderated the impact of the intervention on work-related affective rumination.

c) Hypotheses

Based on a thorough review of the existing literature a number of hypotheses were devised.

1) Firstly it was hypothesised that, compared to completion of a factual writing task, completion of an expressive writing task, would significantly reduce work-related affective rumination (WRAR), measured on WRAR scale (Cropley et al, 2009), in ‘white-collar’ workers who reported finding it difficult to unwind from work in their leisure time.
2) Secondly it was hypothesised that, compared to completion of a factual writing task, completion of the expressive writing task would significantly reduce related health difficulties. These health difficulties were depression (measured on the Patient Health Questionnaire: PHQ8) (Kroenke & Spitzer, 2001), anxiety (measured on the General Anxiety Disorder scale: GAD7) (Spitzer et al, 2006), ‘negative affect’ (measured on the International Positive and Negative Affect scale- short form: I-PANAS-SF) (Thompson, 2007) and poor sleep, measured on the Pittsburg Sleep Quality Index (PSQI) (Buysee et al, 1988).

3) Thirdly it was hypothesised that the effects of the expressive writing intervention would be moderated by levels of Emotional Approach Coping (EAC), measured on the EAC scale (Stanton et al, 2000), although the direction of moderation could not be specified due to conflicting research in this area.

2) METHOD

2.1 Design
This was an experimental study with a two by three repeated measures design. The between subjects variable was the type of intervention, either expressive writing or factual writing. The within subjects variable was the time of measurement, baseline, one month, and three months. The primary dependent variable was the score on a five-item measure of work-related affective rumination (WRAR). The secondary dependent variables were scores measures of depression (PHQ8), Anxiety (GAD7), sleep quality (PSQI), and ‘negative affect’ (I-PANAS-SF:N). Scores on a scale of Emotional Approach Coping (EAC) were analysed as a possible covariate. The study was designed in this way with two intervention groups, rather than as a randomised control trial with a ‘no treatment’ control group, as this design allowed for comparison of the effectiveness of the different types of writing. It also helped to identify the specific components of expressive writing, in comparison to factual writing, that make the paradigm effective.
2.2 Sample

a) Participants

A description of the participants at each stage of the study is provided in figure 2.1.

![Participant flow diagram]

Figure 2.1 Participant flow diagram

b) Sample size

A priori power analysis was conducted using G-power (Version 3) to identify the sample size that would be needed to achieve 95% power when using a two by three mixed ANOVA to analyse the results. The effect size of expressive writing on the measure of work-related affective rumination was not known, therefore the commonly reported effect size (Cohen’s d=.47) for an expressive writing
intervention was used (Smyth, 1998). Sphericity was assumed, and a mid range figure (r=.5) was used for the correlation between repeated measures. Using these parameters it was indicated that a sample size of 44 participants would provide 95% power. However to allow for the possible inclusion of a covariate in the analysis, and to compensate for attrition from baseline to the three month outcome, the figure of 44 was used to indicate the minimum number of participants needed. The study, therefore, sought to recruit the largest sample possible, within the time and financial constraints.

2.3 Ethical considerations and approval
Prior to commencing the study, ethical approval was obtained from the Faculty of Arts and Human Sciences Ethics Committee, University of Surrey (Appendix 4). The withholding of the intervention to the factual writing group was considered, and to comply with ethics, it was agreed that if the intervention was found to be effective this group would be given the opportunity to complete the expressive writing component once the findings of the study had been examined.

2.4 Materials
a) Development and piloting of study information.
A pilot study was conducted to test the usability of the websites used to screen participants and to collect baseline, one month and three month outcome data. Two participants were recruited through informal contacts to test for flaws in the online response options and functionality of the instructions. Changes were made in line with the feedback, specifically the online response options for the Pittsburg Sleep Quality Index (PSQI) were altered to make the ‘other’ question optional.

b) Consent
Consent was obtained online. Informed consent was obtained through the inclusion of an online study information and consent form (Appendix 5) and the participants were also informed that by pressing ‘continue’ on the webpage at each new stage of the study they would be giving their consent to participate.
c) Intervention (Writing packs)

The writing packs were produced in line with previous research (Theadom *et al*, 2010) that conducted a study on expressive writing by posting the intervention to participants. Each writing pack was presented to the participant in an A4 plastic wallet file. The pack contained general instructions (Appendix 6a) followed by specific instructions, held in an envelope, for completing the intervention on each of the three days, and these varied between the expressive writing (Appendix 6b) and factual writing (Appendix 6c) group. The packs also contained blank A4 response sheets, and a page asking for feedback following completion of the writing tasks (Appendix 6d). A pre-paid envelope (90p stamp), with the name and address (Surrey University) of the researcher printed on the front, was placed in the back of the pack.

**Writing Instructions**

The writing instructions for both groups asked the participants to write for twenty minutes a day for three days on the blank sheets provided. They were instructed not to be concerned about spelling, sentence structure or grammar. The detail of the writing instructions differed between the factual and expressive writing groups.

**The Factual Writing Group**: The writing instructions for the factual group on ‘day 1’ asked participants to write a factual description of their daily routine. They were prompted to start the description at the time their alarm went off. It was also suggested that they might include a factual description of the buildings and places they passed or visited during the day. It was emphasised that they should include as much factual detail as possible. On ‘day 2’ they were asked to give a factual account of what they ate on the previous day, again in as much detail as possible. They were prompted to think about the times they ate, whom they were with and, again, it was emphasised that they should include as much factual detail as possible. On ‘day 3’ they were asked to write about the interests or activities they like to do and, again, it was emphasised that they should include as much factual detail as possible.

**The Expressive Writing group**: The writing instructions for the expressive group on ‘day 1’ asked participants to write about their deepest thoughts and feelings about work. They were given the example of writing about a stressful situation that
continues to bother them, that they may find difficult to talk about and makes them feel upset, and they keep thinking about. It was also suggested that it should be an experience that they have not shared too much with others. They were also encouraged to really ‘let go’ in their writing and it was suggested that they might think about the situation in terms of others, the past, present, or future. On ‘day 2’ they were given the same instructions to write about their thoughts and feelings about work. It was suggested that it could be the same topic as the previous day or a new topic, and again they were encouraged to ‘let go’ and explore their thoughts and feelings. On ‘day 3’ they were again given the same instructions to write about their thoughts and feelings about work. It was suggested that they could write on a previous topic or on a new one, and it was emphasised that they should really ‘let go’ during the writing.

d) Measures
The study employed six measures, each given at baseline, one month and three months. Permission to reproduce these measures on a website and as part of a doctoral thesis was sought and obtained prior to commencement of the study. The measures were held online.

This is a five-item measure of Work-Related Affective Rumination (WRAR), part of a fifteen item work-related rumination scale (WRRS) (Cropley et al, 2009). Items are measured on a five point Likert scale ranging from 1 (Never) to 5 (Always). The scale has been shown to have good internal consistency (Cronbach alpha coefficient = .9), and is characterised by questions such as ‘Do you become tense when you think about work?’. In the current study a good level of internal consistency was also reported (Cronbach alpha coefficient = .76). It was reproduced with permission from the author.

2) Patient Health Questionnaire (PHQ8) (Appendix 7b) (Kroenke et al, 2009). This is an eight-item measure of depression. It is a shortened version of the PHQ9 (Kroenke et al, 2001), with item 9 removed ‘do you have thoughts that you would be
better off dead or of hurting yourself in some way'. It has been identified as an appropriate alternative to the PHQ9, if the risk of suicide is low, depression is a secondary outcome, or it is used as an unsupported self-report questionnaire as part of an Internet survey (Kroenke & Spitzer, 2009). The PHQ items are measured on a four point Likert scale ranging from 0 (Not at all) to 3 (Nearly everyday) and have been shown to be a valid measure of depression (Kroenke et al, 2001). The PHQ8 has been shown to have good construct validity, reliability and internal consistency (Cronbach alpha coefficient=.82) (Pressler et al, 2010). In the current study an acceptable level of internal consistency was also reported (Cronbach alpha coefficient=.68) The measure was reproduced with the permission of Pfizer Inc.

3) Generalised Anxiety Disorder Screener (GAD7) (Spitzer et al, 2006) (Appendix 7c). This is a seven-item, self-report measure of anxiety. The items are measured on a four point Likert scale ranging from 0 (Not at all) to 3 (Nearly everyday). It has been validated both with clinical samples and samples from the general population. It has been shown to have high degree of internal consistency for samples from the general population (Cronbach alpha coefficient=.87). It has also been reported to be a valid and reliable measure of anxiety in the population (Spitzer et al, 2006). In this study a good level of internal consistency was also reported (Cronbach alpha coefficient=.81). It was reproduced with permission from Pfizer Inc.

4) International Positive and Negative Affect Schedule-short form (I-PANAS-SF) (Thompson, 2007) (Appendix 7d). This is a 10 item self-rated questionnaire, measuring 'positive affect' and 'negative affect'. It is a shortened version of the Positive and Negative Affect Schedule (PANAS) (WATSON et al, 1988). This shortened scale has been identified as being appropriate for use in research where there is a time constraint, such as research with working populations (Thompson, 2007). It comprises measures of two sub-scales (Positive affect and Negative affect). 'Positive affect' is characterised by questions such as 'to what extent do you generally feel inspired?'. 'Negative affect' is characterised by questions such as 'to what extent do you generally feel afraid?'. Items are measured on a 5 point Likert scale ranging from 1 (Very slightly or not at all) to 5 (extremely). It has been shown
to have a good level of internal consistency (Cronbach alpha coefficient = .84), as well as good general reliability and validity (Thompson, 2007). In this study an acceptable level of internal consistency was reported (Cronbach alpha coefficient = .68). This scale was reproduced with the permission of Sage Publications.

5) *Pittsburg Sleep Quality Index (PSQI)* (Buysee *et al*, 1988) (Appendix 7e). This measure is a 19 item self-rated questionnaire, commonly used to measure sleep in adults. It is composed of seven categories; sleep quality, sleep duration, sleep latency, habitual sleep efficiency, sleep disturbances, use of sleep medication, and daytime dysfunction. Items are either open response or they are rated on a four point Likert scale, ranging from 0 (Not during the past month) to 3 (3 or more times a week). It has been shown to have good internal consistency (Cronbach alpha coefficient = .83), as well as good validity and reliability (Buysee *et al*, 1988). In this study a good level of internal consistency was also reported (Cronbach alpha coefficient = .8). It was reproduced with permission from the author.

6) *Emotional Approach Coping Scale (EAC)* (Stanton *et al*, 2000) (Appendix 7f). This is an eight-item, self-report questionnaire measuring the use of emotional coping. It is composed of two, four item subscales; emotional processing (EP), and emotional expression (EE). Emotional processing is characterised by statements such as ‘I acknowledge my emotions’. Emotional expression is characterised by statements such as ‘I let my feelings come out freely’. It is measured on a four point Likert scale, ranging from 1 (I usually don’t do this) to 4 (I do this a lot). It has been shown to have good internal consistency (Cronbach alpha coefficient = .91), as well as good reliability and validity (Stanton *et al*, 2000). In this study a good level of internal consistency was also reported (Cronbach alpha coefficient = .84) It was reproduced with permission from the American Psychological Association.
2.5 Procedure

a) Recruitment

Participants were recruited as a target sample of people that report difficulty ‘switching off’ from work in their leisure time. Initially ten companies with offices in London, representing a range of job sectors, were approached and invited to participate in the study. Nine out of the ten companies approached did not respond to the invitation. One company declined due to the level of commitment required by the participants. Following this, individuals known to the researcher, working in companies and public sector organisations with offices in London, were approached and asked to assist in recruiting. These companies covered a range of job sectors including:

   a) Media
   b) Financial services
   c) Retail
   d) Information Technology
   e) Tourism and Leisure
   f) Arts
   g) Property
   h) Charity
   i) Public sector

Email distribution lists were used to send potential participants an email introducing the study (Appendix 8a) and inviting them to complete the online rumination screening measure. Further participants were then recruited via snowballing from the original email. To be eligible for the main study participants had to be in employment, based in the U.K., and to have scored above 15 on a measure of work-related affective rumination. Recruitment was on a rolling basis starting in October 2009 and ending in February 2010.

b) Data collection and management

Screening

Participants who scored above 15 on the screening measure of work-related affective rumination and reported being in employment were sent an email inviting them to
participate in the main study and to complete the online baseline measures (Appendix 8c). Participants that scored below 15 were sent an email thanking them for their time (Appendix 8b). Baseline data was collected and stored online.

Group allocation.
In even numbered batches, ranging from two to ten; participants were then randomly allocated to either the factual writing or expressive writing group. To ensure that the allocation was random, a random number generator on the Microsoft Excel program was used to create a random number between 1-2 for each participant in a batch. The participants were then sorted by ascending number and divided into two even groups. The group with the lower numbers were allocated to the factual writing group. The group with the higher numbers were allocated to the expressive writing group.

The Intervention
Depending on their allocation group, participants were either sent the writing pack containing the expressive writing instructions or the writing pack containing the factual writing instructions. On receipt of the pack the participant was instructed to complete the exercise and return the pack in the stamped addressed envelope provided.

Outcome measures
At approximately one and three months following the writing intervention participants completed the online outcome measures. Once completed participants were sent an email thanking them for their participation in the study and informing them that they would receive a copy of the main findings in September 2010 (Appendix 8d).

c) Confidentiality
To run the study, maintain confidentiality and protect personal information the participants’ contact details, progress and outcome data was recorded and updated on four Microsoft Excel spread sheets. Each spread sheet was stored separately and
securely, so that personal contact information could not be matched to participant response data.

2. Data Analysis
The data analysis was conducted using the Statistical Package for the Social Sciences (SPSS) (Version 16, Mac OS).

1) The raw data was screened, checked for missing entries, assessed for outliers and assessed for normality.

2) Participant characteristics and baseline scores on each of the dependent variables were compared between the two groups. This was primarily to identify if the randomisation procedure had been successful and whether baseline scores on the dependent variables should be controlled. The findings are presented in a table comparing the factual and expressive writing group in the results.

3) The writing transcripts were entered into the Linguistic Inquiry Word Count program (Tausczik & Pennebaker, 2010) and the results of the groups were compared in terms of word count, positive/negative words and 'cognitive mechanistic words' using independent sample t-tests. This was to identify if the intervention had been successful in creating a difference, in terms of content, between the expressive writing and factual writing group. A comparison between the output on ‘day 1’ and ‘day 3’ in the expressive writing group was also conducted using a paired samples t-test. This was to examine if repetition of the writing task over three days resulted in an increase in cognitive processing, evidenced by an increase in ‘cognitive mechanistic’ words. The findings of this analysis are described in text form in the results.

4) The scales used in the experiment were checked for internal consistency, this was to ensure that the scales used were a reliable measure of the dependent variables.

5) A correlation analysis was used to explore the relationship between each of the dependent variables at baseline. This was primarily to identify if Emotional Approach Coping (EAC) correlated significantly with the other dependent variables and therefore should be included as a possible covariate. The findings are presented in a correlation table in the results.

6) A two by two repeated measures ANCOVA was then conducted, (Expressive/Control x One month/Three months), with the baseline measures
controlled as a covariate, for each of the dependent variable. This was to identify, with baseline scores controlled, whether there was a significant difference between the expressive writing and factual writing groups on each of the dependent variables following the intervention. For each of the dependent variables a graph showing the scores for the expressive writing and factual writing group at each time point has been presented. A table showing the adjusted mean scores at one month and three months has also been included to show the result of including baseline scores as a covariate.

7) Change scores for the expressive writing group were calculated from baseline to three months for each of the dependent variables, and a correlation analysis was performed to explore the relationship between the change scores. This was to examine if changes in the primary dependent variable, work-related affective rumination, correlated with changes on each of the secondary dependent variables. Although this would not show causality it would provide more information as to the relationship between the variables. The findings are presented in a correlation table in the results.

8) Specific raw data selected from the participant feedback was reported in the results. No analysis was applied to this data and its purpose was to validate the argument that expressive writing in an intervention that people are willing to undertake.

3) RESULTS

3.1 Data screening
No missing entries for any of the dependent variables were found, due to the stringent online entry method. Outliers were checked and no extreme outliers for the dependent variables were reported. Marginal outliers were identified for a number of the variables, therefore the mean scores for these data sets were compared to the 5% trimmed means reported in SPSS (Appendix 9a). As the outliers would not have been entered in error, and they did not impact on the average mean, they were not removed from the data set. An examination of skewness and kurtosis for each of the variables across the two groups was also conducted to assess for normality. The variables were analysed at each time point and for each group, creating 36 data sets,
and 8 out of the 36 data sets violated the assumption of normality (Appendix 9b; Appendix 9c). Given the extent of the violation, and existing literature (Keppel & Wickens, 2004) that suggests that ANOVA would be sufficiently robust to compensate for the lack of normality, it was considered that a transformation to the data would not be required for this analysis.

3.2 Comparison of the groups at baseline

To identify if there was a significant difference between the two groups following randomisation, firstly a comparison of participant characteristics and mean baseline scores, between the two groups, on each of the dependent variables, are presented in Table 3.1.

Significance testing was then conducted on the baseline characteristics and mean scores, with the following results.

1) A Mann-Whitney U test revealed no significant difference on gender between the factual writing and expressive writing group, U=269, z=-.496, p=.62. 2) An independent-samples t-test was conducted on the mean ages of the participants. Equality of variance was checked using Levene’s test. The test was non-significant p>.05, and therefore equal variances can be assumed. The t-test revealed no significant age difference between the participants in the factual writing group (M=31.17, SD=5.81) compared to the expressive writing group (M=33.36, SD=9.35), t(46) =-.96, p=.34.

2) To identify if there was a significant difference between the groups on the dependent variables and to assess and whether baseline scores should therefore be controlled as a covariate, Independent-samples t-tests were also conducted on the mean scores for each of the dependent variables at baseline. Equality of variance was checked for each of the variables using Levene’s test. In each of the cases Levene’s test was non-significant p>.05, and therefore equal variances can be assumed. The results show no significant differences on each of the variables between the groups at baseline. The results are presented in table 3.2.
Table 3.1 Comparison between the factual writing group and expressive writing group on gender, age and scores on each of the dependent variables.

<table>
<thead>
<tr>
<th>Gender (%)</th>
<th>Factual (N=23)</th>
<th>Expressive (N=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>7 (30.4%)</td>
<td>6 (24%)</td>
</tr>
<tr>
<td>Female</td>
<td>16 (69.6%)</td>
<td>19 (76%)</td>
</tr>
<tr>
<td>Age (SD)</td>
<td>31.17 (5.81) range = 24-52</td>
<td>33.36 (9.35) range =24-63</td>
</tr>
<tr>
<td>Dependent Variables with standard deviation (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WRAR</td>
<td>17.78 (2.56)</td>
<td>17.96 (2.33)</td>
</tr>
<tr>
<td>PHQ8</td>
<td>7.13 (3.33)</td>
<td>6.24 (2.93)</td>
</tr>
<tr>
<td>GAD7</td>
<td>7.22 (3.42)</td>
<td>6.12 (3.5)</td>
</tr>
<tr>
<td>PSQI</td>
<td>6.39 (3.34)</td>
<td>5.84 (2.34)</td>
</tr>
<tr>
<td>I-PANAS-SF:N</td>
<td>13 (2.13)</td>
<td>11.96 (2.56)</td>
</tr>
</tbody>
</table>

Table 3.2 Results of independent samples t-test comparing the two groups at baseline on each of the dependent variables.

<table>
<thead>
<tr>
<th></th>
<th>Factual Group</th>
<th>Expessive Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>WRAR</td>
<td>17.78</td>
<td>2.56</td>
</tr>
<tr>
<td>PHQ8</td>
<td>7.13</td>
<td>3.33</td>
</tr>
<tr>
<td>GAD7</td>
<td>7.22</td>
<td>3.42</td>
</tr>
<tr>
<td>PSQI</td>
<td>6.39</td>
<td>3.34</td>
</tr>
<tr>
<td>I-PANAS-SF:N</td>
<td>13</td>
<td>2.13</td>
</tr>
</tbody>
</table>

3.3 Comparison of the output of the Linguistic Inquiry and Word Count

In order to identify if the study had been successful in creating two different intervention groups the output from the Linguistic Inquiry and Word Count (LIWC) programme (Tausczik & Pennebaker, 2010) was compared between the two groups on three dimensions: Total word count, percentage use of ‘positive/negative emotion’ words, and percentage use of ‘cognitive mechanistic’ words. This third category is composed of insight words such as ‘think’, ‘know’ and ‘consider’, as well as causal words such as ‘because’, ‘effect’, ‘hence’ (Tausczik & Pennebaker, 2010). Independent samples t-tests were employed to compare the groups. Equality
of variance was checked for each of the variables using Levene’s test. In each of the cases Levene’s test was non-significant p>.05, and therefore equal variances were assumed.

1) The results showed no significant difference on the word count for the factual writing group (M=1079.3, SD=523.9) compared to the expressive writing group (M=1189.76, SD=478.37): t(46) = -.76, p=.45.

2) There was a significant difference on the percentage of ‘Cognitive Mechanism’ words used between the factual writing group (M=13.16%, SD=1.45) and the expressive writing group (M=19.6%, SD=2.06): t(46) = -12.44, p<.01 (two-tailed), with the expressive writing group using more ‘Cognitive Mechanistic’ words.

3) There was also a significant difference on the percentage of ‘Positive/Negative Emotion’ words used between the factual writing group (M=1.69%, SD=.4) and the expressive writing group (M=3.16%, SD=.62): t(46) = -9.68, P<.01 (two-tailed), with the expressive writing group using more ‘Positive/Negative Emotion’ words.

In order to identify if the expressive writing intervention facilitated increased cognitive processing, evidenced through the increased use of ‘cognitive mechanistic’ words, a further analysis (paired samples t-test) was conducted to compare the percentage of ‘cognitive mechanistic words’ used by the expressive writing group on ‘day 1’ compared to ‘day 3’. There was no significant difference between ‘day 1’ (M=19.44%, SD=2.84) compared to ‘day 3’ (19.68%, SD=3.56), t(24) = -.31, P=.76.

3.4 Reliability of the scales
To assess the reliability of the scales used to measure each of the dependent variables, the internal consistency (Cronbach alpha coefficient) of each of the scales was calculated at baseline, one month and three months, and then averaged. The inter-item correlation was calculated in the same way (Appendix 10). Research has reported that for internal consistency the Cronbach alpha coefficient should ideally be above .7 (DeVellis, 2003). However it has also been identified that, with scales with less than 10 items, it is often hard to report a good level of internal consistency using the Cronbach alpha coefficient, and that the inter-item correlation should be
reported instead (Pallant, 2007). The optimal range for inter-item correlation has been shown to be .2-.4 (Briggs & Cheek, 1986).

In this study the primary dependent variable of work-related affective rumination (WRAR), was measured on a five item scale, but reported a good level of internal consistency (Cronbach alpha coefficient=.76; inter-item correlation =.41). (Appendix 10) Five of the six other scales used to measure the secondary dependent variables, also contained less than ten items but still reported good or acceptable internal consistency (Cronbach Alpha coefficient >.68; inter-item correlations of .22 to .45) (Appendix 10). One scale, the PSQI, contained more than ten items and reported a Cronbach alpha coefficient of .8 (Appendix 10). Therefore, it is clear that, there was a good level of internal consistency reported for all the scales used to measure the dependent variables.

3.5 Correlations between the variables at baseline.

To identify if Emotional Approach Coping (EAC) should be included as a possible covariate, a correlation analysis (Spearman’s rho) was performed to measure the relationship between the EAC and the other dependent variables at baseline. The non-parametric analysis was employed due to the violation of normality in the data set for work-related affective rumination (WRAR), at baseline, in the factual writing group. The results are presented in table 3.3.

Table 3.3: Correlation analysis showing the relationship between the variables at baseline.

<table>
<thead>
<tr>
<th></th>
<th>WRAR</th>
<th>PHQ 8</th>
<th>GAD 7</th>
<th>IPANASSF:N</th>
<th>EAC</th>
<th>PSQI</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRAR</td>
<td>-</td>
<td>.18</td>
<td>.36*</td>
<td>.19</td>
<td>-.17</td>
<td>.35*</td>
</tr>
<tr>
<td>PHQ8</td>
<td>-</td>
<td>-</td>
<td>.36*</td>
<td>.1</td>
<td>-.11</td>
<td>.46**</td>
</tr>
<tr>
<td>GAD7</td>
<td>-</td>
<td>-</td>
<td>.33*</td>
<td>-.1</td>
<td>.27</td>
<td></td>
</tr>
<tr>
<td>IPANASSF: N</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.15</td>
<td>-</td>
<td>-.01</td>
</tr>
</tbody>
</table>

Strength of correlation: Small =.1-.29; Medium =.3-.49; Large =.5-1 (Cohen, 1988)

** p<.01 (2 tailed), * p<.05

3.6 Description and Analysis (ANCOVA) of the impact of expressive writing on each of the dependent variables

Firstly, for each dependent variable the mean scores for both groups, at each time point, are presented in a graph. Secondly, to examine if the mean scores between the groups are significantly different following the intervention the results of a group
(Factual, Expressive) x time (One month, Three months) repeated measures ANCOVA, controlling for baseline scores, are then reported, accompanied by a table of the adjusted means. If a significant interaction effect was reported, a repeated measures ANOVA looking at the groups separately, and a univariate ANCOVA, looking at each time point separately were conducted. Prior to reporting the ANCOVA, in addition to checks for normality (Appendix 9b+c), preliminary checks were also conducted to ensure that assumptions of linearity, homogeneity of variances, homogeneity of regression slopes, and reliable measurement of the covariate, were not violated.

a) Work-Related Affective Rumination

1) The mean scores on a measure of work-related affective rumination (WRAR) at baseline, one month and three months, for both the factual and expressive group, are plotted in figure 3.1.

![Figure 3.1: Mean scores at baseline, one month and three months, for the factual and expressive writing group on a measure of work-related affective rumination (WRAR).](image)

2) The results of the two by two ANCOVA, with baseline scores controlled as a covariate, report no significant main effect of time, \( F(1,45)=.65, p=.43 \). There was a significant main effect of group, \( F, (1, 45)= 6.5, p<.01 \), with a medium effect size (partial eta squared = .13). This effect was due to the expressive writing group scoring lower on WRAR compared to the factual writing group following the
There was also a group x time interaction, $F(1,45)=3.7$, $P=.06^4$, with a medium effect size (partial eta squared $=.08$). The adjusted mean scores are presented in Table 3.4.

**Table 3.4 Adjusted WRAR mean scores with baseline scores controlled as a covariate.**

<table>
<thead>
<tr>
<th>Group</th>
<th>Time</th>
<th>Adjusted Mean</th>
<th>Std error</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Month</td>
<td>2 Months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressive</td>
<td>15.29</td>
<td>17.02</td>
<td>.46</td>
<td>25</td>
</tr>
<tr>
<td>Factual</td>
<td>16.73</td>
<td>15.57</td>
<td>.48</td>
<td>23</td>
</tr>
</tbody>
</table>

WRAR as a baseline covariate was evaluated at the value 17.88

Given the reporting of a significant interaction, a one way repeated measures ANOVA was conducted to compare the scores on WRAR at baseline, one month and three months for each of the groups. The additional assumption of sphercity was not violated in either group. The results show no significant difference on scores of WRAR for the factual writing group over time, Wilk's Lamda $=.86$, $F(2,21)=1.78$, $p=.19$. The results show a significant difference on scores of WRAR, for the expressive group, over time, Wilk's Lamda $=.488$, $F(2,23)=1.21$, $p<.01$, with a 'large' effect size (multi variate partial eta squared $=.512$).

The results of a univarite ANCOVA, looking at one month and three months separately, then show that at one month there was no significant difference between the groups, $F(1,45)=2.1$, $p=.16$. However at three months there was a significant difference, $F(1,45)=8.57$, $p<.01$, with a 'large' effect size (partial eta squared $=.16$). This was due to the expressive writing group reporting lower levels of WRAR ($m=14.4$, $SD=3.23$) than the factual writing group ($m=16.74$, $SD=2.78$) at the three-month outcome stage.

These results suggest that in the expressive writing group work-related affective rumination (as measured on the WRAR scale), reduced both at one month and three months, compared to the baseline. There was no significant reduction in the factual writing group over time at either one month or three months. The results also suggest

---

^4 .06 was considered an acceptable level of significance given that it then allowed for further analysis of the interaction. In studies with smaller samples it has been suggested that .1 or even .15 can be used as levels of significance (Stevens, 1996).
that there was a significant difference between the expressive writing group and the factual writing group at three months.

b) Patient Health Questionnaire (PHQ8)

1) The mean scores on the PHQ8 at baseline, one month and three months, for both the factual writing and expressive writing group, are plotted in figure 3.2.

![Figure 3.2: Mean scores at baseline, one month and three months, for the factual and expressive writing group on the PHQ8.](image)

2) The results of a two by two ANCOVA, with baseline scores controlled as a covariate, report no significant main effect of time on scores on the PHQ8, $F(1,45)=1.65$, $p=.21$. There was also no group x time interaction, $F(1,45)=.08$, $P=.77$. There was however a significant main effect of group, $F,(1,45)= 6.24$, $p<.05$, with a 'medium' effect size (partial eta squared $=.12$). The adjusted mean scores are presented in table 3.5. This result is due to the expressive writing group scoring lower on the PHQ8, compared to the factual writing group, following the intervention.

Table 3.5: Adjusted PHQ8 mean scores with baseline scores controlled as a covariate.

<table>
<thead>
<tr>
<th>Group</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Month</td>
</tr>
<tr>
<td><strong>Expressive</strong></td>
<td>4.92</td>
</tr>
<tr>
<td><strong>Factual</strong></td>
<td>6.77</td>
</tr>
<tr>
<td><strong>Adjusted Mean</strong></td>
<td>.52</td>
</tr>
<tr>
<td><strong>Std error</strong></td>
<td>.47</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>25</td>
</tr>
</tbody>
</table>

PHQ8 (baseline) covariate was evaluated at the value 6.67
c) Generalised Anxiety Disorder (GAD7)

1) The mean scores on the GAD7 at baseline, one month and three months, for both the factual and expressive group, are plotted in figure 3.3.

![Generalised Anxiety Disorder (GAD7)](image)

**Figure 3.3: Mean scores at baseline, one month and three months, for the factual and expressive group on a measure of generalised anxiety disorder (GAD7).**

2) The results of the 2 by 2 ANCOVA, with baseline scores controlled as a covariate, report no significant main effect of time on scores on the GAD7, $F(1,45)=.187$, $p=.67$. There was also no group x time interaction, $F(1,45)=.23$, $P=.63$. There was however a significant main effect of group, $F, (1, 45)= 6.67, p<.05$, with a ‘medium’ effect size (partial eta squared =.13). The adjusted mean scores are presented in table 3.6. This result is due to the expressive writing group scoring lower on the GAD7, compared to the factual writing group, following the intervention.

<table>
<thead>
<tr>
<th>Group</th>
<th>Time</th>
<th>Adjusted Mean</th>
<th>Std error</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Month</td>
<td>3 Months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressive</td>
<td></td>
<td>4.78</td>
<td>.57</td>
<td>25</td>
</tr>
<tr>
<td>Factual</td>
<td></td>
<td>6.91</td>
<td>.59</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>6.16</td>
<td>5.53</td>
<td>.47</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>48</td>
<td>.5</td>
<td></td>
</tr>
</tbody>
</table>

GAD7 (baseline) as a covariate was evaluated at the value 6.65

| 179 |
d) International Positive and Negative Affect Scale-Short Form: Negative.

1) The mean scores on the I-PANAS-SF:N at baseline, one month and three months, for both the factual writing and expressive writing group, are plotted in figure 3.4.

![I-PANAS-SF (Negative)](image)

Figure 3.4: Mean scores at baseline, one month and three months, for the factual writing and expressive writing group on a measure of Negative Affect (I-PANAS-SF:Negative).

2) The results of the 2 by 2 ANCOVA, with baseline scores controlled as a covariate, report no significant main effect of time on scores of negative affect (I-PANAS-SF:N), $F(1,45)=.18$, $p=.67$. There was no group x time interaction, $F(1,45)=2.13$, $P=.15$. There was a significant main effect of group, $F, (1, 45)= 7.27$, $p=.01$, with a 'medium' effect size (partial eta squared =.14). The adjusted mean scores are presented in table 3.7. This result is due to the expressive writing group scoring lower on the measure of 'negative affect' compared to the factual writing group following the intervention.

Table 3.7 Adjusted I-PANAS-SF:N mean scores with baseline scores controlled as a covariate.

<table>
<thead>
<tr>
<th>Group</th>
<th>Time</th>
<th>Adjusted Mean</th>
<th>Std error</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expression</td>
<td>Factual</td>
<td>1 Month</td>
<td>3 Months</td>
</tr>
<tr>
<td>Adjusted Mean</td>
<td>10.99</td>
<td>12.73</td>
<td>12.06</td>
<td>11.65</td>
</tr>
<tr>
<td>Std error</td>
<td>.44</td>
<td>.46</td>
<td>.31</td>
<td>.36</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>23</td>
<td>48</td>
<td>48</td>
</tr>
</tbody>
</table>

I-PANAS-SF (N) (baseline) covariate was evaluated at the value 12.46
e) Pittsburg Sleep Quality Index (PSQI)

1) The mean scores on the PSQI at baseline, one month and three months, for both the factual and expressive writing group, are plotted in figure 3.5.

![Pittsburg Sleep Quality Index](image)

Figure 3.5: Mean scores at baseline, one month and three months, for the factual and expressive writing group on a measure of Sleep Quality (PSQI).

2) The results of the 2 by 2 ANCOVA, with baseline scores controlled as a covariate, report no significant main effect of time on scores on the PSQI, $F(1,45)=.107$, $p=.75$. There was also no group x time interaction, $F(1,45)=1.81$, $P=.19$. There was a significant main effect of group, $F, (1, 45)= 11.01$, $p<.01$, with a ‘large’ effect size (partial eta squared =.2). The adjusted mean scores are presented in table 3.8. This result is due to the expressive writing group reporting better scores on the measure of sleep quality compared to the factual writing group following the intervention.

Table 3.8 Adjusted PSQI mean scores with baseline scores controlled as a covariate.

<table>
<thead>
<tr>
<th>Group</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expressive</td>
</tr>
<tr>
<td>Adjusted Mean</td>
<td>4.36</td>
</tr>
<tr>
<td>Std error</td>
<td>.4</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
</tr>
</tbody>
</table>

PSQI (baseline) covariate was evaluated at the value 6.1
3.7 Correlations between change scores on the dependent variables.

To examine the relationship between change in the primary dependent variable, work-related affective rumination, and changes in each of the secondary variables a correlation analysis was performed between the dependent variables, in terms of change scores, following the intervention, in the expressive writing group. The change scores were calculated by subtracting the three-month outcome scores from the baseline scores for each of the variables. A non-parametric test (Spearman’s rho) was employed due to the violation of normality in the one-month and three-month change scores on the PSQI (Appendix 9d). The results are reported in table below.

Table 3.9
Correlations (Spearman’s rho) between change scores following an expressive writing intervention on work-related affective rumination (WRAR), depression (PHQ8), anxiety (GAD7), 'negative affect' (I-PANAS-SF: N), and sleep quality (PSQI), in the expressive writing group.

<table>
<thead>
<tr>
<th></th>
<th>N=25</th>
<th>WRAR</th>
<th>PHQ8</th>
<th>GAD 7</th>
<th>I-PANAS-SF: N</th>
<th>PSQI</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRAR</td>
<td></td>
<td>.45*</td>
<td></td>
<td>.51**</td>
<td>.37</td>
<td>.46*</td>
</tr>
<tr>
<td>PHQ8</td>
<td></td>
<td></td>
<td>.45*</td>
<td></td>
<td>.38</td>
<td>.47*</td>
</tr>
<tr>
<td>GAD 7</td>
<td></td>
<td></td>
<td></td>
<td>.47*</td>
<td></td>
<td>.43*</td>
</tr>
<tr>
<td>I-PANAS-SF: N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.7**</td>
<td></td>
</tr>
<tr>
<td>PSQI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strength of correlation: Small =.1-.29; Medium =.3-.49; Large =.5-1 (Cohen, 1988)

** p<.01 (2 tailed), * p<.05

3.8 Feedback

At the end of the writing task participants were offered the chance to give written feedback on how they found the exercise. Fourteen out of the forty-eight participants completed the feedback section. Specific quotes from the feedback have been reproduced in this section to highlight some of the participants attitudes towards the expressive writing intervention and to support the assertion that it is an intervention that people are willing to complete. No qualitative analysis has been applied to this data.

Participant 11
‘Actually, I rather enjoyed it. I used to write a daily diary years ago and found it most therapeutic.’
Participant 110
'I found this exercise very interesting. I realised my writing went a lot deeper than I had expected and I found myself reflecting in new ways and drawing different comparisons than I had previously done. This exercise happened at the same time as quite a tough period in my work so there was a lot of raw emotions around already and this exercise has in fact helped me to process some of that.

Participant 213
'This was quite a 'release' a bit like chatting to a friend or writing a diary. However a stressful situation doesn't necessarily occur every day of the week (well it depends on the weeks) so I wouldn't say that this was necessarily applicable to each day. I answered this truthfully however and hope that my thoughts are beneficial to your research. One thing that I learnt having read back my thoughts is that my stress often comes from the worry of people's perceptions of me.'

Discussion
4.1 Overview
Firstly, the discussion considers the main findings of the study, in relation to the initial hypotheses and related research. Secondly, theoretical reasons for the findings are explored. Thirdly, methodological issues are addressed. Fourthly, the implications for clinical practice are considered. Finally, potential areas for future research are identified.

4.2 Main Findings
a) Hypothesis 1: Work-related affective rumination.
It was hypothesised that completion of the expressive writing intervention would reduce work-related affective rumination, in a sample of 'white-collar' workers, in comparison to completion of a factual writing task. The results of the study support this hypothesis. It is evident that participants in the expressive writing group experienced a reduction in work-related affective rumination, following the completion of the intervention, at both one month and three months. The results also identify that the reduction in work-related affective rumination in the expressive writing group was significantly different from the factual writing group at the three month outcome stage, and a 'medium' effect size was reported for this difference.
Considering how this result relates to previous research in the area it is evident that, although this is the first study to report findings in the area of expressive writing and work-related affective rumination, the result is in line with related research. Existing research has shown the positive impact of expressive writing on the area of work, specifically on feelings of organisational injustice (Barclay & Skarlicki, 2009) and job loss (Spera et al, 1994). The result is also in line with research that has indicated the moderating role of rumination on expressive writing (Gotner et al, 2006; Sloan et al, 2008).

The reported ‘medium’ effect size is similar to the effect sizes reported in the 1998 meta-analytic study of expressive writing (Smyth, 1998). However, it contrasts with the ‘small’ effect sizes reported in more recent meta-analytic studies (Frattaroli, 2006; Frisina et al, 2004). A reason offered for the disparity in effect sizes is that the expressive writing intervention is thought to impact on certain populations and difficulties more than others (Mogk et al, 2006). Therefore the ‘medium’ effect size reported in this study suggests that expressive writing is effective for this specific population.

b) Hypothesis 2: Related health benefits  
It was also hypothesised that completion of the expressive writing intervention would reduce related health difficulties, such as depression, anxiety, ‘negative affect’, and poor sleep, compared to the completion of a factual writing task. This hypothesis is supported by the results. It is evident that participants in the expressive writing group scored significantly lower on measures of depression (PHQ8), anxiety (GAD7), and ‘negative affect’ (I-PANAS-SF:N) compared to the factual writing group, following the intervention. Participants in the expressive writing group also scored significantly higher, compared to the factual group, on a measure of sleep quality (PSQI).

These results are in line with previous research on the impact of expressive writing on each of these difficulties (de Moor et al, 2002; Lepore, 1997; Fernandez & Paez, 2008; Smyth & Helm, 2003). However previous research has focussed on very
specific populations. For example the research on the impact of expressive writing on sleep (de Moor et al, 2002) focussed on patients with renal cancer. Therefore the results of this study add to the existing evidence base in the area of expressive writing by reporting that expressive writing is also effective for this specific sample of primarily British ‘white-collar’ workers who experience work-related affective rumination. The study also reported ‘medium’ to ‘large’ effect sizes for the significant differences between the expressive writing and factual writing group, on each of the dependent variables. These effect sizes are consistent with the findings of the 1998 meta-analysis (Smyth, 1998), and add further support to the idea that expressive writing is effective for this specific population.

c) Hypothesis 3: Moderating effect of Emotional Approach Coping
It was also hypothesised that the effect of the expressive writing intervention would be moderated by levels of Emotional Approach Coping (EAC), measured on the EAC scale. The results of the study did not report a correlation between EAC and work-related affective rumination. Therefore it was not included in the analysis as a possible covariate. The finding that EAC did not moderate the impact of the intervention is not consistent with the research in the area, however there are also inconsistencies within the current literature, with both low and high levels of Emotional Approach Coping having been shown to enhance the effects of the paradigm (Gotner et al, 2006; Kraft et al, 2008; Lumley, 2004).

It could be argued that this non-significant finding in this study relates to the fact that the EAC scale is composed of two subscales, emotional processing and emotional expression. Given existing theories of emotion suppression and expressive writing (Pennebaker, 1989), it could be assumed that pre-existing low levels of Emotional Expression would enhance the benefits of the paradigm. However in line with theories of Alexithymia and expressive writing (Lumley, 2004), it could be argued that pre-existing low levels of Emotional Processing would reduce the benefits of the paradigm. Therefore it would appear that levels of Emotional Processing and Emotional Expression would moderate the impact of the intervention differently. As a result further research on expressive writing and work-related affective rumination
may wish to look at the moderating role of emotional expression and emotional processing separately.

d) Timing of outcome measures

No specific hypothesis was tested regarding whether changes in the expressive group, on each of the dependent variables, would be observed at the one month or three month outcome stage. This was due to the mixed evidence, regarding the durability of the intervention (Pennebaker & Chung, 2007). Previous research suggests that there is no set pattern regarding the time that health benefits occur following the intervention (Pennebaker & Chung, 2007). Studies have shown that benefits can occur immediately and subside quickly or benefits may only be observed months after the intervention (Pennebaker & Chung, 2007). For example Sloan et al (2009) looked at the effects of expressive writing on a number of physical and psychological health difficulties in college students (Sloan et al, 2009). The findings report that the expressive group differed significantly, on a measure of depression, from the ‘control’ group at the two month outcome stage, but not at the four or six month outcome stage. This indicates that the intervention had short-term benefits. However an earlier study by Sloan et al (2008) had found that expressive writing reduced depressive symptoms in people with a ‘brooding’ ruminative style up to six months after completing the intervention (Sloan et al, 2008).

Given the similarity between a ‘brooding’ ruminative style and ‘affective rumination’ it could be argued that the effects of the intervention in this study would be less short lived and would be observed at the three month outcome stage. This idea is partially supported by the findings; There was a significant difference in levels of work-related affective rumination between the factual writing and expressive writing group, following the intervention at three months but not at one month outcome. However for depression, anxiety, ‘negative affect’ and sleep quality, although an overall difference was observed between the factual and expressive writing group following the intervention, there was no significant difference between the one month and three month outcome stage.
4.3 Theoretical explanations for the findings

The results of the Linguistic Inquiry and Word Count (LIWC) indicate possible reasons for the significant changes reported for each of the dependent variables, following the expressive writing paradigm. These reasons are consistent with theories of emotional disinhibition (Pennebaker, 1989) and cognitive restructuring (Lu & Stanton, 2010, Pennebaker & Chung, 2007). The analysis of the output of the LIWC indicates that the expressive writing group used a higher percentage of ‘positive/negative emotion’ words than the factual writing group. This suggests that the expressive group may have benefitted from increased emotional disinhibition, regarding work difficulties, during the intervention. The expressive writing group also used a higher percentage of ‘cognitive mechanistic’ words than the factual group. This again would suggest that the expressive group benefitted from the opportunity to employ increased cognitive restructuring, regarding work difficulties, compared to the factual writing group.

This finding, however, is qualified by the non-significant difference reported between the use of ‘cognitive mechanistic’ words used on ‘day 1’ compared to ‘day 3’, in the expressive group. Research indicates that the expressive writing paradigm promotes health by facilitating increased cognitive restructuring (Pennebaker & Chung, 2007), which is often evidenced by a significant difference in the percentage of ‘cognitive mechanistic’ words used on ‘day 1’ compared to ‘day 3’ (Tausczik & Pennebaker, 2010). This difference did not occur in this study. Therefore the results only partially support the theory that a combination of emotional expression and cognitive restructuring are responsible for the observed changes.

4.4 Methodological Issues

Weaknesses

a) Sample Attrition

There was a 68% attrition rate between inviting the 147 participants to take part in the main study and the 48 participants that were included in the final analysis. This loss was perhaps due to the level of commitment needed from each participant.
Certainly the feedback from one participant, who completed the baseline measures but not the writing instruction, was that the task would take too long.

This attrition impacted on the external validity of the findings, in terms of the generalisability to the general population. The initial 147 participants invited to take part reported a range of ethnicities, however this range was smaller in the final sample, especially in the expressive writing group, but also in the factual writing group. Therefore the findings of the study can only be generalized primarily to a sample of British 'white-collar' workers. This is in line with the majority of the research on work-related rumination, which has also focused on 'white-collar' workers (Cropley & Millward, 2003; Cropley et al, 2006).

In terms of the level of attrition, previous research attempting to conduct an RCT of expressive writing in a clinical setting reported that the attrition rate was too great to conduct the study (Bruera et al, 2008). Similarly research (Stone, 2006), looking at the effects of expressive writing on re-employment following job loss, reported significant difficulties caused by high levels of attrition. The measures in the Stone study (Stone, 2006) were recorded online and the author comments that increased personal interaction with the researcher, and the use of briefer outcome measures may have enhanced retention (Stone, 2006).

Given the existence of this research, brevity was considered in choosing the outcome measures for the current study. Within the ethical limitations the study also sought to increase personalisation, by writing the participants' names on the correspondence emails, rather than employing an anonymous standard email. The option of having the writing exercise completed online was also considered. It was thought that an online intervention may have improved retention due to accessibility, however it was felt that given research on the work/home boundary (Chesley, 2005), it may have impacted on levels of rumination and reduced the potential benefits. Therefore although there was attrition in the sample, this was expected given previous research (Bruera et al, 2008; Stone, 2006), and attempts were made to minimise its impact.
b) Adherence
The postal design of the study meant that a possible confounding variable, relating to adherence, was introduced. Although the study requested that participants write for 20 minutes a day, it is evident that there were large differences in the average word count for each participant. This variation could be due to writing speed, however it could indicate that the 20 minute writing time was not adhered to, and this could not be controlled for. However, research indicates that the amount of words produced should not impact on the effectiveness of the intervention (Pennebaker & Chung, 2007) and therefore this variation should not be a significant factor in mediating the potential benefits of the writing task in the expressive writing group.

c) Confidentiality
Participants were informed that, although the writing would remain confidential, the transcripts would be read. In line with theories of emotional expression, and avoidance of negative evaluation (Pennebaker, 1989), it could be argued that the emotional content of the transcripts for the expressive group may have been restricted due to a fear of negative evaluation by the researcher. Feedback from one participant suggests that the participant had felt restrained in their writing, given that they knew the writing would be read. Considering this finding, in relation to the general research trials of expressive writing, it is evident that most trails would experience the same limitation. It would also indicate that the benefits of expressive writing might be greater in a ‘real world’ setting, when the transcripts are not being read as part of a study.

d) Causality
As discussed, participants in the expressive writing group reported a reduction in work-related affective rumination. They also reported reductions in related somatic and psychological difficulties, such as depression, anxiety, ‘negative affect’ and poor sleep. It appears, given that no significant reductions were reported in the factual writing group, that the expressive writing intervention was the primary agent of change. Extrapolating this inference further, it could also be argued that it was the
reduction in work-related affective rumination that then caused the reduction in the related health difficulties.

This pathway is supported by the results that show that work-related affective rumination was positively correlated with depression, anxiety, and poor sleep at baseline (Table 3.3, P46). It is also supported by the results that show a reduction in work-related affective rumination positive correlated with a reduction in depression, anxiety and poor sleep (Table 3.9.1, P53). These findings are also consistent with research that has previously found a correlation between rumination and both anxiety and depression (Harrington and Blakenship, 2006), and poor sleep (Guastella & Moulds, 2007).

However expressive writing has also been shown to directly impact on these health difficulties, in studies where rumination has not been measured (de Moor et al, 2002; Fernandez, & Paez, 2008; Lepore, 1997; McGuire et al, 2005; Smyth & Helm, 2003), Therefore it cannot be assumed that a reduction in rumination caused the changes in the other dependent variables. For example it could be argued, although contrary to research, that the intervention caused a reduction in anxiety, which then led to a reduction in rumination and other health difficulties. As a result the relationship between a reduction in work-related affective rumination and a reduction in the related health difficulties cannot be viewed as causal.

**Strengths**

a) The design

By employing a rigorous randomised experimental design the study adds robust findings to the evidence base in the area of expressive writing and work-related affective rumination. The fact that no significant differences were observed between the expressive writing group and factual writing group at baseline, suggests that the randomisation procedure was successful.
b) Reliability and appropriateness of the scales

A good level of internal consistency was reported for each of the measures, which adds to the robustness of the findings regarding the reported significant difference between the expressive writing and factual group on each of the dependent variables, post intervention. The scales for the dependent variables were also chosen to be appropriate for the sample; The International Positive and Negative Affect Scale-short form (I-PANAS-SF) was used to measure ‘negative affect’, as research (Thompson, 2007) suggests it is more appropriate to use this form of the PANAS with participants in employment, who have limited spare time. Similarly, the PHQ8 was chosen to measure depression, as it has been identified as an appropriate alternative to the PHQ9, if it is being used as an unsupported self-report questionnaire as part of an Internet survey (Kroenke & Spitzer, 2009).

c) Diversity of the sample population

A number of research studies on expressive writing and rumination have used college students as participants (Sloan et al, 2008, Sloan et al, 2009). Also previous research specifically on work-related rumination has often used teachers as participants (Cropley & Millward, 2003; Cropley et al 2006). Despite the noted attrition in this study, it is evident that the sample in this study did succeed in recruiting a more diverse population, in terms of occupation (Appendix 3); Participants reported working in a range of job sectors, primarily within the ‘white-collar’ professions. Therefore the findings have good external validity, as they are relevant in a ‘real world’ setting and can be generalised to a range of occupations.

4.5 Clinical Implications

a) Statistical vs. Clinical Significance

In discussing the clinical implications a distinction between statistical significance and clinical significance has been drawn. Although the results show a significant statistical reduction in work-related affective rumination and related health difficulties, it is evident that this reduction may only have been clinically significant in a number of cases, due to the sample being drawn from a ‘healthy’ population. For example only 10 out of the 48 participants scored above 10 on the GAD7 at baseline,
thus meeting the criteria for a diagnosis of generalised anxiety disorder (Robinson et al, 2010). In addition only 4 participants (from the expressive writing group) out of the 10 reported a 50% reduction in anxiety at the three month outcome stage, which would meet the criteria for a clinical recovery (Robinson et al, 2010). Therefore, although the results indicate a statistically significant reduction on each of the dependent variables following the expressive writing intervention, clinical significance may only have been reached in a minority of cases.

Despite this qualification, the ‘medium’ to ‘large’ effect sizes reported in this study, suggest that the intervention can be effective in reducing work-related affective rumination, and impact positively on depression, anxiety, ‘negative affect’ and poor sleep. Given that one of the benefits of expressive writing is that it allows for emotional expression without fear of negative evaluation (Pennebaker, 1989), it could be argued that levels of emotional expression would have been higher if the intervention had not been part of a clinical trial, where the participant was aware that the transcripts would be read. This in turn might have enhanced the impact of the intervention.

Therefore, in terms of the clinical implications, it is evident that expressive writing could be a cost effective, easy to administer intervention for reducing work-related affective rumination. In terms of time and cost, the intervention only requires an hour to complete, spread over three days, and it can be self-administered. In terms of the relevance to population under investigation it has been shown that high work-related affective ruminators work more than their contracted hours and report having limited spare time (Cropley & Millward, 2009). Therefore expressive writing would appear to be an appropriate intervention for reducing this type of difficulty in a population with time limitations. The suggestion that this intervention would be of benefit to this ‘time poor’ client group is further supported by the feedback, reported in the results, from a number of participants in the expressive writing group, which suggests that they found the intervention, ‘enjoyable’ ‘interesting’ and ‘cathartic’.
b) Application

The findings from the study suggest that expressive writing is an appropriate intervention, that people are willing to undertake, for reducing work-related affective rumination. The rationale for identifying ways of reducing work-related affective rumination was that research suggests that the 'affective component' of the rumination causes arousal, which then inhibits detachment and prevents 'switching off'. This results in increased work stress, and causes a number of health difficulties (Cropley & Millward, 2009). Therefore it would appear that expressive writing would be of benefit to people that affectively ruminate about work.

Previous research has identified that a number of techniques can be employed to reduce rumination, such as distraction, goal attainment and disengagement (Martin and Tesser, 1989). Applying these concepts to work-related rumination, more recent research has suggested that a number of strategies, such as re-defining the work/home boundary, increasing goal attainment by breaking tasks into manageable chunks and promoting disengagement, through cognitive strategies, could be used to reduce this form of rumination (Cropley & Millward, 2009). Therefore it could be argued that it would also be appropriate to include expressive writing, focusing on the 'affective' component, as part of a comprehensive intervention designed to reduce work-related rumination.

4.6 Suggestions for future research

a) Developments to the current study

**Gender**

The current study was able to answer the initial hypotheses, and indicates the effectiveness of expressive writing on work-related affective rumination, and related health benefits. However, limitations regarding the sample size prevented further analysis of the moderating role of variables such as gender. Past research has indicated than men may benefit more from expressive writing than women (Smyth, 1998). In this study the sample size was small, and contained a significant gender bias. Of the 269 participants that were screened 64.7% were women, and of the 48 participants that completed the study 72.9% were women. As a result it was not
possible to accurately identify if expressive writing was more effective at reducing work-related rumination for men or women. Future research, therefore, might wish to examine if the effects of expressive writing on work-related affective rumination, are moderated by gender.

**Durability**

The study was also unable to provide evidence regarding the long-term durability of the intervention on work-related affective rumination. The results indicate that the most significant difference between the expressive writing and factual writing group occurred at the three month outcome stage. However, as the only time points measured were at baseline, one month and three months, there are no findings to indicate if this difference would have increased or reduced in the following months. Previous research has also shown an effect of expressive writing at six months (Sloan et al, 2008). Therefore future research might also wish to measure the impact of expressive writing on work-related affective rumination at six months, to further add to the evidence base regarding the durability of the intervention in this area.

**Underlying Mechanisms**

Theories state that emotional expression and cognitive re-structuring are possible mechanisms that contribute to the health benefits of expressive writing (Lu & Stanton, 2010; Pennebkaer & Chung, 2007). The same body of research also indicates that improved social activity and integration may also contribute to improved health benefits (Pennebaker & Chung, 2007). In order to add further evidence to the research on the underlying mechanisms by which expressive writing results in a reduction in work-related affective rumination, future research might wish to measure levels of social activity following the intervention.

**b) Alternative interventions**

This study showed that, in comparison to the factual writing task, the expressive writing task was effective in reducing work-related affective rumination. However it would also be useful to be able to compare its effectiveness to other possible interventions. Previous research has identified that Mindfulness (Kabat-Zinn, 1990)
may be an appropriate intervention for reducing rumination (Borders et al, 2010) and it would be useful to compare the effectiveness of these two strategies on work-related affective rumination. It is apparent from the transcripts that when prompted to write about past experiences and thoughts of the future the views expressed by the participants’ were often negative. Therefore it would seem appropriate to identify if Mindfulness could be employed to reduce rumination by emphasising a greater awareness of the present, which is a key aim of Mindfulness technique (Kabat-Zinn, 1990).

Considering alternative strategies to reduce work-related affective rumination, research might also wish to examine the use of ‘blogging’ through Internet sites such as ‘Twitter’\(^5\). Blogging is described as the process of posting thoughts, experiences and feelings online (Wapner, 2008). This form of written expression would appear to share a number of characteristics with expressive writing. It has also been shown to be growing in popularity. It is estimated that in the U.K there are 5.5 million Twitter users and a recent study has shown that people are joining the site at the rate of 300,000 a day (Huntingdon Post, 2010, April). Therefore it could be argued that some people are already using this as a form of emotional expression (Wapner, 2008). However in terms of work-related affective rumination, it would be interesting to explore the dichotomy between the use of ‘blogging’ to facilitate expression, and the fact that the devices used to ‘blog’, such as mobile phones and ‘Blackberries’, have been shown to blur the work/home boundary (Chesley, 2005), and hinder disengagement. It would also be important to consider that ‘blogging’ is different to expressive writing, given that it is designed to be viewed by others, although it could be argued that it still protects against negative evaluation because the ‘blogger’ is not aware of the recipient or their response.

c) Wider Implications
The specific aim of this study was to identify if expressive writing can be used to reduce work-related affective rumination, and the findings suggest that it can. Related research has suggested that a reduction in work-related affective rumination

\(^5\) Twitter is a social network website where people post their thoughts and feeling on the internet.
may facilitate the process of ‘switching off’ by reducing the ‘affective’ arousal causing component of work-related rumination (Cropley & Millward, 2009). This may then result in reduced work-related stress (Cropley & Millward, 2003) and impact positively on related health difficulties (Suadicani et al, 1993). However this pathway was not directly explored in this study. Ongoing work stress has been shown to be associated with physiological difficulties, such as increased blood pressure (Steptoe et al, 1999; Vrijkotte et al, 2000). Future research might, therefore, use levels of ambulatory blood pressure as an outcome measure to identify if, as predicted, a reduction in work-related affective rumination then lowers arousal levels, facilitates ‘switching off’ and impacts positively on work-related stress.

CONCLUSION
This experimental study was successful in effectively demonstrating the positive impact of expressive writing on work-related affective rumination, in a sample of British ‘white-collar’ workers. This finding is the first in the area to explicitly address expressive writing and work-related affective rumination, and contributes to the existing evidence base. The results also show that the expressive writing intervention impacted positively on related health difficulties, such as anxiety, depression, ‘negative affect’ and poor sleep.

Interestingly, the results of the study do not support the initial hypothesis that the impact of the intervention would be moderated by pre-existing levels of Emotional Approach Coping (EAC). As discussed earlier, this finding perhaps relates to the use of a homogenous scale that combines emotional processing and emotional expression, and future research might wish to look at these factors separately.

In considering whether the initial hypotheses were met, a number of weaknesses associated with the study were considered. Firstly it was evident that the external validity of the findings was reduced due the attrition in the sample. Secondly it was also clear that adherence could not be controlled, and may have caused variations in word count scores between participants. However research indicates that this should not impact on the benefits of the expressive writing paradigm. Thirdly the fact that
anonymity could not be offered was also considered to be a weakness, which may have reduced participants' willingness to share sensitive information and reduced the potential effect of the intervention. Fourthly the impact of a reduction in work-related affective rumination on the related health difficulties could not be identified as causal.

It is evident, however, that there were also a number of strengths to this study. Firstly the diversity of the population, in terms of occupation, secondly the effectiveness of the randomisation procedure, and thirdly the appropriate choice of scales to measure the dependent variables, Considering these strengths, and qualifications to the weaknesses, it is evident that there are clear clinical implications associated with the results, as the findings suggest that expressive writing can be used to reduce work-related affective rumination. This is of importance as expressive writing is a cost effective, accessible intervention that can reach a population that has limited time.

However expressive writing is not the only technique thought to reduce rumination, and therefore future research might wish to compare the effectiveness of expressive writing to interventions such as Mindfulness (Kabat-Zinn, 1990), or behavioural interventions that seek to reinforce the work/home boundary (Cropley & Millward, 2009), with a view to creating a comprehensive intervention to reduce work-related affective rumination. In line with the rationale for the study, future research might also wish to identify if a reduction in work-related affective rumination then facilitates 'switching off' and impacts positively on work-related stress.
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Appendices
Appendix 1

Literature review process
Literature Review

1) Initial Searches were conducted for 'work-related affective rumination', 'affective rumination', 'work and rumination' and 'expressive writing', as well as 'emotional disclosure'. Secondary searches then cross checked 'expressive writing' with, 'work', 'job' and 'rumination'. Reference sections of key articles by Pennebaker, J.W. for expressive writing, and Cropley, M. for work-related rumination, were then used to generate further references. The results of the search are listed in Tables 1-5 below.

The searches resulted in 796 citations. From which 129 relevant abstracts in English were selected for the review. Abstracts were selected on the grounds of how they related to rumination in the context of work, or expressive writing in the context of work, or other related health benefits. Studies that sought to explain the underlying mechanisms of expressive writing were also included. Only peer reviewed articles, and articles with adult samples, were included.

Out of the 129 abstracts 43 abstracts were identified as being directly relevant to the study, and the full texts were retrieved and included in the review. The quality of the studies was considered, however, given the paucity of research on the topic, the type of design did not exclude studies.

Tables 1-5 show the results of the Literature Search on each of the search engines
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209
Appendix 2

Reported ethnicities
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Reported Ethnicities of the 269 participants screened
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Appendix 2b

Reported Ethnicities of the 25 participants in the expressive writing group
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Appendix 2c
Reported ethnicity of 23 participants in the factual writing group
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Reported job sectors
Table of the job sectors that the 48 participants reported working in.

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<td>Restaurant</td>
</tr>
<tr>
<td>Corporate Finance</td>
<td>Marketing</td>
<td>Sport Science</td>
</tr>
<tr>
<td>Design &amp; Branding</td>
<td>Media advertising</td>
<td>Surveying - commercial</td>
</tr>
<tr>
<td>Design Industry</td>
<td>NHS</td>
<td>Teaching</td>
</tr>
<tr>
<td>Education</td>
<td>Occupational Therapist</td>
<td>Theatre</td>
</tr>
<tr>
<td>Environmental services</td>
<td>Physiology</td>
<td>Theatre Management</td>
</tr>
<tr>
<td>Film</td>
<td>Politics/government</td>
<td>Voluntary</td>
</tr>
</tbody>
</table>
Appendix 4
Letter of Ethical Approval
7th August 2009

Dear Richard

Reference: 342A-PSY-09 RS
Title of Project: a randomised control trial of expressive writing: Does expressive writing reduce affective rumination and related negative health symptoms in people that affectively ruminate about work during their leisure time

Thank you for your re-submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[ Signature ]

Dr Adrian Coyle
Appendix 5
Online study information and consent form
Affective Rumination, Expressive Writing and Health Study

Participant Information

Purpose of the Study?
This study aims to identify if expressive writing can reduce the amount of people think about work (ruminate) during their leisure time.

What will the study involve?
The first part of the study will ask you to fill in an online questionnaire about work and rumination. This will take approximately 5 minutes. If your responses suggest that you ruminate about work you will be invited to complete the second part of the study which requires you to fill in an online questionnaire about your health and you will be sent one of two writing exercises. The exercise involves writing about work for 20 minutes on three consecutive days. It is completed in your own home. You will then return the completed exercise in a pre-paid stamped addressed envelope. A copy will then be made and the originals returned to you. Approximately one month and three months after completing the writing exercise you will be asked to again complete the online questionnaire. At the end of the study you will receive a sheet explaining the study and you will be able to email the researcher to receive feedback on your results. In total the study should require no more than two hours of your time and could have a positive impact on your ability to disengage from work.

Will my answers and writing script be confidential?
Your responses will only be viewed by the researcher and you will be allocated a numerical I.D and this will insure that your responses, including the writing transcript, will remain anonymous and confidential. During the study you will be asked to supply your name and contact details. These will be used to send you three emails guiding you through the study and your postal address will be used to send the writing exercise.

The data from the study will be kept for five years and may be used for publication and no information from the writing exercise will be used. No identifiable details will be stored with the data or appear in a publication.

Are there any risks in taking part?
It is considered that the risks in taking part in the study are negligible. Previous research has shown that people very occasionally experience a slight increase in psychological distress for a brief time immediately following completion of the writing exercise. This is thought unlikely to occur in most instances, however if this does happen and the symptoms of distress persist then you can contact the researcher who will signpost you to the appropriate support. In the first instance this will be to seek advice from your G.P. If you wish to find out more you can also visit the Royal College of Psychiatry website, which provides information about common forms of psychological distress.

Contact Information
This study is being conducted by a doctoral student from the Clinical Psychology programme at the University of Surrey. If you have any further questions, concerns or complaints about the study please feel to contact the researcher, Richard Doherty at r.e.doherty@surrey.ac.uk.

Consent

I have received read and understood all advice explaining the project. Any questions or concerns I might have had about the project have been answered.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I agree to apply with the instructions and co-operate fully with the project, I also understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study and by choosing Yes and then clicking "Next" I am giving my consent to participate in the study.

C Yes
C No
Appendix 6

Intervention
Appendix 6a
Writing pack: General instructions
Introduction to the writing exercise

- On receipt of the pack please set aside 20 minutes a day to do the writing exercise for three consecutive days.

- Instructions for each day are in a sealed envelope in the sections of this folder called day 1, day 2 and day 3.

- Please open each set of instructions on the relevant day.

- Spare sheets of paper are at the back of the folder.

- Do not worry about spelling, sentence structure or grammar. The only rule is that once you begin writing continue to do so until 20 minutes are up.

- After the three days of writing please return the completed exercise and the folder in the freepost envelope provided.

- If you would like a copy of your writing please email the researcher and a copy will be posted back to you.

- Please use the page in the feedback section to note down any comments you have about the exercise.

A month after completing the exercise you will be sent an email asking you to complete an online questionnaire. If you have any questions or concerns throughout this study please contact Richard Doherty at r.e.doherty@surrey.ac.uk.

Thank you very much for your contribution to the study.
Appendix 6b
Writing instruction: Expressive Writing Group Day 1-3
[Writing Instruction: Expressive Writing Group]

Day 1

Please use the paper provided and note down the date and time that you complete the exercise. Please also write down your participant id number, which can be found on the first page of this pack.

Today I would like you to set aside 20 minutes to write about your very deepest thoughts and feelings about your work. This could be a stressful experience at work that continues to bother you. For example a situation that is difficult for you to think/talk about, makes you feel anxious or upset when you are reminded of it or that keeps coming back into your thoughts. This should preferably be an experience that you have not shared too much with others.

In your writing I would like you to really let go and explore your very deepest emotions and thoughts. You might tie your topic to your relationship with others, such as partner or friends. You might link your writing to your future and who you would like to become, to who you were in the past, or to who you are now.

Do not worry about spelling, sentence structure or grammar. The only instruction is once you writing continue until the 20 minutes are up. All of your writing will remain confidential. We will identify your writing with an I.D number rather than your name.

Day 2

As before please use the paper provided and note down the date and time that you complete the exercise. Please also write down your participant id number, which can be found on the first page of this pack.

Today I would like you to set aside 20 minutes to write about your very deepest thoughts and feelings about your work. This could be a stressful experience at work that continues to bother you. For example a situation that is difficult for you to think/talk about, makes you feel anxious or upset when you are reminded of it or that keeps coming back into your thoughts. This should preferably be an experience that you have not shared too much with others.
You can write about the same thing you wrote about yesterday or you can write about something different, it is entirely up to you. In your writing I would like you to really let go and explore your very deepest emotions and thoughts. You might tie your topic to your relationship with others, such as partner or friends. You might link your writing to your future and who you would like to become, to who you were in the past, or to who you are now.

Remember there is no need to worry about spelling, sentence structure of grammar. The only instruction is once you begin writing continue until the 20 minutes are up. As I mentioned before all of your writing will remain confidential. We will identify your writing with an I.D number rather than your name.

Day 3

As before please use the paper provided and note down the date and time that you complete the exercise. Please also write down your participant id number, which can be found on the first page of this pack.

It is the last day of writing. As before I would like you to set aside 20 minutes to write about your very deepest thoughts and feelings about your work. This could be a stressful experience at work that continues to bother you. For example a situation that is difficult for you to think/talk about, makes you feel anxious or upset when you are reminded of it or that keeps coming back into your thoughts. This should preferably be an experience that you have not shared too much with others.

You can write about the same thing you’ve written about on the last two days or you can write about something different, again it is entirely up to you. In your writing I would like you to really let go and explore your very deepest emotions and thoughts. You might tie your topic to your relationship with others, such as partner or friends. You might link your writing to your future and who you would like to become, to who you were in the past, or to who you are now.

Remember there is no need to worry about spelling, sentence structure of grammar. The only instruction is once you begin writing continue until the 20 minutes are up. As I mentioned before all of your writing will remain confidential. We will identify your writing with an I.D number rather than your name.
Appendix 6c
Writing instruction: Factual writing group day 1-3
[Writing Instruction: Factual Group]

Day 1

Please use the paper provided and note down the date and time that you complete the exercise. Please also write down your participant id number, which can be found on the first page of this pack.

Today I would like you to set aside 20 minutes to write about your weekday routine, from the time that you get up to the time that you go to bed. I want you to be as detailed as possible. I would like a factual account rather than details of your emotions or opinions.

You might start when your alarm goes off and you get out of bed. You could include a factual description of the activities you do, the places you go, which buildings and objects you pass by as you go from place to place. The most important thing in your writing is for you to describe your day as accurately and in as much detail as possible.

Do not worry about spelling, sentence structure of grammar. The only instruction is once you writing continue until the 20 minutes are up. All of your writing will be remain confidential. We will identify your writing with an I.D number rather than your name.

Day 2

As before please use the paper provided and note down the date and time that you complete the exercise. Please also write down your participant id number, which can be found on the first page of this pack.

Today is the second day of writing and I would like you to again set aside 20 minutes to write. In today’s writing exercise I would like you to give a factual account of exactly what food you ate yesterday from the time you got up until the time you went to bed. I want you to be as detailed as possible.

You might describe what times of the day you ate and who you were with. You could include details of who prepared the food, how it was prepared and where you were when you ate. The most important thing in your writing is for you to describe exactly what you can remember about
your meals and snacks yesterday as accurately and in as much detail as possible.

Remember there is no need to worry about spelling, sentence structure of grammar. The only instruction is once you begin writing continue until the 20 minutes are up. As I mentioned before all of your writing will be remain confidential. We will identify your writing with an I.D number rather than your name.

Day 3

As before please use the paper provided and note down the date and time that you complete the exercise. Please also write down your participant id number, which can be found on the first page of this pack.

It is the last day of writing. As before I would like you to set aside 20 minutes to write. Today I would like you to describe what you do with your leisure time. As before this should be a factual account and as detailed as possible.

You might include a description of your interests or the activities you like to do, the place(s) where you do these things or how long you have been interested in them. The most important thing in your writing is for you to describe exactly what you do in your leisure time as accurately and in as much detail as possible.

Remember there is no need to worry about spelling, sentence structure of grammar. The only instruction is once you begin writing continue until the 20 minutes are up. As I mentioned before all of your writing will be remain confidential. We will identify your writing with an I.D number rather than your name.
Appendix 6d
Feedback response sheet
Feedback sheet

We would be interested to hear your feedback on the writing exercises we’ve asked you to do. Please use this page to note down any comments you have about the writing exercises.

Please return this folder including your comments along with your completed writing exercises in the freepost envelope provided.

Thank you for your participation.
Appendix 7

Measures
Appendix 7a

Work-Related Rumination Scale (WRRS)

Questions 3, 7, 11, 13, 15 measure work related-affective rumination
These next questions relate to work-related thoughts you may experience in your leisure time. Please answer each question on a scale from "very seldom or never" to "very often or always".

<table>
<thead>
<tr>
<th>Question</th>
<th>Very seldom or never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very often or always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. After work I tend to think of how I can improve my work-related performance</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you feel unable to switch off from work?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you become tense when you think about work-related issues during your free time?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. In my free time I find myself re-evaluating something I have done at work.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you think about what tasks need to be done at work the next day?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I am able to stop thinking about work-related issues in my free time.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Are you annoyed by thinking about work-related issues when not at work?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I find thinking about work during my free time helps me to be creative.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you find it easy to unwind after work?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I make myself switch off from work as soon as I leave.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Are you irritated by work issues when not at work?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I find solutions to work-related problems in my free time.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do you become fatigued by thinking about work-related issues during your free time?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Do you leave work issues behind when you leave work?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Are you troubled by work-related issues when not at work?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 7b
Patient Health Questionnaire (PHQ8)
Over the last 2 weeks how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling bad about yourself or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 7c
Generalised Anxiety Disorder scale (GAD7)
Over the last 2 weeks (or other agreed time period) how often have you been bothered by any of the following problems?

| Feeling nervous, anxious or on edge | - | - | - |
| Not being able to stop or control worrying | - | - | - |
| Worrying too much about different things | - | - | - |
| Trouble relaxing | - | - | - |
| Being so restless that it is hard to sit still | - | - | - |
| Becoming easily annoyed or irritable | - | - | - |
| Feeling afraid as if something awful might happen | - | - | - |

- not at all
- several days
- more than half the days
- nearly every day
Appendix 7d
International Positive and Negative Affect Scale, Short Form (I-PANAS-SF)
Please tick the box that best corresponds to your feelings. Number one is never and number five is always. Thinking about yourself and how you normally feel, to what extent do you generally feel:

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alert</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashamed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspired</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determined</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attentive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afraid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

242
Appendix 7e
Pittsburg Sleep Quality Index (PSQI)
Instructions
The following questions relate to your usual habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all the questions.

During the past month, what time have you usually gone to bed at night?

During the past month, how long [in minutes] has it usually taken you to fall asleep each night?

During the past month, what time have you usually gotten up in the morning?

during the past month, how many hours of actual sleep did you get? [This may be different than the numbers of hours you spent in bed.]

For each of the remaining questions, check the best response. Please answer all questions.

During the past month, how often have you had trouble sleeping because you...

Cannot get to sleep within 30 minutes
Wake up in the middle of the night or early in the morning
Have got up to use the bathroom
Cannot breathe comfortably
Cough or snore loudly
Feel too cold
Feel too hot
Had bad dreams
Have pain
Other reason(s), please describe

6. During the past month, how would you rate your sleep quality overall?

□ Very good  □ Fairly good  □ Fairly bad  □ Very bad
7. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?
- Not during the past month
- Less than once a week
- Once or twice a week
- Three or more times a week

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?
- Not during the past month
- Less than once a week
- Once or twice a week
- Three or more times a week

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?
- No problem at all
- Only a very slight problem
- Somewhat of a problem
- A very big problem

10. Do you have a bed partner or roommate?
- No bed partner or roommate
- Partner/roommate in other room
- Partner in same room, but not same bed
- Partner in same bed

If you have a roommate or bed partner, ask him/her how often in the past month you have had...

<table>
<thead>
<tr>
<th>Condition</th>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loud snoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long pauses between breaths while asleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legs twitching or jerking while asleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episodes of disorientation or confusion during sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other restlessness while you sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Next
Appendix 7f
Emotional Approach Coping Scale (EAC)
Please read the following 8 statements and answer by choosing one of the four options.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 almost always</th>
<th>1 don't do this at all</th>
<th>1 do this</th>
<th>1 do this a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>I take time to figure out what I'm really feeling.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I delve into my feelings to get a thorough understanding of them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I realize that my feelings are valid and important.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I acknowledge my emotions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I let my feelings come out freely.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take time to express my emotions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I allow myself to express my emotions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel free to express my emotions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Next...
Appendix 8
Recruitment emails
Appendix 8a
Email introducing the study.
Researchers at the University of Surrey are currently conducting a study looking at ways to help people ‘switch off’ from work related thoughts during their leisure time.

If you are in employment and are interested in taking part in this study please go to website http://www.fahs.surrey.ac.uk/survey/rd01/ for more information and to complete the brief online questionnaire. If your scores suggest that you do ruminate about work in your leisure time you will be invited to take part in the main study.

Please forward this email to anyone who you think may be interested in taking part in the study

Yours Sincerely

Richard Doherty
Trainee Clinical Psychologist (Surrey University)

This project has been approved by Surrey University’s Faculty of Arts and Human Sciences Ethics Committee.
Appendix 8b
Thank you email to participants that did not meet the inclusion criteria.
Dear, NAME INSERTED

‘Affective Rumination, Expressive writing and Health Study’

Thank you for completing the online rumination questionnaire. Your affective rumination scores suggest that you sometimes/seldom affectively ruminate about work in your leisure time.

The second part of the study aims to find ways to reduce high levels of affective rumination. As your affective rumination scores were not high you are not required to continue with the study.

Thank you for your participation.

If you have any further questions or concerns about the study please email the researcher at r.e.doherty@surrey.ac.uk

Could you please forward the study http://www.fahs.surrey.ac.uk/survey/rd01 to anyone you think might be interested in taking part.

Yours Sincerely

Richard Doherty
Trainee Clinical Psychologist (Surrey University)
Appendix 8c

Invitation to eligible participants to take part in the main study and link to website 2
Dear, NAME INSERTED

Thank you for completing the online rumination screening questionnaire. Your scores suggest that you do affectively ruminate about work.

We would like to invite you to participate in the second part of the study.

The study asks you to write for 20 min on three days (a pack is sent to you) and to complete a brief questionnaire before and after.

In total the study should take just over an hour of your time and all the writing is completely anonymous.

To complete the next stage please go to

http://www.fahs.surrey.ac.uk/survey/rd02/

If you have any further questions or concerns about the study please email the researcher at r.e.doherty@surrey.ac.uk

Yours Sincerely

Richard Doherty
Trainee Clinical Psychologist (Surrey University)
Appendix 8d
End of study thank you email
Dear, NAME INSERTED

Thank you for your time and effort in completing the study. The study is running until June and then the results will be analysed. An email will be sent to you informing you of the overall findings of the study in September.

Thank you again.

If you have any further questions or concerns about the study please email the researcher at r.e.doherty@surrey.ac.uk

Yours Sincerely
Richard Doherty
Trainee Clinical Psychologist (Surrey University)
Appendix 9
Data screening
Appendix 9a
Mean and 5% trimmed mean scores for each of the variables
Mean and 5% trimmed mean scores for each of the variables for both groups.

<table>
<thead>
<tr>
<th></th>
<th>Factual Group</th>
<th></th>
<th>Expressive Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Trimmed Mean</td>
<td>Mean</td>
<td>Trimmed Mean</td>
</tr>
<tr>
<td>WRAR(base)</td>
<td>17.78</td>
<td>17.6</td>
<td>17.96</td>
<td>17.87</td>
</tr>
<tr>
<td>WRAR(1m)</td>
<td>17.17</td>
<td>17.15</td>
<td>16.28</td>
<td>16.24</td>
</tr>
<tr>
<td>WRAR(3m)</td>
<td>16.74</td>
<td>16.66</td>
<td>14.4</td>
<td>14.52</td>
</tr>
<tr>
<td>PHQ8(base)</td>
<td>7.13</td>
<td>7.04</td>
<td>6.24</td>
<td>6.17</td>
</tr>
<tr>
<td>PHQ8(1m)</td>
<td>7.91</td>
<td>7.83</td>
<td>5.64</td>
<td>5.56</td>
</tr>
<tr>
<td>PHQ8(3m)</td>
<td>5.96</td>
<td>5.96</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>GAD7(base)</td>
<td>7.22</td>
<td>7.15</td>
<td>6.12</td>
<td>5.83</td>
</tr>
<tr>
<td>GAD7(1m)</td>
<td>7.39</td>
<td>7.22</td>
<td>4.96</td>
<td>4.72</td>
</tr>
<tr>
<td>GAD7(3m)</td>
<td>6.91</td>
<td>6.84</td>
<td>4.16</td>
<td>3.89</td>
</tr>
<tr>
<td>I-PANAS- SF(N)(base)</td>
<td>13</td>
<td>13.05</td>
<td>11.96</td>
<td>11.87</td>
</tr>
<tr>
<td>I-PANAS- SF(N)(1m)</td>
<td>13.52</td>
<td>13.53</td>
<td>10.64</td>
<td>10.61</td>
</tr>
<tr>
<td>I-PANAS- SF(N)(3m)</td>
<td>12.74</td>
<td>12.71</td>
<td>10.6</td>
<td>10.59</td>
</tr>
<tr>
<td>PSQI(base)</td>
<td>6.39</td>
<td>6.33</td>
<td>5.84</td>
<td>5.77</td>
</tr>
<tr>
<td>PSQI(1m)</td>
<td>7</td>
<td>7.05</td>
<td>4.4</td>
<td>3.65</td>
</tr>
<tr>
<td>PSQI(3m)</td>
<td>5.83</td>
<td>5.85</td>
<td>4.12</td>
<td>3.9</td>
</tr>
<tr>
<td>EAC(base)</td>
<td>21.43</td>
<td>21.42</td>
<td>20.04</td>
<td>19.91</td>
</tr>
<tr>
<td>EAC(1m)</td>
<td>22.26</td>
<td>22.41</td>
<td>20.16</td>
<td>20.16</td>
</tr>
<tr>
<td>EAC(3m)</td>
<td>21.61</td>
<td>21.86</td>
<td>20.24</td>
<td>20.42</td>
</tr>
</tbody>
</table>
Appendix 9b

Test of normality (Skewness, kurtosis and z-scores) for each of the variables across, at each time point, for the factual writing group.
Skewness, kurtosis and z-scores for each of the variables at each time point for the factual writing group.

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>N=23</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statistic</td>
<td>Std. Error</td>
<td>Z-score</td>
</tr>
<tr>
<td>WRAR (Base)</td>
<td>-1.1</td>
<td>.48</td>
<td>-2.29*</td>
</tr>
<tr>
<td>WRAR (1m)</td>
<td>-.3</td>
<td>.48</td>
<td>-.63</td>
</tr>
<tr>
<td>WRAR (3m)</td>
<td>.19</td>
<td>.48</td>
<td>.4</td>
</tr>
<tr>
<td>PHQ8 (Base)</td>
<td>.18</td>
<td>.48</td>
<td>.38</td>
</tr>
<tr>
<td>PHQ8 (1m)</td>
<td>.58</td>
<td>.48</td>
<td>1.21</td>
</tr>
<tr>
<td>PHQ8 (3m)</td>
<td>0</td>
<td>.48</td>
<td>0</td>
</tr>
<tr>
<td>GAD7 (Base)</td>
<td>.18</td>
<td>.48</td>
<td>.38</td>
</tr>
<tr>
<td>GAD7 (1m)</td>
<td>.63</td>
<td>.48</td>
<td>1.31</td>
</tr>
<tr>
<td>GAD7 (3m)</td>
<td>.72</td>
<td>.48</td>
<td>1.5</td>
</tr>
<tr>
<td>I-PANAS-SF (N) (Base)</td>
<td>-.31</td>
<td>.48</td>
<td>-.65</td>
</tr>
<tr>
<td>I-PANAS-SF (N) (1m)</td>
<td>-.04</td>
<td>.48</td>
<td>-.08</td>
</tr>
<tr>
<td>I-PANAS-SF (N) (3 m)</td>
<td>.09</td>
<td>.48</td>
<td>.19</td>
</tr>
<tr>
<td>PSQI (Base)</td>
<td>.29</td>
<td>.48</td>
<td>.6</td>
</tr>
<tr>
<td>PSQI (1m)</td>
<td>-.12</td>
<td>.48</td>
<td>-.25</td>
</tr>
<tr>
<td>PSQI (3m)</td>
<td>-.05</td>
<td>.48</td>
<td>-.1</td>
</tr>
<tr>
<td>EAC (Base)</td>
<td>.14</td>
<td>.48</td>
<td>.29</td>
</tr>
<tr>
<td>EAC (1m)</td>
<td>-.25</td>
<td>.48</td>
<td>-.52</td>
</tr>
<tr>
<td>EAC (3m)</td>
<td>-1.36</td>
<td>.48</td>
<td>-2.8*</td>
</tr>
</tbody>
</table>

Normality is considered violated if z-score >1.96 on either kurtosis or skewness (Field, 2005). * = Significant violation
Appendix 9c

Test of normality (Skewness, kurtosis and z-scores) for each of the variables across, at each time point, for the expressive writing group.
Skewness, kurtosis and z-scores for each of the variables at each time point for the expressive writing group.

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statistic</td>
<td>Std. Error</td>
</tr>
<tr>
<td>WRAR (Base)</td>
<td>.27</td>
<td>.46</td>
</tr>
<tr>
<td>WRAR (1m)</td>
<td>.35</td>
<td>.46</td>
</tr>
<tr>
<td>WRAR (3m)</td>
<td>-.55</td>
<td>.46</td>
</tr>
<tr>
<td>PHQ8 (Base)</td>
<td>.3</td>
<td>.46</td>
</tr>
<tr>
<td>PHQ8 (1m)</td>
<td>.45</td>
<td>.46</td>
</tr>
<tr>
<td>PHQ8 (3m)</td>
<td>1.04</td>
<td>.46</td>
</tr>
<tr>
<td>GAD7 (Base)</td>
<td>1.26</td>
<td>.46</td>
</tr>
<tr>
<td>GAD7 (1m)</td>
<td>1.25</td>
<td>.46</td>
</tr>
<tr>
<td>GAD7 (3m)</td>
<td>1.37</td>
<td>.46</td>
</tr>
<tr>
<td>I-PANAS-SF (N) (Base)</td>
<td>.6</td>
<td>.46</td>
</tr>
<tr>
<td>I-PANAS-SF (N) (1m)</td>
<td>-.06</td>
<td>.46</td>
</tr>
<tr>
<td>I-PANAS-SF (N) (3 m)</td>
<td>.2</td>
<td>.46</td>
</tr>
<tr>
<td>PSQI (B)</td>
<td>.63</td>
<td>.46</td>
</tr>
<tr>
<td>PSQI (1m)</td>
<td>.29</td>
<td>.46</td>
</tr>
<tr>
<td>PSQI (3m)</td>
<td>1.77</td>
<td>.46</td>
</tr>
<tr>
<td>EAC (Baseline)</td>
<td>.73</td>
<td>.46</td>
</tr>
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<td>EAC (1m)</td>
<td>-.14</td>
<td>.46</td>
</tr>
<tr>
<td>EAC (3m)</td>
<td>-1.11</td>
<td>.46</td>
</tr>
</tbody>
</table>

Normality is considered violated if z-score >1.96 on either kurtosis or skewness (Field, 2005). *=significant violation.
Appendix 9d

Test of normality (Skewness, Kurtosis and Z-scores) for the change scores (Expressive Group) on the measures WRAR, PHQ8, GAD7, PANAS-SF:N, and PSQI.
Skewness, kurtosis and z-scores for the change scores (expressive writing group) on the measures WRAR, PHQ8, GAD7, 1-PANAS-SF:N, PSQI.

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statistic</td>
<td>Std. Error</td>
</tr>
<tr>
<td>WRAR</td>
<td>-.06</td>
<td>.46</td>
</tr>
<tr>
<td>PHQ8</td>
<td>-.45</td>
<td>.46</td>
</tr>
<tr>
<td>GAD7</td>
<td>-.18</td>
<td>.46</td>
</tr>
<tr>
<td>1-PANAS-SF (Negative)</td>
<td>.12</td>
<td>.46</td>
</tr>
<tr>
<td>PSQI</td>
<td>-1</td>
<td>.46</td>
</tr>
</tbody>
</table>

Normality is considered violated if z-score >1.96 on either kurtosis or skewness (Field, 2005). * = significant violation.
Appendix 10
The internal consistency of the scales measuring each of the dependent variables
The Cronbach alpha coefficient, and inter-item correlation for each of the scales used to measure the dependent variables.

<table>
<thead>
<tr>
<th>Scale reliability (internal consistency)</th>
<th>Number of Items</th>
<th>Cronbach alpha coefficient</th>
<th>Inter-item reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRAR</td>
<td>15</td>
<td>.76</td>
<td>.41</td>
</tr>
<tr>
<td>PHQ8</td>
<td>8</td>
<td>.68</td>
<td>.22</td>
</tr>
<tr>
<td>GAD7</td>
<td>7</td>
<td>.81</td>
<td>.39</td>
</tr>
<tr>
<td>PSQI</td>
<td>21</td>
<td>.8</td>
<td>N/A</td>
</tr>
<tr>
<td>I-PANAS-SF (N)</td>
<td>5</td>
<td>.68</td>
<td>.31</td>
</tr>
<tr>
<td>EAC</td>
<td>8</td>
<td>.84</td>
<td>.45</td>
</tr>
</tbody>
</table>
End