A Study to Design a Questionnaire to Measure Self-disclosure of Upsetting things and Examining the Relationship between Physical and Mental Health

By

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Volume 1

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INTRODUCTION TO THE PORTFOLIO

The portfolio is a compilation of the academic, clinical and research work completed for the Doctorate in Psychology Course in Clinical Psychology (PsychD) for the University of Surrey.

Volume 1

This volume contains the academic dossier of the PsychD course portfolio – comprised of four essays; the research dossier comprised of a service related piece of research conducted in the first year, a major research project completed in the third year and a research logbook showing progress of development in and use of research skills over the three years of the course; and a summary of the clinical dossier – comprised of brief overviews of clinical experience and summaries of submitted case reports.

Volume 2

This volume contains the full components of the clinical dossier, including placement contracts, supervisor evaluations and clinical logbooks from the six clinical placements; in addition to five formal case reports of work conducted whilst on placement.

The aim of this portfolio is to highlight the diversity of experience and development of competence in academic, clinical and research skills during the three years of the PsychD course.
Academic Dossier

This section of the portfolio contains four essays, which critically examine a diversity of psychological issues concerning theoretical and practical aspects of clinical psychology.
Psychotic experiences (hallucinations and delusions) are not understandable or meaningful. Critically discuss this statement and any implications for treatment.
1 Introduction

Psychotic experiences such as hallucinations and delusions have traditionally been viewed by both clinicians and the general population as the classic signs of madness. In recent years researchers have began to study the specific symptoms of psychosis rather than the diagnoses themselves. This is due to them being interesting in their own right and because of doubts about the validity of diagnoses (Bentall, Jackson & Pilgrim, 1988).

This essay will examine the traditional view of seeing psychotic experiences (hallucinations and delusions) as resulting from a biological dysfunction and not being understandable or meaningful. It will then look at evidence contrary to this view, which suggests that psychotic experiences lie on a continuum with normality and are not necessarily synonymous with insanity. It will then examine the main current cognitive models of hallucination and delusions and will discuss what insights these provide about whether psychotic experiences can be understood or made sense of. The essay will focus mainly on four cognitive models that were chosen because each have instigated a considerable amount of research. They are the models of Maher (1988), Kaney & Bentall (1989), Frith (1992), Garety and Hemsley (1994) and Garety, Kuipers, Freeman, Fowler and Bebbington (2001).

Psychotic experiences can occur as symptoms in a variety of diagnoses. These diagnoses are divided into three main groups. These are the organic psychoses (e.g. dementia, epilepsy), the Affective psychoses (e.g. Depressive psychosis, Bipolar Disorder) and the Non-affective psychoses (e.g. Schizophrenia, Schizoaffective Psychosis, Delusional Disorder). This essay will only examine psychotic symptoms associated with non-organic functional psychosis since these are the disorders in which the majority of research has focused.
1.1 **Definition of a Delusion**

Oltmans (1988), described a delusion as follows: -

a) "The balance of evidence for and against the belief is such that other people consider it completely incredible.

b) The belief is not shared by others.

c) The belief is held with firm conviction. The person's statements or behaviours are unresponsive to the presentation of evidence contrary to the belief.

d) The person is preoccupied with (emotionally committed to) the belief and finds it difficult to avoid thinking or talking about it.

e) The belief involves personal reference, rather than unconventional religious, scientific or political conviction.

f) The belief is a source of subjective distress or interferes with the person's occupational or social functioning.

g) The person does not report subjective efforts to resist the belief (in contrast to patients with obsessional ideas)."

1.2 **Definition of a Hallucination**

Slade and Bentall (1988) defined a hallucination as "any percept-like experience which

a) Occurs in the absence of an appropriate stimulus.

b) Has the full force or impact of the corresponding actual (real) perception.

c) Is not amenable to direct and voluntary control by the experiencer."

1.3 **Definitions of Understandable and Meaningful**

Before exploring further into different types of delusions and hallucinations it may be useful to define both of the concepts identified in the question. The Oxford Senior Dictionary (1984) provides the following two definitions:

"Understandable - (adjective) able to be understood."
1.4 Types of Delusions and Hallucinations

There are many different types of delusions (e.g. grandiose, persecutory, reference). Grandiose delusions are when someone believes that they have special talents (for example, being cleverer than others or being able to fly). Some people have grandiose identity delusions where they believe that they are famous people or are related to royalty. Delusions of persecution are when a person believes that others are out to harm them in some way (e.g. to kill them, drive them mad). Delusions of reference are when neutral events acquire special significance and refer to the person personally. They may think that the television is making references to them, that some organisation is spying on them, or that objects are being left in particular places which mean certain things.

Hallucinations also come in many different forms. Hallucinations can occur in any one of the senses. Some examples are non-verbal, visual, somatic, olfactory, gustatory and auditory. Auditory hallucinations refer to hearing voices. Their source could be unlocatable, they may emanate from a particular part of the room or they may originate within the head. These voices are commonly derogatory, but can be neutral observing, encouraging or praising. Some individuals dislike their voices and report that they cause them severe distress whilst some individuals report positive elements about hearing voices (e.g. they stop them from feeling lonely).

During a disorder delusional beliefs and hallucinations vary in conviction, preoccupation and distress. At times individuals may hold what could be classed as eccentric ideas and at other times these may be intense delusions. An individual may also range from having mild abnormalities in thinking to strong hallucinations. Outcomes also vary considerably.
"Since time immemorial, delusion has been taken as the basic characteristic of madness. To be mad was to be deluded." Jaspers stated that psychotic symptoms were "ununderstandable" in that they did not reflect patient's personalities and experiences (as cited in Walker, 1991). He asserted that primary delusions are psychologically irreducible, arising from an unknown pathological change or a change in personality. Delusions arising from personal experiences or hallucinations were seen as delusion-like ideas, not true delusions. Jasper's influential ideas led to researchers trying to find a biological basis for psychosis.

A considerable amount of research has attempted to ascertain whether psychotic symptoms resulted from a biological dysfunction. Studies have looked at structural and functional brain abnormalities (Weinberger, Berman, & Zec, 1986), biochemical disturbances (Waddington, 1993), and genetic studies. The strongest positive finding in support of the biological model has been the proposal that there is a genetic component to the disorder.

Gottesman (1991) studied the results of forty studies into the familial occurrence in schizophrenia and produced a table of risks for developing schizophrenia in first, second and third degree relatives of people with the disorder. He discovered that the risk increases with cosanguinuity to reach almost fifty percent in monozygotic twins and the children of two schizophrenic parents. Although this suggests a genetic link to developing schizophrenia, the lack of 100% concordance in identical twins underlie the point that some additional factor may be involved.

However, the methodology of many of the studies is questionable. Many individuals in those studies who received a diagnosis of schizophrenia would not meet diagnostic criteria for the disorder by contemporary standards. When it came to diagnosing their relatives, 'borderline' 'latent' and 'pseudo-neurotics' were all classed as schizophrenic. Much of the evidence collected was anecdotal and a few studies even included individuals who were psychologically abnormal but were not psychotic. However, further and improved studies have been carried out since and also found
substantial rates of psychiatric ill health among first degree relatives of those with schizophrenia (McGuffin et al, 1984; Farmer, McGuffin & Gottesman, 1987).

Another reason that these types of studies do not necessarily suggest a biological basis for psychosis is because families tend to share a familiar environment as well as common genes. Studies have looked at the children of individuals with schizophrenia who have been adopted and when compared to children of non-schizophrenic mothers, mental illness was significantly more common in the adopted children of the mothers with schizophrenia (Wender, Rosenthal, Kety, Shulsinger & Welner, 1974). These studies suggest that at most, only a predisposition to develop psychoses can be biologically determined.

3 Continuities Between Normal and Psychotic Experiences

Research has promoted changes into understanding about delusions and it is now more widely accepted that psychotic disorders are likely to be a heterogeneous group of disorders that lie on a continuum with normality (Garety & Freeman, 1999).

By focusing on the symptoms of psychosis, studies have highlighted connections and continuities between normal experiences and beliefs, and those of people with psychosis. The experiences and beliefs of people with psychosis then start to make sense rather than be regarded as not meaningful and not understandable.

There are various studies that argue that hallucinations are a normal psychological phenomenon, which can potentially be experienced by anyone. Oswald (1974) studied the effects of sleep deprivation. He found subjects consistently reported perceptual distortions and hallucinations. Grassian (1983) examined the psychopathological effects of solitary confinement. In one of the subjects the illusions “became more complex and personalised.” Grimby (1993) interviewed fifty individuals in their early seventies one month following the death of their spouse. “Half of the subjects felt the presence of the deceased (illusions); about one third reported seeing, hearing and talking to the deceased (hallucinations).” Allen & Argus (1963) found that they
could induce hallucinations in subjects through hyperventilation. It has also been found that people who have experienced potentially life threatening situations, for example mining accidents (Comer, Madow & Dixon, 1967), terrorist attacks (Siegal, 1984) and sustained military operations (Belensky, 1979), have had hallucinatory experiences.

Surveys of the general population suggest that 10-25% of the population have had a hallucinatory experience at least once (Slade & Bentall, 1988). Additional support for the notion of hallucinations being normal phenomena comes from Romme, Honig, Noorthoon & Escher’s (1992) finding that of 173 subjects experiencing auditory hallucinations who had responded to a request on television, 39% were not in psychiatric care. These studies all seem to suggest that hallucinations can occur as normal responses to certain events or triggers. It also implies that as long as a person’s behaviour does not exceed the limits of socially accepted norms and expectations they may have psychotic experiences but still be considered normal.

4 Cultural Influences on Psychotic Experiences

If Jasper’s assumptions that psychotic experiences reflect the biological rather than social adaptation of an individual then it would be expected that cultural influences would have no impact on hallucinations. Considerable cultural differences exist in the experience of hallucinations. They are reported as being relatively common and a positively valued experience in some cultures (Al-Issa, 1978). Also, different types of hallucinations are reported in different parts of the world. It has also been noted that attitudes towards hallucinations may effect the frequency, the content and the emotional response to the experience (Al-Issa, 1978).

5 Cognitive Models
5.1 Maher (1988)

The idea that delusions and hallucinations are continuous with normal beliefs has led to the proposal that delusions represent rational attempts to make sense of abnormal experiences. Maher asserted that mechanisms, which produce delusions, are the same as the ones that produce beliefs in the non-clinical population. He argues that individuals experience abnormal perceptions (caused by biological mechanisms) and then attempt to find an explanation for this. The explanation is arrived at through normal cognitive processes. Therefore, the person has no abnormality of thought or reasoning and the delusional belief is an attempt to explain unusual events. Once a belief is formed it is maintained by normal processes such as self-fulfilling prophecy, confirmation bias, a tendency to look for evidence consistent with beliefs, and is reinforced by the relief of having an explanation. (e.g. I'm glad it is that, I thought I was going mad). This explanation differs from the traditional view of understanding psychotic experiences as it sees delusions as being an individual’s attempt at trying to understand or make sense of an event.

Maher proposes that there is evidence for his model as irrational beliefs can be induced in the general population under aberrant conditions (as discussed above). For example, deafness may be a vulnerability factor in paranoia. Individuals with hearing difficulties are vulnerable to thinking that others are expressing negative opinions of them (Kay, Cooper, Garside & Roth, 1976). He also argues that delusions serve an adaptive function in psychotic illness to reduce anxiety over puzzling experiences.

However, it seems unlikely that psychotic experiences are entirely the result of perceptual abnormalities. This is also supported by the fact that the majority of people with perceptual disorders are not deluded. Also, it does not account for the fact that different types of abnormal reasoning may be present in some deluded individuals (Kaney & Bentall, 89). Furthermore, individuals with schizophrenia perform normally on syllogistic reasoning tasks, which does not suggest a relationship between reasoning errors and delusions (Garety and Freeman, 1999).
5.2 Kaney & Bentall (1989)

Kaney and Bentall (1989) also examined the role of reasoning in delusions. They argue that individuals devise persecutory delusions to maintain self-esteem to avoid differences between how they perceive themselves and how they would like to be. They studied the attributional styles of people with persecutory delusions compared with matched depressed controls. They found that both groups made excessively global and stable attributions for significant events. However, the deluded participants made external attributions for negatively valued events and internal attributions for positively valued events. They suggest that blaming external causes for bad events and taking the credit for good events maintains an individual’s self-esteem. They suggested that this could make people vulnerable to forming persecutory and grandiose interpretations about life events. They also examined the role of attributions in hallucinations. They argue that there is an impairment in the skills involved in discriminating between real and imaginary events. This causes individuals to make hasty and overconfident judgements about the source of their perceptions and to be more likely to attribute their perceptions to an external cause.

Findings from suggestibility studies also support this viewpoint. Barber & Calverley (1964) designed a study in which participants were asked to close their eyes and listen to a stimulus (the song “White Christmas”) without the stimulus actually being presented. Approximately 5% of otherwise normal subjects will report hearing the song and believing that it has been presented.

However, the Attributional Style Questionnaire (ASQ) which was used in many of the studies has received considerable criticism for poor reliability (Garety and Freeman, 1999). As a result Kinderman & Bentall (1996) devised a new scale the Internal, Personal and Situational Questionnaire (IPASQ). This further divides external attributions into personalising and situational factors. It was found that when individuals with persecutory delusions were compared to depressed and non-clinical controls they were more likely to blame other people for negative events rather than situational events.
Another way of trying to show whether persecutory delusions act as a defence is by examining discrepancies between overt and covert self-esteem. The notion is that the self-serving attributional bias will minimise discrepancies between the actual self and ideal self to maintain self-esteem. Therefore, it would be expected that paranoid delusions would be associated with positive self-ratings in the actual-self domain and the ideal-self and ought-self concepts. However, findings have been inconsistent so that it cannot yet be assumed that persecutory delusions act as a defence.

Although Kaney and Bentall (1989) discuss how negative events are attributed to being the fault of others they do not address what occurs with neutral events. In clinical practice it has been noted that individuals with persecutory delusions often construe neutral events (e.g. glancing at the person) or even positive events (e.g. smiling) as threatening. Although Bentall does study the role of depression he has not discussed other variables which could contribute to psychotic experiences, such as gender, ethnicity, other psychiatric difficulties etc. It is also unclear how participants were allocated into delusional sub-groups. However, this model offers insights into how and why people form the beliefs that they do. Being able to understand why people reach some of the conclusions that they do, allows one to make sense of what may otherwise appear as irrational and illogical.

5.3 Frith (1992)

Cognitive neuropsychological models provide a basis for developing new insights into understanding the meaning of psychotic experiences. They acknowledge that biology has a major influence but also see psychotic experiences as being understandable. Frith (1987) asserted that a cognitive deficit occurs from a breakdown in neuronal pathways in the brain which monitor and control actions. He believes that there is a cognitive mechanism that distinguishes automatically between actions that derive from external stimuli and those that are our internal intentions. An impairment in this mechanism would take away the sense of effort that accompanies our willed thoughts and actions. This may then result in the feeling or experience of being controlled by external forces in our mind which appear unintended and not our own. This
explanation attaches a coherent meaning to why people with psychosis often report these types of experiences.

In 1992 he extended his model to provide an account of delusion formation. It states that delusions are caused by a dysfunction in a person’s meta-representational ability or theory of mind. Theory of mind refers to being able to accurately understand the beliefs, desires, feelings and intentions of others. This could result in difficulties understanding social interactions. Individuals may become confused about the intentions of others or make bad judgements. They could start to view the world as unusual and odd social experiences could initiate the development of paranoid delusions. The person thinks that they understand others, without realising that they have lost the ability to make inferences about others. For example, delusions of reference could occur because an individual mistakenly labels an action as having an intention behind it.

Garety and Freeman (1999) examined the finding from theory of mind studies and discovered that all studies showed that individuals with schizophrenia performed significantly worse than non-clinical controls on theory of mind tasks. However, the model is highly reductionistic. This model assumes that psychosis is almost exclusively formed by a biological deficit. It does not recognise that there are other important factors in explaining psychotic experiences such as environmental influences, adaptation and learning.

5.4 Garety and Hemsley (1994)

Rather than there being one discrete explanation for psychosis there seems to be a number of different factors contributing to psychosis. Garety and Hemsley proposed a multi-factorial model, which sees a delusional belief being made as a result of a judgement, when an individual encounters or seeks out information and interprets it. It argues that beliefs are formed and maintained by normal processes such as selective attention and confirmation bias. They see judgements as being influenced by many factors and propose that different types of delusions may involve different
mechanisms. These can be past experiences, affect, motivation, self-esteem, expectations and biases in some delusions, or perception and judgement processes in others. They suggest that a few of these different processes may operate and collectively contribute. It acknowledges that there needs to be careful formulation of which of these factors it could be in each individual case.

Garety & Freeman (1999) reviewed fourteen studies that looked at evidence for reasoning bias in delusions. Evidence was found of jumping to conclusions in eleven of the studies. Individuals with delusions used less information to reach a decision but when presented with information they showed that they were able to use it. The studies used information that was not emotional in content and was not relevant to the participant’s concerns. They suggest that rather than it being a reasoning bias it is a data gathering bias, a tendency for people to gather less evidence so that they jump to conclusions.

5.5 Garety et al (2001)

Garety, Kuipers, Fowler, Freeman and Bebbington’s (2001) cognitive model of positive symptoms builds on her own and others’ research findings and has integrated these ideas into one multidimensional model. It explains psychotic symptoms in terms of phenomenological experiences, social, psychological and neurobiological explanations. The model posits that people have a predisposition to psychoses and that a triggering event causes a disruption in their cognitive processes of attention, perception or judgement. The triggering event may be stressful life events, adverse environments, drug abuse or isolation. Symptoms can either develop from an affective disturbance or by a cognitive and an affective disturbance.

A cognitive disturbance could undermine the structure of the sensory input and lead to unintended memory intrusions into consciousness (Hemsley, 1993). It could also be that individuals can not monitor their actions and intentions which lead to them not recognising them as their own (Frith, 1992). This causes anomalous experiences (e.g. thoughts being heard as voices, actions discerned to be unintended, or heightened perception). Emotional changes also occur in response to both the trigger and the
anomalous experiences. Emotional factors (e.g. beliefs about the self, others and the world) are taken into account in the processing of the anomalous experience and influence their content. For example, if the person is anxious due to a partner leaving the voices may be critical. “Everyone hates you. No wonder he has gone.” If a person is depressed the voices may contain themes of guilt. These in turn shape views about the self. These experiences then trigger a search for an explanation for the meaning as to what is happening. The explanations will also be influenced by cognitive biases associated with psychosis, jumping to conclusions, externalising attributional biases and difficulties understanding the intentions of others and social situations.

Therefore, explanations will be sought from the internal and external events, pre-existing beliefs and cognitive biases all interacting with each other. People who have these psychotic experiences still do not develop full psychotic symptoms if they reject the external cause of them. For example, I thought I heard a voice calling me, but it must be because I’m so tired I imagined it.” It is possible to have hallucinations without being deluded as discussed earlier. Psychosis occurs when the experiences are assigned as external and personally significant.

This multi-dimensional model has amalgamated much of what researchers have discovered about hallucinations and delusions. Given the complex and heterogeneous nature of psychotic phenomena it is likely that there are many interacting factors that contribute to them. The model is speculative, but considering the research findings that have been discussed above, it seems plausible. It is still relatively new and can be further developed as more is discovered.

6 Clinical Implications

Since it was believed that hallucinations and delusions were spontaneous and beyond the control of the individual suffering with psychosis, treatment was not focused on trying to learn about the symptoms. In fact, the belief was that talking about them would only reinforce them and perhaps exacerbate them, so that discussing them was not encouraged. The emphasis has traditionally been on medication. The research
findings that hallucinations and delusions can be understood and that they have meaning has had enormous implications for the treatment of those suffering with psychosis.

Traditionally clients had to make a choice between believing in their delusion or hallucination or believing that they were mad. The aim of recent therapy is to help the person find an alternative, plausible and less distressing explanation of their experiences. However, if that individual can not accept an alternative explanation, then the therapist helps the client to become less distressed and disrupted by their belief. The application of cognitively orientated approaches has begun to fill a serious gap in the management of people struggling to grapple with the impact of these disorders on their lives. The personal predicament of the person with a psychotic disorder is at last being recognised and responded to.

The models provide a useful aid to understanding the nature and meaning of hallucinations and delusions. Many cognitive strategies for people with psychosis have resulted from these models. The heterogeneity viewed both in clinical presentations and in research findings suggests that psychotic experiences can be best understood within a multi-dimensional approach. This method of viewing delusions as explanations of experience and regarding them as attempts to make sense of events has changed the way that clinicians work with their clients.

Each person’s treatment is guided by a formulation, made specifically for that individual, of the factors that maintain the disorder. It is now recognised that differences in causal processes may exist even between delusions of the same content. Recognition of the role of life experiences in shaping the nature of the interpretations made should be taken into account in producing a formulation and assessment of factors commonly associated with the development of psychosis such as sexual and physical assault history.

Recognition that psychotic experiences are related in certain ways to individuals’ personalities and to stresses in their environment influences the way that they are worked with. For example, psychotic beliefs that are consistent with ingrained
negatively distorted beliefs about the self (e.g. I am bad) are more firmly held by the individual. Generation of an alternative explanation for a person's psychotic experiences and a good rationale for therapy by collaborative development of a formulation will help engage the client and determine the type of intervention. Particular treatment approaches involve focusing on the voices, challenging the evidence for beliefs about the voices and integrated CBT approaches to various symptoms. Now that it is more commonly believed that psychotic experiences are understandable rather than being ignored, gathering information about actual symptoms has become more important rather than following a treatment for a specific diagnosis. Along with the development of this view researchers have developed reliable and valid psychometric rating scales so that severity of symptoms and distress can be clinically measured and used for treatment issues and for measuring outcome.

The fact that clinicians understand more about the meaning and manifestation of hallucinations and delusions has resulted in being able to help psychosis sufferers to use their own coping tactics for their psychotic symptoms more effectively. It is also important to encourage them to monitor symptoms so that early signs of relapse can be detected and appropriate action can be taken.

The role of a person's beliefs has been pinpointed as important in understanding psychotic experiences. Current interventions focus on beliefs and the understanding that the person develops in the context of the experience of psychosis. This has important clinical implications as it suggests that treatment is likely to be more effective if offered early.

Findings have consistently shown that emotion has an important role to play in psychotic experiences, as they are associated with high levels of emotional distress (e.g. anxiety, depression, etc.) (Garety, Fowler & Kuipers, 2000). It could also be that emotion is a consequence of the psychotic symptoms. Therefore, it is important to recognise emotional disturbance and to take into account the ways in which it contributes to the formation and maintenance of psychotic experiences. Approaches to treatment should not just attempt to change the hallucinations and delusions or to isolate the content or emotionally related themes. Therapy should focus more on
alleviating distress, dysfunctional patterns of thinking associated with emotional disturbance and to try to improve self-esteem. Working in this way may also be more helpful to the client rather than them thinking of the causes of the psychotic experiences (e.g. internalisation).

The findings also suggest that individuals with psychosis may be sensitive to people regarding them as mad. Individuals can benefit from knowing de-stigmatising information about the nature of psychotic symptoms. They can be reassured that the experience happens to many other people and that it seems to be on a continuum with normal experience and therefore not necessarily dangerous or threatening. They can also learn about how psychological processes, such as cognitive biases, can lead to subjective experiences.

Classical views must have been frustrating and distressing for the client. It must have been hard for clients to form a rapport with their therapists when they felt that they were not being listened to. Research findings that the content of these psychotic experiences can be understood in terms of certain factors and made sense of has led to a more supportive therapeutic environment. Supportive counselling has been found to lead to improvements in hallucinations and delusions, which suggests that even providing a safe environment in which a person can discuss their problems can be beneficial (Chadwick, Birchwood and Trower, 1996).

These findings also highlight the importance of social support. If a person is isolated they will not have an opportunity to reconsider alternatives to their psychotic experiences in interactions with others and ideas of threat may be more likely to prosper. This also has implications for those who do not generally like to share their feelings with others or those for individuals who are secretive or find it difficult to trust people.

7 Conclusions

The available evidence does not support the view that psychotic experiences are not understandable and exclusively associated with mental illness. It is also unlikely that
this is due solely to a biological basis. However, it is likely that some individuals have a genetic predisposition to developing psychosis. Recent research findings have suggested that psychotic experiences are experienced by many people in the non-clinical population and that they are on a continuum with normality.

Cognitive theoretical models and research examining their validity have provided useful insights into whether psychotic experiences are understandable or meaningful. The most useful model, which provides the most insight into how peoples psychotic experiences can be made sense of, is Garety and her colleagues’ (2001) model. This views psychotic experiences arising from a search for meaning. This is effected by a complex interaction of psychotic processes, pre-existing beliefs and the personality of the individual and the environment.

This has important clinical implications for working with people with psychosis. The complex interaction of factors in understanding psychotic experiences means that treatment needs to be guided by each individual’s own formulation. There needs to be recognition of any relevant factors such as amount of emotional distress, cognitive biases, individual’s social support networks, etc. Normalising, de-stigmatising and explaining some of the psychological processes within delusions and hallucinations can help the individual feel more in control of the situation. Clinicians listening and actively working with clients in dealing with their symptoms will also improve the therapeutic alliance.

Further research could look at improving clinicians’ understanding of psychotic symptoms by taking more notice of the person’s subjective experience of psychosis and the way that they try to make sense of these experiences and cope with them. Research that studies clients in remission or use longitudinal methodology, or non-clinical populations with high delusional type ideation could provide valuable insights into mapping how these cognitive processes interact over time.
References


What role do clinical psychologists have in the assessment and treatment of people with learning disabilities who have been sexually abused? How can they assist with the prevention of such abuse?

Year 1: August 2004
Introduction

The subject of the abuse of vulnerable adults is a contentious issue. There are many different types of abuse: physical, neglect, financial, emotional, racial, etc. This essay will only be examining sexual abuse. Historically, there has been ignorance and denial about the prevalence of sexual abuse with people with learning disabilities (Bambrick & Craft, 1992). Recent research examining the prevalence of abuse among people with learning disabilities eliminate any doubts regarding the importance of protecting vulnerable people as well as empowering them.

This essay will define sexual abuse, explore the legal viewpoint of what constitutes sexual abuse and examine prevalence rates and various findings that have been highlighted through research. It will also examine the role of the clinical psychologist when assessing sexual abuse, examining issues such as consent, facilitating discussion of the abuse and influencing factors of severity. It will discuss various interventions that can be used such as working with psychological difficulties resulting from the abuse, the impact of the court case, individual therapy and family therapy. It will then explore how clinical psychologists can assist in the prevention of abuse through the development of policies and guidelines for services, training for staff, clients and other people with learning disabilities, supervision, treating offenders and research.

Definition of sexual abuse

Turk and Brown (1992) define sexual abuse as occurring “where sexual acts are performed on or with someone who is unwilling or unable to consent to these acts.” They also distinguish sexual between contact and non-contact abuse.

“Non-contact abuse – Looking, photography, indecent exposure, harassment, serious teasing or innuendo.

Contact abuse – Touch, e.g. of breast, genitals, anus, mouth.

Masturbation of either or both persons.
Penetration or attempted penetration of vagina, anus, mouth with or by penis, fingers, other objects”.

Sexual abuse can be ongoing or may have occurred on an isolated incident. It is difficult to judge one sort of abuse as more serious than another as individuals differ so much in their reactions to the same event. Research studies vary in what situations they include as sexual abuse and how they group them together.

Sexual Abuse and the Law

If someone does not give consent to sexual activity then that person is protected by the law against rape or sexual assault. The law recognises that there are some people who cannot consent (e.g. people under the age of 16, within sadomasochistic acts, people who are detained under the Mental Health Act). In regards to people with a learning disability the Sexual Offences Act (1956) states that it is an offence for a man to have sexual intercourse with or procure for others, a woman who has a severe learning difficulty (Brown & Turk, 1992). The definition of severe learning difficulties is determined by the jury and is therefore arbitrary especially since most of the general public have had limited contact with the wide range of people with learning disabilities, who clinicians may argue, fall outside this definition. Therefore, this removes from many women, who are able to do so, the right to consent to mutual sexual relationships. However it also provides an opportunity to challenge abusive relationships (Brown & Turk, 1992).

Prevalence and Reporting Rates

The barriers often associated with reporting abuse suggest that many cases do not come out into the open. Prevalence studies looking at the sexual abuse of people with a learning disability have been published which show a wide range of figures. Turk & Brown (1993) examined reports filed through statutory agencies and reported that 0.5 per 1000 people with a learning disability had been sexually abused. Only one in ten
of these cases led to prosecutions. Buchanan and Wilkins (1991) asked staff working with people with a learning disability and concluded that there was 8% prevalence of sexual abuse. Cooke (1990) estimated a prevalence of 4.5% as a result of questionnaires that he sent to psychiatrists. Dunne and Power (1990) did a retrospective study by interviewing staff and examining case notes of adults with learning disabilities seen by a community team over a three year period and arrived at a figure of 2.88 per 1000 adults with learning disabilities.

McCarthy and Thompson’s (1997) study reported that out of 185 people with learning disabilities 61% of the women and 25% of the men had been sexually abused. Hard and Plumb’s (1987) study asked service users themselves about their experiences with non-consensual sexual contact. 58% reported sexual abuse.

Clearly, estimates of the extent of abuse vary considerably and this seems to depend on who is asked, about what and how the researchers gain access to the data. It is difficult to compare studies which have different methodologies. However, it seems apparent that the incidents of sexual abuse decrease the further away from individuals with learning disabilities a researcher goes for information.

**Patterns of Abuse**

A more consistent picture emerges from studies about patterns of sexual abuse. Both women and men are victims. Studies estimate that two thirds to three quarters of the victims are female (Carmody, 1991; Stein, 1998). The abusers are predominantly male and are usually known rather than strangers, often in positions of trust or authority and many will have abused before (Brown, Turk & Stein, 1995). These perpetrators come from four main groups: staff and volunteers, family members, trusted adults within the community such as family friends, neighbours, etc. and other people with learning disabilities (Furey, 1994). Brown, Stein & Turk, (1995) conducted a two year incidence survey looking at the sexual abuse of people with learning disabilities. They found that the largest proportion of cases were in the moderate to severe level of learning disability (61%).
Vulnerability

There are a number of factors which make people with an intellectual learning disability particularly vulnerable to sexual assault. Cross, Kaye & Ratnofsky, (1993) asserted that children with learning disabilities and physical disabilities have a risk for sexual abuse that is 1.8 times greater than that of their peers without disabilities. The majority of people with a learning disability have little understanding of sexual feelings and behaviour and their rights to choose or decline sexual partners. This creates uncertainty about what is acceptable behaviour from others and increases the possibility of sexual exploitation (Lumley & Miltenberger, 1997).

Many people with learning disabilities have restricted social lives. This can create increased reliance on family, caregivers and may foster a desire to be compliant and please other people (Rosen, Floor & Zistein, 1974). It also limits their contact with protection or victim support services (Carmody,1991).

Impaired communication skills could also contribute to increased risk of abuse. First, they may be perceived as a “safe” victim as they will be unable to report an occurrence of abuse. In cases where abuse is reported it is often not investigated to the same degree of intensity, generally because of legal issues surrounding the acceptability of the individual’s testimony (Robertson, 1987). Brown & Turk (1995) recorded in their incidence study that 31% of people with learning disabilities who had been sexually abused had additional communication difficulties.

Sexual abuse is not just a sexual act but is an abuse of trust authority and power. Adults with learning disabilities often find themselves being cared for and controlled by more powerful individuals (Carmody, 1991). Some people particularly those who are also physically disabled have special needs which means that carers often have more access to their bodies than would be considered typical. Having limited mobility could also result in an inability to escape from unwanted advances (Sobsey & Mansell, 1990).
People with learning difficulties often live and work in congregate settings like residential homes and day centres where they are more vulnerable to the exploitation of both authoritative figures and other service users. Sobsey and Mansell (1990) assert that “the risk of being sexually abused in an institutional setting is two to four times as high as for being sexually abused in the community”. In addition, people with a learning disability often have a tendency to acquiesce to the suggestions of others. Walmsley (1989) stated that they “tend to obey rather than challenge their caregivers. They tend to have less choice and frequently have not been educated to believe that they have control over what happens to them”.

**Clinical Psychologist’s Role In Assessing Sexual Abuse**

The occurrence of sexual abuse may be presented either overtly or covertly. The majority of abuse is discovered through disclosures made by the victim. Brown & Turk (1995) reported that 53% of individuals whom they had surveyed had disclosed the abuse themselves. Some people disclose their abuse and are able to make some degree of connections between the experience and their current problem and therefore seek treatment as a result of the abuse. Others do not readily disclose their abuse and often do not connect it in any way with their difficulties. Some individuals may not understand what constitutes abuse despite indications of it’s probable occurrence. This essay will only examine the assessment of sexual abuse which is openly disclosed to the therapist.

A particularly important area that clinical psychologists often need to assess is the individual’s capacity to consent. Although the law states that this can be performed by a medical professional, clinical psychologists are often asked to assume the responsibility. This may be because they can assess more objectively things such as intellectual level and can educate and support the client at the same time.

Brown & Turk (1992) stipulate that there are three main issues when considering consent:
1. whether the individual consented because otherwise he or she has been sexually assaulted.

2. Whether the individual could give consent. Does the individual understand about sexual behaviour and realise what was happening?

3. To judge whether the person with learning disabilities was under undue pressure in that particular situation (e.g. in a caregiving or authority relationship, perhaps with staff or a family member or where force, trickery or exploitation was used. Physical force, threat of violence or reprisals are also indicative that the individual did not consent.

This can be done using formal assessments. A cognitive abilities assessment could be administered such as the Wechsler Adult Intelligence Scale – III. The Gudjonsson Compliance test which assesses compliance could also be used or the clinical psychologist could assess specific skills such as memory, skills, knowledge, sexual awareness, decision making, money skills, etc. Alternatively informal assessments could be carried out such as discussions with families and carers, examining case notes and records, observations and conversations with the client and comparisons to other people who do not have learning disabilities. Together this should provide the clinician with more understanding of the client’s understanding of sexual issues, capacity to consent and their level of learning disability (C. Hagland, lecture notes, 21.06.04).

The clinical psychologist must make the decision of whether they need to alert others to the abuse. For example, if the abuse is still going on, if others are at risk or if the individual would like to take legal proceedings against the abuser then other agencies need to be involved. The person should be listened to, safeguarded and all information should be carefully recorded (British Psychological Society, 2001). There may need to be negotiation with the individual over who will be informed. Where there is concern about abuse which may not constitute a criminal offence it should be reported to the service’s line manager. If there are concerns that a vulnerable adult has been the victim of a criminal offence then it should be reported to the police and community care services (ARC/NAPSAC, 1993). The individual should be encouraged to have as
active a role in the situation as possible and where possible their wishes should be incorporated into whatever action is taken (Furey, 1994).

Within the assessment the clinical psychologist should aim to facilitate the disclosure and exploration of the abuse and its' consequences and take a history from the victim and perhaps other informants. Details of the abuse such as duration, age at onset, type of abuse, relationship with abuser, nature of the sexual activity, level of violence are considered important factors in assessing the severity of the psychological impact of the abuse (British Psychological Society, 2001).

Examples of information that would be useful to know would be the client's perception of their problems, their needs and any suicide-risk; the specific history of the abuse - who did what to whom, when and how; the meaning of the abuse to the client; if there was any neglect or exacerbation of any original problems as a result of the abuse; the relation of earlier life themes to abuse as perceived by client; previous functioning and vulnerabilities and more general information about the client such as earlier life history.

The therapist should offer reassurance and show that they are comfortable with discussing the abuse and regard it a relevant issue for therapy. The individual may find discussing the sexual abuse difficult and the psychologist should be mindful of the reasons for this. The perpetrator may have been threatening or pressurising them and they may be afraid now that they have disclosed (ARC/NAPSAC, 1993). Pressure can also be exerted through an intense loyalty that many victims feel to the abuser so that discussing it feels like a betrayal, particularly if one or more of their parents have abused them (Finkelhor & Brown, 1986). They may be emotionally attached and or dependent on their abusers and fear consequences such as the break up of their family or may blame themselves for the abuse (Finkelhor & Brown, 1986).

Victims may fear stigmatization and rejection by others (Lumley & Miltenberger, 1997). For people with a learning disability this may not be wholly unrealistic as they may have tried to disclose in the past and had their claims ignored, rejected or criticised by professionals (ARC/NAPSAC, 1993). They, may find it difficult to open
up to others because they do not trust other people which may have arisen from the abuse and the surrounding circumstances. For example, they may have been isolated and repeatedly told to fear people outside the family (Carmody, 1991). However, they may be unaware of certain events of the abuse because of denial, repression, suppression or dissociation (Johnson, 2001).

The therapist should be aware of the client’s social, emotional and cognitive level of development and use appropriate language, being mindful of the individual’s capacity to understand certain concepts (e.g. locating events in time). They should also be aware of research, which examines the impact of questioning, on individual’s memory and reliability (Steward, Bussey, Goodman & Saywitz, 1993).

Some clients may not have the verbal skills to enable them to talk about their experiences (Grove, Bunning, Porter & Olsen, 1999). It may be beneficial to work more visually. The clinician could use anatomically correct dolls or anatomical drawings (Valenti-Hein, 2002). They could ask the individual to draw pictures or show them pictures that have different types of sexual abuse presented visually (Hollins & Sinason, 1992).

It is also important to be aware of gender differences in the impact of abuse and abuse indicators. Research has tended to focus on the impact for female victims (Bentovim, 1996). Relevant impact factors for males to consider are whether there was use of homosexuality and homophobia in threats to prevent the individual disclosing and whether the potential sexualisation of fear occurred. One could also explore what tension reducing coping strategies were used during the abuse and if the abuse has resulted in shame of their own sexual functioning (Sequiera & Hollins, 2003).

Cultural differences and values are also important to consider. Different cultures have different views on which parts of the body are ‘private’ and may feel more or less violated at having these areas touched. Different beliefs within cultures may have an impact on how themselves and their families respond to the abuse.
The Clinical Psychologist’s Role in Treating Sexual Abuse

Many emotional and behavioural symptoms have been associated with the experience of sexual abuse. The clinical psychologist needs to be mindful of these whilst working with their clients. Post Traumatic Stress Disorder (PTSD) symptoms may be present. This anxiety based disorder is often associated with the subjective experience of threat to life and safety. Ryan (1994) reported that 16.5% of 310 referrals for sexual abuse met the DSM-III-R (American Psychiatric Association, 1987) criteria for PTSD. However, this sample was drawn from a clinical population so it is unclear whether this is representative of the wider population of people with a learning disability who experience trauma.

Some symptoms that appear more prevalently in people who have been abused are depression and low self worth (Johnson, 2001), withdrawn passive behaviour (Sobsey & Mansell, 1994), anxiety (Dunne & Power, 1990), psychosis (Varley, 1984), eating problems (Dunne & Power, 1990), somatic problems (Burke & Bedard, 1995), increased activity levels and decreased concentration (Sobsey & Mansell, 1994), sexual problems (Mansell, Sobsey & Calder, 1998), sleeping problems and increased body self consciousness (Mansell, Sobsey & Calder, 1998) and challenging behaviour (Burke & Bedard, 1995). Increased sexual interest and sexual knowledge is also common and this can lead to greater levels of sexualised behaviour (Vizard, 1989). Sexualised behaviour has been identified as perhaps the only symptom which might be expected to differentiate abused from non-abused children (Monck et al, 1996).

Some symptoms which are linked more to male than females are aggressive behaviour (Mansell, Sobsey & Moskal,1998), sexual offending (Brown & Stein, 1997) and other victimising or offending behaviour (Mansell, Sobsey & Calder, 1992).However, there can often appear to be an absence of symptoms, which may be due to protective factors or the suppression of trauma (Hollins & Sinason, 2000).

Some researchers assert that the effects of sexual abuse are more devastating for those with a learning disability because of coping difficulties and additional vulnerability to abuse (Tharinger, Horton & Millea, 1990; Mansell, Sobsey & Moskal, 1998).
There are very few outcome studies that assess treatment effectiveness particularly within a learning disability setting. Clinicians are left with few evidence based guidelines as to the severity of the impact on the person and the most appropriate interventions to make (Finkelhor & Brown, 1986).

Some people may present with serious psychological symptoms. These may have been present before the abuse and contributed to their vulnerability, they may have worsened as a result of the abuse or the presenting problem or could be a direct result from the abuse (Furey, 1994). He/she may decide to address the psychological symptoms related to the abuse or to deal with specific aspects of the abuse such as the court case.

**Individual Therapy**

Cognitive behavioural therapy is commonly used to treat sexual abuse (British Psychological Society, 2001). Due to the different emotional difficulties that can result from sexual abuse clinicians can feel that they have a complex list of problems to which clients are vulnerable. The clinical psychologist should develop an individually tailored treatment plan based on the formulation. Finkelhor & Brown (1986) state that when treating individuals who have been sexually abused it is useful to analyze the experience in terms of four trauma causing factors and the psychological impact of each. These are traumatic sexualisation, stigmatization, betrayal and powerlessness.

Cognitive restructuring can focus on these four areas and any associated symptoms. The stigmatisation distorts an individual’s sense of value and self worth and can result in feelings of badness, shame, guilt. Powerlessness distorts their sense of ability to control their lives causing anxiety, fear, low self efficacy. Traumatic sexualization may shape sexuality inappropriately and effect interpersonal relationships causing sexual identity confusion and sexual norms, increased preoccupation or aversion to sex. Betrayal can occur through the realisation that a trusted person has manipulated them, lied to them or disregarded them and may result in grief, dependency, anger,
mistrust, depression (Finkelhor & Brown, 1986). This model does allow one to organize and theorize about many of the outcomes and encourages deeper understanding of the problem. Although it was not developed specifically for people with learning disabilities the authors posit that it can still be applied when working with people with a learning disability.

For some individuals with learning disabilities it may be that more traditional types of interventions are more difficult to implement. Living your life (Craft & Nottinghamshire SLD, 1991) is a package which has been developed for use with people with severe learning difficulties. It covers physical emotional and personal development but also looks at issues of exclusion and difference which come up in sexual awareness. It offers practical advice about sexual abuse and other issues such as HIV. Sex and the three R's is another package aimed for people with moderate to severe learning disabilities. This looks at options available to people living in hospitals and explores abusive relationships that are experienced by many people in residential settings (McCarthy & Thompson, 1993).

Hollins and Sinason (1992) have published visually clear books that are designed to help people name abusive sexual experiences. These are designed to enable a person with learning disabilities to open up about their experience of sexual abuse. They are pictorial and can also be useful for those who have limited verbal ability (Hollins & Sinason, 1992). The clinician should be creative in thinking of the best way for their clients to express themselves using an array of visual stimuli (Valenti-Hein, 2002).

Psychologists could work on issues surrounding the impact of the abuse on their lives in more practical ways. Very few cases involving the sexual assault of people with a learning disability reach the court system (Brown, Stein & Turk, 1995). When they do reach court, the experience can be very confusing. Clinical psychologists can work with their clients in preparation for the experience. They could address the difficulties that may arise from the court appearance such as long gaps in time between court appearances, seeing the abuser, the complex language used, the cross-examination process and limitations that may make it more difficult for them (e.g. memory
problems) and the trial outcome. This can also be done in other areas of their lives such as effects on relationships, occupation, etc.

The clinical psychologist may need to work with the families, carers or staff involved with the client so that the client receives the optimum support (British Psychological Society, 2001). The psychologist may need to make recommendations on residential placement, daytime activities, and refer the individual for other appropriate forms of treatment (e.g. art therapy). They should be mindful of where the likelihood of more abuse is minimal and aware of any options for specialist services or treatment (ARC/NAPSAC, 1993).

The System

Family therapy can be an effective intervention for sexual abuse particularly if the perpetrator is a family member (Furniss, 1983). While some advocate immediate use of family treatment in order to restore appropriate role relationships (Pittman, 1976) others assert that families are not ready for joint meetings until all members have had individual therapy (Porter, Blick & Sgroi, 1982). Similarly, Furniss (1983) uses a family systems approach but feels that initial work must be with individuals and dyads. However, for this intervention to be most effective, the perpetrator must admit responsibility, apologise to the child and reassure the person that it will not happen again which is not always the case. The non offending parent must take responsibility for not protecting their son/daughter. Much work on denial and responsibility would have to be done before this would be possible.

How Can Clinical Psychologists Assist in the Prevention of Sexual Abuse?

Prevention of abuse requires the combined efforts of many individuals and disciplines. Many of the following points being made in this section are already happening in some services to differing degrees but these need to be happening routinely and to the same standard nationwide.
Clinical Psychologists could develop policies and guidelines for good practice and effective responses within services. Policies are needed that recognise adults with learning disabilities have a choice about issues such as their sexuality (ARC/NAPSAC, 1993). These policies should provide direct service staff with guidance about issues such as determining consent, offering privacy, and allowing individuals the necessary education to make informed choices.

In Turk and Brown’s (1993) incidence survey none of the learning disabled men who sexually abused others with learning disabilities were prosecuted showing that attitudes towards abusing are inconsistent and that convictions depend more on the status of the individual than on the nature of the offence. Each service should have well established procedures to be followed when an allegation of sexual abuse is made. This improves knowledge and awareness, and agreed channels of reporting would lead to more consistent patterns of recognition and reporting (ARC/NAPSAC, 1993). Policies and guidelines are important in ensuring that vulnerable adults are protected and not viewed as such easy targets within services. All policies should be accessibly presented, clearly understood and implemented. However, these policies are essentially reactive as they offer advice about responding to abuse that has already occurred.

Clinical psychologists could also develop training packages that could be implemented by themselves or by other mental health professionals. People with learning disabilities are being integrated into the community more and more but without the support and protective measures that need to go with it. Individuals need to have training in recognising, preventing and reporting sexual abuse. This is especially important for people unable to verbally communicate. Training would also be useful for helping other mental health professionals recognise the indicators of abuse so that there can be more prompt recognition of abuse when it does occur.

Sexuality training is also essential for people with learning disabilities. Having no knowledge about sexual matters increases their risk as they may not realise when they
are putting themselves at risk and can not explain or understand what has happened to them when something does occur.

Rusch, Hall & Griffin (1986) suggest there is an association between challenging behaviour and abuse. Training by clinical psychologists would be useful to offer staff insights and understanding into the function of the behaviour for that individual rather than them seeing it as being deliberate, wilful and directed against them. This labelling of “challenging behaviour” can mask the importance of specifically sexualised behaviours as a form of language (Vizard, 1989).

Studies that have looked at types of staffing have identified high levels of sickness leave, staff turnover and shortages contribute to the vulnerability of sexual abuse. This is due to understaffing, increased numbers of new and inexperienced staff and requiring existing staff to work longer hours with associated risks of stress, fatigue and the development of a controlling style of care (ARC/NAPSAC, 1993). Although there have been concerns associated with new staff, it has also been observed that new staff are also more likely to make complaints than established staff (Wardhaugh & Wilding, 1993). Therefore, it could be beneficial for clinical psychologists to have a role in training new staff about patterns of abusing, recognising reporting abuse with the confidence that any allegations that they do make will be acted on promptly and with sensitivity. Appropriate training and guidance could promote good practice and promote the confidence to recognise and report poor practice (Brown, Stein & Turk, 1995). Psychologists need to consider the environments that their clients live in and whether these promote abuse.

Merely increasing training opportunities is not sufficient. It is important that in conjunction with this, strategies are identified so that the training positively influences practice (McCarthy & Thompson, 1996). This is an area which would benefit from further research.

If a person with learning disabilities discloses to another mental health professional then a clinical psychologist could undertake a supervisory role. This can guide the individual in methods of supporting their client in exploring and dealing with the
abuse. It also provides support to the staff member through what can often be a difficult and demanding experience that could otherwise leave one feeling isolated and unsupported (ARC/NAPSAC, 1993).

Maintaining positive attitudes to people who display challenging behaviour can be difficult. Supervision by clinical psychologists could help staff maintain non-discriminatory perceptions of individuals which could be beneficial in maintaining a non-abusive environment (Sequiera & Hollins, 2003).

Bentovim (1996) asserts that sexual abuse can sometimes be a factor in triggering abusive action in children who have been abused. Effective treatment from clinical psychologists may break the cycle of abused becoming the abusers. When sexual abuse does occur, appropriate treatment services should be made available not only to the victims but also to the offenders to try to prevent them from re-offending. This will highlight the perpetrator's own problems which may before have been going unnoticed and may prevent them from serial offending.

Part of the clinical psychologist's role is to carry out research. Research has increased the recognition of mental health needs and risks of sexual abuse for people with learning disabilities (Turk & Brown, 1992). More research and dissemination of the results of this throughout services can make other individuals more aware of the patterns and effects of abuse within this group. This knowledge can in turn help them to develop effective detection and treatment strategies. Future research is also important in helping us understand more about areas in which less is known (for example, the interactions that can occur between having a learning disability and the variable psychological problems associated with sexual abuse.

Clinical Psychologists are playing an important role in the treatment, education and prevention of sexual abuse with people with learning disabilities. However, research has highlighted the fact that most abuse comes to light through disclosure (McCarthy & Thompson, 1997). This suggests that clinicians are still not recognising physical and behavioural evidence of abuse. Therefore, individuals who feel unable to disclose because of fear, distress or communication difficulties, remain vulnerable to continued
abuse. This highlights a need for more proactive research and policy development which takes more of a protective stance. Although there is much literature on identifying factors that place people with learning disabilities at risk of sexual abuse the evidence base for many of the recommendations remains unclear and would also benefit from more research.
References


“Divorce is bad for children.” Critically discuss with reference to the literature on the psychological effects on children of divorce and parental conflict.
Introduction

There has been a considerable rise in the rates of divorce over the past several decades (Bray & Hetherington, 1993). Currently, one in two marriages end in divorce and 40% of children born in this decade will experience their parents’ divorce (Peterson & Steinman, 1994). Remarriage following divorce is common although there is a higher risk of second marriages breaking down (Tzeng & Mare, 1995). When there are children involved the risk is even higher (Bumpass, 1984). As a result, every year more than one million children will experience their parent's divorce (U.S. Bureau of the Census, 1998). These figures vary in different cultures. For example, African American children are twice as likely to experience at least one parental divorce (National Centre for Health Statistics, 1988).

These numbers underestimate the actual scale of parental relationship breakdowns that children are exposed to as many couples cohabit as an alternative to marriage (Bumpass & Raley, 1995). This increase in household reorganisations has major implications for the ways in which children are nurtured and socialised. This has resulted in growing concern over the number of children exposed to divorce and its psychological effects and has fuelled much research into the area. This essay will look at the types of psychological effects that can impact on children whose parents divorce. It will also look at how the range of responses can be understood by looking at research findings and the divorce stress adjustment perspective (Amato, 2000). This essay will also focus on mediating factors such as decline in parental support, loss of contact with the non-residential parent, interparental conflict, economic decline and other stressful divorce related events. It will also examine moderators such as individual and interpersonal resources.

Types of difficulties

Research findings have varied considerably in their opinions about the psychological effects of divorce on children (Amato & Keith, 1991). These effects range from developing clinical levels of problematic behaviour to gaining enhanced competence.
To clarify these contradictory research findings, Amato & Keith (1991) conducted a meta-analysis of 92 studies. They postulated that parental divorce was associated with children's educational achievement, exhibiting externalizing and internalizing behaviours, psychological adjustment, social competence, self-esteem and relationships with others.

Adolescents from divorced families also exhibit some of these difficulties. However, they are also more likely to drop out of school, become sexually active at an early age, be unemployed, have children out of wedlock, become involved in delinquent activities, abuse substances and associate with antisocial peers (Amato & Keith, 1991; Hetherington & Clingempeel, 1992).

Effect sizes

A great deal of inconsistency exists in the literature as to how large these differences are. Amato & Keith (1991) concluded that these effect sizes are significant but small and that effect sizes had decreased since the 1950's. When adjustment preceding the marital dissolution is controlled the effect sizes are even weaker (Cherlin et al, 1991). However, Amato's (2001) meta-analysis found that effect sizes had increased since the 1991 meta-analysis. One reason he cited for this was the increase in the two parent family wage and the decline of the single parent's wage, thereby putting single parents at an increasing disadvantage. Other studies indicate that 20 – 25% of children in divorced families have problems with psychological adjustment compared to 10% in non-divorced families (Hetherington, 1989; Hetherington & Clingempeel, 1992). However, these difficulties tend to co-occur and present themselves as an array of problems in each child. Therefore, the majority of children from divorced families do not experience these problems (Emery, 1994).

Although Amato and Keith's (1991) and Amato's (2001) meta analyses have been useful in highlighting consistent patterns amongst the divorce literature they have some common limitations. The studies within the meta-analyses differed in many ways that could not be controlled. The authors categorized whether the studies were
poor or good quality using crude decision tree questions such as whether they used convenience or random samples and did not consider other important aspects such as whether the study was longitudinal or cross-sectional. Additionally, the conclusions reached can only be a reflection of the original study quality and many of the studies are flawed with methodological problems. Many of the studies had large samples but inadequate measures perhaps only involving single informants and too few items to assess family characteristics and variables.

**Divorce stress adjustment perspective**

Many theories have been proposed to explain the ways in which divorce affects individuals, such as attachment theory (Hazan & Shaver, 1992), systems theory (Emery, 1994) and attribution theory (Grych & Fincham, 1990). However stress theory perspectives are the most prevalent in the divorce literature (Hetherington & Stanley-Hagan, 1999). Amato (2000) combined these stress perspectives to formulate the divorce-stress-adjustment perspective. This provides a framework that can be used to describe the psychological effects of divorce on children.

Rather than viewing divorce as a one off event, the divorce stress adjustment perspective regards it as being a series of transitions and changes in family relationships and circumstances. This begins when the couple first cohabit and ends long after the legal divorce process. Stressful events associated with the divorce increase the likelihood of experiencing emotional, behavioural and health difficulties. The theory proposes that the severity and duration of these difficulties vary between individuals depending on what mediators (stressors) or moderators (protectors) accompany the divorce experience. Children who experience less of the psychological effects of divorce are able to function effectively in their new family circumstances, at school and in their identity and lifestyle which is separate to their previous marriage (Amato, 2000).

The theory also extends to adults. However for children mediators include: a decrease in the quality of parenting from the residential parent, a decrease in involvement from
the non-residential parent, exposure to interparental conflict, a decrease in economic resources and other disruptive life events such as remarriages and divorces.

Moderators are protective factors that can serve to buffer the effects of the divorce and the mediating factors for each individual. They lessen the child’s experience of stress and the likelihood of negative psychological, behavioural and physical effects. These can include factors such as social support, individual personality traits, coping skills, etc. (Amato, 2000).

Mediators

Decline in parental support and effective control

Amato and Keith’s (1991) meta-analysis indicated that children in divorced single parent families have less positive relationships with custodial parents than do children in intact families. Divorce is an extremely stressful life event and most adults have difficulty adjusting. Hetherington, Cox & Cox, (1985) asserted that within the first year of getting divorced custodial mothers were more depressed, angry, anxious, had lower self esteem, showed less affection to their children, communicated with them less, punished them more and were inconsistent in their methods of discipline. (Whiteside & Becker, 2000).

Parents who are supportive and monitor and control their children effectively, facilitate well being in their children (Belsky, 1990). However, stress impacts on the quality of adult’s childrearing skills and this can have a negative effect on children. A meta-analysis of twelve studies found that within divorced families, maternal depressive symptoms were associated with more child behaviour problems and maternal warmth was associated with fewer child behaviour problems (Whiteside & Becker, 2000).

The quality of the relationship between the parent and child is associated with better psychological adjustment (Amato, 1993). If a distressed parent can maintain qualities
such as responsiveness, warmth, firm control monitoring and communication, adverse effects on children are less likely to occur (Hetherington, Bridges & Insabella, 1998).

Hetherington, Cox and Cox’s (1985) longitudinal study found that a mother’s psychological state and her relationship with her children improved after two years. This is consistent with other findings that most adults adjust to divorce within a few years (Booth & Amato, 1991). However, the wellbeing of children is not as positively associated with length of time since divorce (Bray & Berger, 1993). There are mixed findings within the literature and study quality does not seem to influence one opinion over the other. Amato and Keith (1991) concluded that, overall the findings suggested that there was some improvement in children’s psychological adjustment within the first two years, but that some differences associated with parental divorce persist over a long period of time and often into adulthood.

Children in post divorce families are often give extra responsibilities, independence and increased power in decision making. Generally, daughters have the greatest responsibility for household tasks, care of younger siblings and often confidante to their mother (Hetherington, 1989). Age inappropriate demands are related to resentment, anxiety, depression, antisocial and delinquent behaviour and psychopathology (Bray & Berger, 1993). However, if mothers are supportive and create an egalitarian atmosphere adolescents can benefit from increased participation and responsibility in family life (Peterson & Zill, 1986).

Loss of contact with one parent

Following divorce the majority of children spend a period of time in a single headed households. In 85% of cases this is headed by the mother (Depner & Bray, 1993). Contact with non-residential parents often decreases substantially following divorce. Over 20% of children have no contact with their non-residential fathers and only one quarter of children see their fathers once a week (Seltzer, 1991). Decreased involvement is related to residential distance, low socioeconomic status, high conflict between the parents, having all female rather than male children and remarriage.
(Seltzer, 1991). Under conditions of low conflict, the involvement of authoritative fathers can promote children’s adjustment especially that of boys (Hetherington, 1989). In high conflict conditions, frequent contact with non-residential parents may exacerbate children’s problems (Kline, Johnston & Tschann, 1991).

However, research suggests that it does not seem to be the quantity of contact which facilitates positive adjustment in children, but the quality (Amato and Keith, 1991). This challenges the more traditional perspective that the absence of a parent is detrimental to a child’s upbringing. Amato and Gilbreth (1999) performed a meta-analysis on 63 studies that looked at the relationship between non-residential fathers and their children. They concluded that an authoritative style of parenting was associated with fewer internalizing and externalizing behaviours and higher levels of academic achievement. They also found that more recent studies are reporting more instances of positive effects of father contact. This suggests that fathers are improving their parenting styles and relationships with their children are having beneficial effects on the well being of their children.

Both girls and boys report feeling closer to their residential parent (Hetherington, Bridges & Insabella, 1998). However, Amato & Keith’s (1991) meta-analysis suggested that children in their father’s custody had fewer problems than those in the custody of their mothers. Non-residential mothers tend to have approximately double the amount of contact with their children as non-residential fathers, are more likely to sustain contact and are more likely to continue to parent their children in an authoritarian style (Zill, 1988). Perhaps this supportive role played by mothers could partially account for the difference.

The introduction of a stepparent forces a renegotiation of the non-residential parent’s role (Hetherington, Bridges & Insabella, 1998). The remarriage of the residential parent is not related to withdrawal by the non-residential parent but if the non-residential parent remarries their contact usually subsides (Amato, 1993).
Parental conflict

Interparental conflict and lack of cooperation between parents during divorce is a consistent predictor of poor outcomes among children (Amato & Keith, 1991; Davies & Cummings, 1994). Conflict contempt and anger often antecede divorce and can escalate in the immediate aftermath (Hetherington, Cox & Cox, 1985).

By the time the marriage breaks down children have often spent years feeling fearful and unsupported by their parents in a conflict ridden home (Hetherington, 1989). There is also strong support that indicates that problems in the children’s behaviour are often visible before the marital dissolution in conflict ridden marriages (Bray & Hetherington, 1993).

Cherlin et al (1991), looked at national longitudinal data sets in the U.S. and England. They found that prior to divorce children within high conflict families showed more behaviour problems and lower academic achievement than low conflict intact families. This has led authors to conclude that many of the outcomes attributed to divorce are caused by conflictual marriages and that divorce can be a preferable alternative to remaining in a distressing marriage. There is consistent evidence that children function better in a harmonious single parent household than in a conflictual two parent household (Hetherington, 1989; Grych & Fincham, 1990).

The frequency of the conflict is not as detrimental as the type of conflict (Amato, 2000). Conflict is particularly detrimental if it involves physical violence or makes children feel as though they are caught in the middle while their parents denigrate each other, initiate loyalty conflicts or communicate using their children (Amato & Keith, 1991).

This conflict is not only extremely stressful for children but can also have an impact on children’s attachment to their parents resulting in emotional insecurity (Davies & Cummings, 1994). Even when children are not directly involved in their parent’s conflict, the adverse effects of it can still be experienced through diminished monitoring, involvement and support and increased irritability levels (Patterson, 1991). Children in high conflict families often learn that they can use the situation to
exploit and mislead their parents and escape monitoring of their activities as they get older (Hetherington, Law & O'Connor, 1992).

Although cooperative parenting between parents who have divorced is in the best interests of the children, this is only achieved in one quarter of cases (Maccoby & Mnookin, 1992). It is most likely to occur when the family size is small and when there is little conflict at the time of divorce (Maccoby, Buchanan, Mnookin & Dornbusch, 1993).

With low conflict and cooperative parenting children adapt not only better to their parents divorce but tend to have more positive relations with their stepparents (Buchanan, Maccoby & Dornbusch, 1991). However, it is difficult to conclude too much from this as the explanations for this could be multiple. One explanation may be that cooperative parents are more likely to agree to joint custody than other parents.

Even in families that have joint custody, the most common parenting style is parallel parenting in which parents rarely consult each other, and each parent makes important decisions about the welfare of the children (Maccoby, Depner & Mnookin, 1990). However, this study was conducted two years following the divorce which is still relatively soon after the divorce. It would be interesting to see if parenting styles changed as time progressed. Conflict often increases in the first few years following divorce as couples negotiate economic issues, visitation, parenting issues and rights and responsibilities (Hetherington, 1993).

When divorce is associated with a move to a less stressful and happier situation, children in divorced families tend to be higher in social responsibility and cognitive ability and lower in externalizing and internalizing behaviours than those in high conflict distressed families (Amato, Loomis & Booth, 1995). A shift to a less stressful and more harmonious household is advantageous for children’s psychological well being (Hetherington, Bridges & Insabella, 1998).

When divorce is associated with high levels of conflict and stress children show more problems in divorced families than in high conflict non divorced families. (Amato,
Booth & Loomis, 1995). Perhaps high levels of conflict have a more detrimental impact on the adjustment of children in divorced than in intact families because of the stressful life events and changes that also accompany the divorce. Therefore, if conflict is going to continue following the divorce, it is better for children to remain in a high conflict two parent house than to endure a divorce (Hetherington, 1989).

**Economic decline**

The divorce stress adjustment perspective suggests that marital dissolution often triggers a series of negative economic and social changes. In the first year following divorce the average income received by women falls by approximately 40% (Amato, 1993). This loss of income has repercussions for where children live, what school they attend, the quality of neighbourhood and local services, peer group and accessibility to jobs, healthcare and support networks (Amato, 1993). Due to economic necessity the residential parent may have to go out to work or increase their workload because of economic necessity (Hetherington & Stanley-Hagan, 1999). This economic decline can also be stigmatizing for children (Amato, 2000). For custodial mothers remarriage is the fastest route out of poverty (Amato, 1993). Custodial fathers do not experience the same decrease in finances (Leon, 2003). Therefore, it might be expected that children who live with their father may exhibit fewer behavioural difficulties than those who live with their mother.

In addition, single parents with low incomes may not be able to afford educational toys, books, computers, private lessons and many other items that one may associate with academic improvement. Negative events such as an illness or housing difficulties may be a far greater concern to a single parent than for two parents who have greater resources and mutual support (Amato, 2000). However, one must also consider that there are cases in which single parenting may be easier than living with a non-supportive spouse who causes additional stressful problems.

Economic decline can account for some of the negative consequences of divorce. However, Guidubaldi, Cleminshaw, Perry & McLoughlin (1983), studied children in
divorced families and children in intact families and stated that the children in divorced families scored below the controls on 27 out of 34 outcomes. However, when the two samples were controlled for income the number of significant differences were reduced to 13. Therefore, income seems to account for a significant part of the variance in children’s outcomes associated with divorce, particularly academic achievement. This evidence supports the divorce stress adjustment model because it suggests that although economic decline has a detrimental impact on the psychological effects on children, there are other factors that are also at work. It is the interplay of these factors that cause the variable outcomes on children’s adjustment.

Other stressful divorce events

When children are exposed to multiple stressors it makes children more vulnerable to experiencing detrimental effects (Amato & Keith, 1991). Children are often exposed to many stressors such as parental conflict, changes in parenting styles, changes in availability of both parents, depressed economic resources more chaotic household routines and adjusting to different roles such as having to look after younger siblings (Leon, 2003). Children often seem to grow up fast in response to these changes. One has often heard this observation remarked upon by parents in clinical practice.

For many children, adolescence and the developmental changes that accompany it such as individuation and intimacy can trigger problems that have either not previously emerged or have subsided (Hetherington, 1989). Approximately one third of adolescents become disengaged with their families. If this leads to greater involvement with constructive relationships outside the family this can be an adaptive coping strategy. If it is associated with antisocial groups and activities that have little adult monitoring this can have a detrimental effect on behaviour (Hetherington & Anderson, 1987).

75% of divorced mothers and 80% of divorced fathers remarry (Glick & Lin, 1986). African Americans and Hispanic Whites are more likely to separate but not legally
Amato (1993) analysed 21 studies and concluded that children in stepfamilies compared with children from single parent divorced families scored lower in psychological adjustment and slightly lower in conduct. Children in new stepfamilies report higher levels of both positive and negative life changes than those in intact families (Hetherington et al, 1985). Although there is economic improvement there are often conflicts over finances, parenting skills and family relations which can often counter the benefits associated with increased income (Amato & Booth, 1991).

Remarriage can also put children at greater risk of being abused. Rates of physical abuse are 7 times higher for step fathers on their stepchildren (Daly & Wilson, 1996). There is also agreement amongst the research that children who have experienced multiple divorces are at greater risk of experiencing psychological difficulties (Capaldi & Patterson, 1991; Kurdek, Fine & Sinclair, 1995).

Newly married parents can become depressed or pre-occupied as they cope with the new changes to family life which has implications for their parenting skills (Hetherington & Clingempeel, 1992). The changes in family relationships can undermine or support the efforts of children to adapt to their new situation. The restabilising of the family following remarriage has been estimated as taking five to seven years (Bray, 1992). One quarter of remarriages are terminated within five years, with higher rates where there are stepchildren (Bray, 1992). Therefore, for many families this restabilisation never occurs.

Hetherington, Cox & Cox (1985) found that although girls in mother headed households had largely adjusted to divorce after two years, the subsequent remarriage of the mother seemed to increase problem behaviours. This situation can be even more difficult for the child if there are also children from the stepparent who all have to adjust to life together (Zill, 1988). Less involved harsher parenting is associated with rivalry and aggression in step siblings and biological siblings. These negative sibling
relations are associated with low social competence, less responsibility and more behaviour problems (Hetherington & Clingempeel, 1992).

Amato (1993) examined studies to look at whether wellbeing associated with living with a stepfather could vary with the gender of the child. He discovered that a stepfather seemed to improve the well being of boys but had either had no effect or a detrimental effect on the well-being of girls. However, it has also been found that regardless of gender when there is a positive marital relationship, custodial parents are authoritative and the step-parents support them being warm and involved, but not making independent control attempts, children can be accepting and adjust well (Bray & Berger, 1993). In long established remarriages the parenting of residential mothers and their children become increasingly similar to intact families (Bray & Hetherington, 1993).

Moderators

Resources (Individual and interpersonal)

Some factors seem to facilitate children’s adjustment to divorce. Extrafamilial support can be beneficial in helping children cope with the difficult family transitions. Samara and Stolberg (1993) identified children’s social support from their peers as being associated with well-being when rated by children, parents and teachers. Supportive friends at school can enhance children’s self-esteem and competence (Hetherington, 1993). Day care centres and schools that offer structured environments can offer stability and predictability to children undergoing stressful events at home and enhance well-being (Hetherington, 1989). Lee, Picard and Blain, (1994) implemented school based support groups for children and outcomes suggested that these types of therapeutic interventions can be beneficial.

Support from extended family can also be beneficial to children. Following divorce approximately 25% of residential mothers reside with their own mothers (Hetherington, Stanley-Hagan & Anderson, 1989). They can share child care and
household duties and provide economic support. This can be reassuring for the child to enter a familiar household where there are established routines and can be less unsettling than a move to an unfamiliar environment. The grandparents can also offer the child another strong bond of emotional support. Hetherington, Bridges & Insabella (1998) asserted that sons who live with their residential mothers show fewer behaviour problems when a supportive grandfather is present rather than when no grandfather is present.

Hetherington, Bridges & Insabella, (1998) investigated how the role of temperament predicted adjustment in children whose parents had divorced. They asserted that increased stress was associated with less adaptability for children with difficult temperaments, even where there were high levels of support. Children with easy temperaments could adapt to moderate levels of stress with greater adaptability.

Garmezy (1991) postulates that the different ways in which children adapt to stressful life events is dependent on their intelligence. Intelligence increases the likelihood of children being more skilled at social relations, using more effective coping skills, being more popular and having better academic achievements and extracurricular activities. These can all serve as buffers against the adverse stressful events.

Due to young children’s limited ability to cognitively process and understand their parents’ divorce it has been suggested that being older at the time of divorce may be a protective factor (Leon, 1993). However, few studies have directly compared groups of children in distinct age groups. Amato, (2001) concluded that the difference between divorced and non-divorced children on outcomes of academic achievement and psychological adjustment was irrespective of age. However, older children can better understand the reasons for the divorce and utilize other sources of support to help them cope with it (Amato, 1993).

Gender has also been thought to influence children’s outcomes. Amato and Keith (1991) found that gender was not associated with any specific problems apart from boys from divorced families had more difficulty adjusting socially than girls. This is
surprising given that in clinical practice one has observed that boys are referred more than girls for behavioural difficulties.

Parental age is associated with children’s behaviour difficulties following divorce. Whiteside & Becker (2000) found that younger age of the parents were associated with more difficulties when comparing preschoolers of divorced parents to a control group. Although this study has the limitation of using a small sample size a strength of the study is the outcomes were monitored by observer ratings rather than by parents’ judgements.

Clarke- Stewart et al (2000) performed a longitudinal study and stated that maternal level of education was associated with positive outcomes such as cognitive performance, social skills, secure attachment and mother child interactions regardless of marital status.

**Meaning of divorce**

People divorce for different reasons and come from different family traditions with differing histories and beliefs. Traditionally in Britain, divorce was viewed as a failure or shameful event and individuals often received a considerable amount of criticism. Children of divorce often had to contend with disapproving comments from the community and families and children were often teased at school (Kurdek, 1983). With the introduction of the ‘no-fault’ divorce and the dramatic growth in the number of marital dissolutions the public attitude to divorce has become less stigmatized (Amato, 2001). Different cultures differ as to how they view divorce and this is important to think about on how this can impact on their reactions to it. Additionally, the beliefs that children have about divorce can also be important in determining their reaction and adjustment to it.

A strength of the divorce stress adjustment model is that it examines adjustment across time and on multiple levels. It acknowledges that there are interactions among the different factors. It promotes understanding of individual differences so that one
can understand the variable reactions in response to divorce and suggests why other perspectives have received inconsistent support. It acknowledges that although many factors are important mechanisms in children’s reaction to divorce no single model can fully account for all the findings. However, it does not differentiate between which factors may be more important than others. For example, interparental conflict seems to be the strongest and most consistent factor of children’s poor adjustment to divorce (Amato, 1993).

**Clinical implications**

Children from divorced families are two to three times more likely to seek psychological treatment (Emery, 1994). It is crucial for practitioners to be aware of the child’s developmental level and to consider how this may impact on their understanding of the divorce and ways in which they cope with it. Practitioners need to emphasise to parents that they do have some control over how their children cope with divorce and that their relationship with their child is important for their children’s development. It is necessary to be aware that stressors and protective factors fluctuate as circumstances shift throughout the different stages of divorce. Additionally, it is important to recognise ongoing behavioural changes as early as possible to address them and to keep reassessing the child’s needs.

Divorce occupies a very different place in Muslim and Jewish cultures and very little research is available on differences for these groups. The white often middle class volunteer samples may not reflect family differences and processes found in ethnically and economically diverse families. More studies are also needed that take a family systems approach to divorce so that the influences and interactions among family subsystems on child development can be examined.
Conclusions

Most children find divorce a difficult and stressful period in their lives particularly initially. It is clear that there are many psychological effects that divorce can have on children and children from divorced families consistently score lower than children from non-divorced families on a variety of outcomes. Yet divorce and remarriage can also remove the children from stressful family relationships and provide additional resources. If divorce is not accompanied by multiple and prolonged stressors most children adapt to their new life situation well and emerge as competent well functioning individuals. The diverse reaction in response to divorce is related to a complex interaction of risk and protective factors associated with individual characteristics of the child, the family and extrafamilial environment.

Parents can have a considerable impact on the outcomes of their children by both maintaining authoritative, supportive and cooperative parenting and minimizing conflict. Conflictual parenting can effect the quality of parenting, have detrimental psychological effects on the child and can result in less or no contact with the non-residential parent.

Remarriage increases the probability of children finding themselves in a dysfunctional family environment. However, there are often positive experiences associated with this such as an increase in economic resources and a positive role model. Positive interactions between stepparents and their children appear to be facilitated by emotional bonding, clear communication between family members and by positive marital relations.

The risks can also be moderated by factors such as social support from family and peers, structured and supportive school environments, supportive co-parenting, individual characteristics such as temperament and intelligence and therapeutic interventions. Therefore, in the absence of conflict and with a positive parenting environment even with the stresses that accompany single parent roles children in divorced families can grow up competent with little or no long-term psychological effects.
References


What factors do we need to take into account in the assessment of suspected Alzheimer's Dementia (e.g. ethical issues around sharing the diagnosis, emotional experience of adjusting to the diagnosis) and what methods of assessment have proved helpful?

Year 2: August 2005
Dementia is a syndrome which main features are acquired memory disorder and intellectual decline. These symptoms are associated with changes in behaviour and personality that result in impaired psychological and social functioning (Cheston & Bender, 1999). There are many common causes of dementia; degenerative, vascular, infection, toxic, as a result of neurological disorders or injury, endocrine, systemic diseases and vitamin deficiencies (McLoughlin & Levy, 1996). However, all types result in differing degrees of changes in cognition, behaviour and personality (Cheston & Bender, 1999). UK surveys indicate that approximately 6% among those aged 75 - 79 years, 13% aged 80 – 84 years and 25% of individuals aged over 85 will suffer from dementia. (Ely, Melzer, Opit & Brayne, 1996).

Alzheimer’s disease is the most common form of dementia. There are approximately 600,000 individuals in the UK suffering from Alzheimer’s Disease (Roth, 1996). It is the third commonest cause of death in the UK (Bousanquet, May & Johnson, 1998). With current projections asserting that the elderly population is expanding as people’s life expectancies rise this is estimated to escalate further (Vollman, 2001).

In Alzheimer’s there is considerable variation in the profile of decline (Agnew, 1996). Clinical features in the early stage of Alzheimer’s (the first two to three years of the illness) include memory impairment, difficulties performing everyday tasks, impaired concentration, mood disturbance, spatial disorientation, fatigue and lack of spontaneity.

As the illness continues these may deteriorate further and other features may include apraxia and agnosia, deterioration in reading and writing, speech problems, emotional lability, disorientation in time or place and, delusions and hallucinations (Cheston & Bender, 1999). In the late stage of the illness symptoms may include lack of communication, emaciation, incontinence, limb contractures and primitive reflexes. Death usually occurs within 8 – 10 years from the onset of the illness (Post & Whitehouse, 1995).
This essay will look at factors that are important to take into account whilst assessing for Alzheimer’s disease such as sharing the diagnosis, issues of capacity, whether the individual is undertaking any risky behaviours such as driving and how the person is adjusting to their difficulties. It will also examine what assessments have been helpful such as clinical interviews, screening and neuropsychological tests and assessments of mood, risk, environment and caregivers as well as acknowledging their limitations.

**Sharing the diagnosis**

Traditionally, there has been controversy over whether to reveal the diagnosis of dementia (Pinner, 2000). A recent study suggested that only 40% of healthcare professionals working with the elderly tell them of their diagnosis and 20% see no benefit in telling the patient (Holroyd, Snustad & Chalifoux, 1996). However, 90% of individuals questioned stated that they would like to be told their diagnosis (Erde, Nadal & Scholl, 1988).

The rationale for withholding the information seems to be based on preventing harm. However, this view is gradually becoming more outdated (Drickamer & Lachs, 1992). Arguments include the fact that neurological tests used to diagnose Alzheimer’s are not 100% accurate, which may lead to people receiving inaccurate diagnoses (Milne, Woolford, Mason & Hatzidimitriadou, 2000). Other reasons that have been put forward for not sharing the diagnosis is that the prognosis is highly variable, treatments are limited and that receiving a diagnosis can often worsen the symptoms (McLoughlin & Levy, 1996). Sometimes, it is the family who may ask the clinician not to disclose the truth to the client out of fear that the client will not be able to cope with the information (Bender & Cheston, 1999).

The stage of the illness is also an important factor. If the person is in advanced stages of dementia then their capacity to understand and retain information surrounding their diagnosis and the implications may not be possible and explaining it to them will be futile (Pinner, 2000).
However, it has also been argued that it is the individual’s basic right to know their diagnosis and have involvement in their own medical care. The President’s Commission for the study of Ethical Problems in Medicine and Behavioural Research (1983) stated that “patients be given information about possible courses of action and that their choice of health care be honoured whenever possible.” To accept or refuse specific treatments, individuals need to be given the best information so that their decisions can be based on that information and their values. Additionally people may want to try experimental or unconventional treatments if they believe that these treatments may help them that they would not look into without knowing their predicament (Drickamer & Lachs, 1992).

With many conditions, clients’ experiences of their different symptoms prompt them to seek consultation on their own. However, clients with Alzheimer’s disease are often brought by family members who suspect a dementia diagnosis (Cheston & Bender, 1999). When assessing an individual for suspected dementia it is important that due consideration is given to obtaining their informed consent for assessment, treatment and management at every stage (Astell, 2004). This should begin with finding out whether the person wants to know what is wrong with them and how they would like to be told. Disclosure should allow time for questions from the client and the family and for recommendations from the health professional disclosing (Williams, 2002).

Although clinicians cannot always diagnose Alzheimer’s with complete certainty this is often a similar situation with other medical presentations (Milne, Woolford Mason & Hatzimitriadou, 2000). However, one can still give an open and honest presentation of what is perceived or known and explain the degree of certainty on which this is based. In clinical practice one has noted that many individuals want to know so that their behaviour can be explained and better understood by friends and family.

It is particularly important for individuals in the early stages of dementia to be told their diagnosis. Individuals with progressive cognitive impairment become less capable of making informed decisions (Desai, Grossberg & Sheth, 2004). The individual’s ability to understand discussions, retain facts and process information and communicate feelings and decisions become progressively more limited. Even if the
person does not have the capacity to make decisions but is able to express feelings and fears, the need to hold a truthful discussion is still important (Post & Whitehouse, 1995). This can increase the clinician’s ability to make more appropriate decisions for the client in the future if they know how their client feels about certain possibilities.

Particularly in the early stages of dementia individuals often have a sense that they are losing control of their abilities and worry that they are “losing their minds” (Bahro, Silber & Sunderland, 1995). They may want to express those concerns and feelings before they lose their ability and that opportunity forever.

Although the diagnosis requires an emotional adjustment that is difficult to deal with this can be enhanced by support. Disclosure means that the individual and their families can participate in support groups and counselling which can help to alleviate feelings of anger, fear and depression (Philpot & Levy, 1987).

People may want to know their diagnosis to plan for their future. By telling people early in the stage of the illness allows them to plan their remaining years of relatively unimpaired functioning to the utmost (Drickamer & Lachs, 1992). A care plan should be discussed and agreed upon including discussions about personal values and life-prolonging technologies. They may need to make financial arrangements, settle personal affairs, or make advance directives (durable powers of attorney for health care or living wills) (Vollman, 2001). They would not have these opportunities if they were unaware of their diagnosis.

Drugs for the treatment of mild to moderate Alzheimer’s disease are now available and the sooner such drugs can be given the greater the potential clinical benefit (Cheston & Bender, 1999).

Participation in medical research is also an important area to consider. Clients with cognitive impairments have been exploited in the past in the name of medical research (High, 1994). Often decisions made on behalf of clients have not been in their best interests. It is important for clients to decide whilst they are still competent whether they would be willing to enrol in research studies and if so which types they would
agree to (Vollman 2001). By discussing this with their loved ones they will be more aware of their wishes concerning future participation.

**Capacity**

The progression of Alzheimer's means that individuals eventually lose the capacity to understand the information necessary to make an autonomous decision (Vollman, 2001). This loss of capacity makes the client's care and treatment in respect for the client's self-determination more difficult. It is important when working with individuals with dementia that they are given the opportunity to make their own personal choices and do not have their wishes overridden in areas in which they are still capable of making reasonable decisions (Cheston & Bender, 1999).

Clinicians often have to make decisions about whether a client has capacity. Individuals cannot be labelled incapable as a result of a particular diagnosis (Astell, 2004). Decisional capacity is not an all or nothing concept but varies across each situation (Caralis, 1994). For example, a client may have lost the ability to handle financial matters but may still have capacity to decide their medical treatment.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. This has put further protections in place for people who have lost capacity and need decisions made in their best interests. It describes how individuals must be assumed to have capacity unless proven otherwise and that individuals should be given appropriate help before concluding that they cannot make their own decisions. It also states that individuals still retain the right to make unwise decisions and that anything done for the individual must be in their best interests. Additionally, anything done on behalf of the individual should be the least restrictive of their basic rights and freedom (C. Dooley lecture notes 01.08.05). The Act also outlines situations where designated decision makers can act on behalf of someone lacking capacity.
When trying to ascertain whether the client has capacity to make a decision the clinician needs to check that the client understands the information and consequences relevant to the decision and can retain this information even if this is only for a short enough period to allow him/her to make that decision (Caralis, 1994). The client needs to be able to use the information as part of the decision making process and to communicate that decision. This may require at least two contacts on separate occasions to ensure that they maintain sufficient decisional stability over time (Astell, 2004). Even clients with advanced dementia may have intermittent periods of lucidity that allow for significant decision making (Cheston & Bender, 1999).

The family or caregiver’s role is essential to the care of the individual with Alzheimer’s. Two thirds to three quarters of Alzheimer’s clients are cared for at home by family members (Dunkin & Anderson-Hanley, 1998). It can often be difficult to separate the interests of each. The client’s care is often the centre of their carer’s existences with any decisions having a direct impact on their lives too (Dunkin & Anderson-Hanley, 1998). Clinicians need to be aware that they need to balance their desire to acquiesce to families needs and demands with their primary responsibility to the client.

Driving

When assessing an individual with Alzheimer’s disease one should enquire about whether they drive. When an individual receives a diagnosis of Alzheimer’s he or she should inform the DVLA who can formally assess their driving ability. The client needs to be informed of this. Eventually all individuals with Alzheimer’s must stop driving when they become a danger to themselves and others. However, individuals are often capable of driving for many years after the diagnosis depending on the disease progression and the time of diagnosis (Hunt, Morris & Edwards, 1993).

Within two to three years following diagnosis the majority of people stop driving because they have noted difficulties (Freedman & Freedman, 1996). (E.g. they do not
feel safe or keep forgetting where they have parked). However, others have less insight into their difficulties (Clare, 2003).

Individualised risk assessments are important to appraise any impairment of driving ability or any other risky behaviours. Family members can be asked their opinions with the consent of the client. Often limits to driving can be agreed by the client with their families such as driving in daylight and on familiar routes. Driving should never be stopped without offering the individual ways to replace the loss and retain a sense of self-control (Johnson & Bouman, 1997). Clinicians can work with the family to identify alternatives to any risky activities. If clients refuse to inform the DVLA then they need to be advised that the clinician may have to for their own safety.

Adjusting to the diagnosis

When assessing for Alzheimer’s clinicians should be mindful that individuals cope with their diagnosis in different ways. Keady, Nolan & Gillard (1995) interviewed people with early stage dementia and reported that many individuals tried to cover up their difficulties in order to protect themselves and their families.

Clare (2002) illustrates a model of response to a diagnosis of early stage Alzheimer’s disease based on detailed interviews with individuals. Clare asserts that the impact of cognitive change is experienced in the context of the individual’s social network, relationships and self-concept. Individuals undergo in a cycle of five processes that all impact on each other. These are registering the changes, reacting to the changes, trying to explain the changes, the emotional impact of the changes and making adjustments. Individuals seemed to fall within a spectrum of avoidance of the difficulties as a form of protecting their self-concept to “spending time in the depths” to confront the changes and integrate them into their self-concept. This model accounts for individual differences in adjusting to the diagnosis of Alzheimer’s disease. This may be useful for clinicians to bear in mind when assessing clients and developing future care plans with them. It is important that they work with the client
from their point on this spectrum rather than from their own view of what is beneficial for them.

Helpful Methods of Assessment

Clinical Interview

An assessment is important for diagnostic purposes but is also essential as part of formulation and deciding on interventions and management. The assessment process should place the individual within the context of their whole life (Nolan & Caldock, 1996). A thorough interview should include their developmental history (early years, marriage / relationships, parenthood/ grandparenthood, education, employment, interests, roles and goals, residential moves, losses and transitions, culture and religion). It should include support networks, friends, family, carers, and frequency and quality of contact. It should cover medical and psychiatric history (including any family history of memory problems), current medication, current psychiatric symptoms (e.g. depression or psychotic symptoms) past and present functioning and any current difficulties. Resources (e.g. income, housing, etc), local environment (e.g. transport, proximity to amenities and significant others), regular routines and activities, and personality factors are also important to know. Personal beliefs are also important to enquire about such as their views of death and the afterlife (Vollman, 2001).

It is essential to learn about the history and current presentation of the problem, what ways it has impacted on their lives, their understanding of this and their outlook for the future. Also important is what coping strategies they use, what makes their difficulties better or worse and how they handle failure/loss. A thorough risk assessment should also be undertaken during the clinical interview (Cheston & Bender, 1999).
Medical Assessment

Following the clinical interview the individual should be referred for a medical examination to ensure that their presentation is not due to physiological causes such as a urinary tract infection, hepatic disease, etc. (McLoughlin & Levy, 1996). Various examinations can be performed such as kidney, liver, thyroid functioning and other blood tests. Additional investigations can also be undertaken such as ECGs, chest x-rays and neuroimaging techniques (CT / MRI scans) to help clarify the diagnosis or to identify any other cause for the cognitive impairment (McLoughlin & Levy, 1996).

Neuropsychological assessments

These are a familiar feature of the services for individuals with dementia and are an integral part of the diagnostic process. Short screening tests are available for use by mental health professionals. Common tests are the Mini-Mental State Examination (MMSE) (Folstein, Folstein & McHugh 1975), Clifton Assessment Procedures for the Elderly (CAPE) (Pattie, 1981) and the Middlesex Elderly Assessment of Mental State (MEAMS) (Golding, 1989). However, these are only screening tests and should not be used as diagnostic tests. The MMSE has been criticized for having a ceiling effect, meaning that it is not effective at detecting milder forms of Alzheimer’s disease (Teng & Chui, 1987).

Individuals who are suspected to have dementia need to be further evaluated to obtain a diagnosis and the cause of this. Different assessments can be used with demonstrated relationship to brain function (Myron & Weiner, 1991). Therefore, the results can provide inferences concerning likely aetiology and by characterising cognitive abilities to assist client’s management of their difficulties. Results from these assessments can also be used as baseline measurements to compare individual’s performance to in the future to monitor change.
**Intellectual Assessment**

General intellectual decline is one of the hallmarks of Alzheimer’s disease (Roth, 1996). However, in the early stages clients may only manifest mild declines in intellectual ability (Roth, 1996). The cognitive deficiencies are complex. However, non-verbal measures appear to be affected to a greater extent than are verbal measures (Fuld, 1984).

The Wechsler Adult Intelligence Scales (WAIS-III) is the most commonly used test of intellectual functioning and has good reliability and validity (Wechsler, 2001a). It has Verbal and Performance indexes. There are also shorter versions of the test that can be used if this is beneficial for particular clients.

Wechsler has also designed the Wechsler Test of Adult Intelligence (WTAR) (Wechsler, 2001b) which estimates pre-morbid intelligence. This can be useful to use so that the clinician can explore whether there seems to be a decline in the general cognitive functioning of the client. There are similar tests that can be used such as the National Adult Reading Task (NART) (Nelson & O’Connell, 1978). Therefore intelligence tests can provide a measurement of cognitive functioning comparable to the client’s peers, an estimate of pre-morbid functioning and an estimate of a person’s new learning capacity. They may suggest a diagnosis of dementia but are not sufficient to make a diagnosis from alone.

**Memory**

Memory deficits are on of the most common complaints in people with Alzheimer’s (Myron & Weiner, 1991). Memory deficits are often reported by family who state that the client forgets significant recent events, conversations or will repeat themselves. Clients are often acutely aware of their memory problems early in the disorder and may attempt to overcome this with different coping strategies. These become less effective as the illness progresses.
Assessments aim to determine whether this is due to a neuropathological process, a functional disturbance or a normal variation. The Wechsler Memory Scale (WMS-R) (Wechsler, 1997) is one of the most familiar measures of memory. There are many other widely used memory tests (e.g. the Recognition Memory Test, Warrington, 1984). Common findings in Alzheimer’s profiles are that there are problems in short-term memory with the acquisition of new information and memory storage and that recognition and recall memory are both impaired (Agnew, 1996). Marked memory loss after a short delay is one of the most sensitive and specific finding observed in early Alzheimer’s disease (Myron & Weiner, 1991).

**Perceptual and Visuo-spatial Skills**

Perception is dependent on functioning sensory inputs. This may become affected in the progression of Alzheimer’s and can lead to poor auditory or visual input and cause erratic perceptions, which can result in what appear to be irrational actions (Fuld, 1984). As the sensory systems normally decline with age it is important not to confuse these.

Some individuals with Alzheimer’s encounter visuo-spatial deficits, experiencing declines in their sense of direction or their visuo-motor abilities. They become unable to perform once familiar tasks such as sewing or dressing. (Cheston & Bender, 1999). The Visual Object and Space Perception Battery (VOSP) (Warrington & James, 1991) is a commonly used test that can be used to assess functioning in these areas.

**Executive functioning**

A loss of executive processing abilities such as organizing and planning, evaluating one’s problem solving behaviour and ability to think abstractly is often present in Alzheimer’s disease (Myron & Weiner, 1991). Executive functioning can be measured by tests such as the Delis–Kaplan Executive Function Test (D-KEFS) (Delis, Kaplan & Kramer, 2001), the Behavioural Assessment of the Dysexecutive Syndrome
Language impairment is a presenting major symptom in 8 – 10% of Alzheimer's clients and both expressive and receptive language abilities often become disrupted (Agnew, 1996). Receptive language abilities rely on comprehending written and oral communication. Comprehension difficulties may involve individual words or sentences. An individual may not be able to attach semantic word meaning to a sentence or understand its syntax in a sentence.

There are also many types of expressive language disorders. These include disorders of articulation, word finding, paraphasias (presence of misspoken words), loss of grammar, syntax, repetition, verbal fluency and writing (Myron & Weiner, 1991).

In Alzheimer's disease, impairment on verbal fluency present in the early stages, with more significant impairment in category fluency than letter fluency due to impairment in semantic memory. However, eventually all aspects of language become affected (Myron & Weiner, 1991).

When assessing individuals, it is important to watch out for examples of language difficulties in their communications. There are tests, which can also be used to assess these difficulties such as D-KEFS Verbal Fluency test and Graded Naming Task (Warrington & McKenna, 1983). However, clinicians could also refer the client to Speech and Language Therapists if they wanted a more thorough assessment of language functioning.
Activities of daily living

The loss of ability to perform activities of daily living (e.g. managing finances, cooking, etc.) is a defining feature of dementia (Desai, Grossberg & Sheth, 2004). Some assessments look primarily at these areas. Generally, studies reveal that clients tend to overestimate how they perform tasks and carers tend to underestimate their ability (Mahurin, DeBettignies & Priozzolo, 1991). By directly exploring how an individual is functioning with their daily activities one can assess the level of support they may need which can guide placement decisions or how to assist individual’s independence (Desai, Grossberg & Sheth, 2004). They are also useful to provide a baseline in the performance of individuals. This information can guide rehabilitation interventions and response to treatment can be assessed. A common test that is used to measure this is the Bristol Assessment of Daily Living (BADL) (Bucks, Ashworth, Wilcock & Siegfied, 1996).

Mood

The difficulties that accompany Alzheimer’s disease often impacts on individuals’ mood. Particularly in the early stages of the disease it is common for people to experience significant anxiety, depression, etc. Tests such as the Hospital Anxiety and Depression Scale (HADS) (Zigmund & Snaith, 1983), the Geriatric Depression Scale (GDS) (Yesavage, Brink, & Rose, 1983) are commonly used. These findings can often provide clinicians with important information about how they are coping emotionally that may not otherwise be available from the client immediately.

The differential diagnosis of Alzheimer’s from other disorders is also important. The commonest alternative diagnosis is depression with prevalence rates of 5-10%. Depression has always been a confounder in memory difficulties. Late onset depression is associated with reduced cognitive scores in validated tests. Additionally, depression is concurrent in 20% of dementia cases (Ballard, Bannister & Solis 1996). Other conditions often incorrectly diagnosed as dementia are normal aging, delirium, amnestic syndromes, psychiatric syndromes such as schizophrenia or Ganser
syndrome and conditions where progression to dementia is uncertain (e.g. cerebrovascular accidents) (McLoughlin & Levy, 1996).

Environment and Risk

It is vital to be aware of the risks in an individual’s environment. Thom and Blair (1998) suggest that the following areas should be reviewed:

- physical risks – cuts, falls, impaired mobility
- ability to safely use household appliances
- personal risks – self-care, nutrition, medication, compliance
- coping with the outdoor environment – shopping, getting lost going out at night
- general risks – financial management, risk of abuse, home security, substance abuse, coping with emergencies, self harm and suicide.

There is evidence that even individuals with late stage Alzheimer’s are sensitive to environmental influences (Lord & Garner, 1993). There are obvious interventions such as reducing clutter to provide a less confusing environment and moving items that increase risk of falling. Enhanced stimulation can also impact on individual’s wellbeing. Unchanging and monotonous environments do little to improve the functioning of those with Alzheimer’s (Cleary, Clamon & Price, 1988). Music appears to be effective in both increasing social interaction and enhances the recall of personal information (Lord & Garner, 1993). However, overstimulation may be unhelpful and lead to confusion (Lord & Garner, 1993).

Carer’s assessments

There have been several legislative and policy developments in recent years which have relevance for carers of people with Alzheimer’s. The Carer’s Recognition Act (1995) was the first piece of legislation to recognise the role of carers. It states that
carers should be entitled to a separate assessment of their own needs and ability to care, which local authorities must take into account when making decisions about providing services.

The development of Alzheimer's in a family member affects individuals in different ways. Research suggests that high caregiver burden can result in loss of intimacy within the relationship (Miller et al, 1995), mood and behaviour disturbances and psychotic symptoms (Cantor, 1983). Dunkin & Anderson-Hanley (1998) have asserted that there is a relationship between the overall functioning of the person with Alzheimer's and the carer. Studies that have included both client and carer variables have consistently found that carer variables such as physical health and burden are stronger predictors of institutionalisation than client variables (Lieberman & Kramer, 1991) (Cantor, 1983).

Ethnicity also seems to be an important variable in the caregiving process. Miller et al, (1995) asserted that white Americans report higher levels of burden and depression than African-Americans even when there is equal severity of impairment in the sample. The African American group reported greater levels of satisfaction and mastery. This may be because the carers have developed more effective coping strategies or have more informal sources of support. However, this seems to vary across different cultures. Adamson (2001) studied African Caribbean and South Asian families and concluded that there was a lack of awareness and little knowledge about Alzheimer's disease.

**Difficulties with Assessments**

There are difficulties which complicate the assessment of Alzheimer's disease. Those assessed tend to be older adults so many are subject to sensory loss or other physical illnesses such as heart disease which can impair cognitive functioning (Cheston & Bender, 1999). Additionally, many psychological tests only have norms up to the age of 75 or 80 which presents limitations on the instruments that can be used or the validity of the results if used. However, this situation is gradually improving.
Many of the tests if administered in their full forms may take considerable time to administer and reduce their acceptability with elderly clients. However, many do have shorter versions that can be used.

Diagnosis is a key issue when an individual first presents to services and this is usually in the early course of the disorder (Myron & Weiner, 1991). At this point, psychological differences are likely to be small and a key difficulty is having to detect small changes in psychological functioning particularly when there is no reliable information as to how the individual may have performed before the onset of their difficulties.

Another difficulty occurs when assessing individuals from different cultural backgrounds. Individuals from other cultural backgrounds who have been raised in the UK tend to score similarly to the indigenous population although may still score slightly lower because of cultural differences. Those who do not speak English fluently and have been in the UK less time tend to perform significantly lower on the tests (Jitapunkul et al, 1996). Therefore, it is important to be mindful of this when assessing individuals from different cultures.

Many less developed countries have high levels of illiteracy. The Chula Mental Test (Jitapunkul et al, 1996) is a screening test for cognitive impairment designed for individuals with low educational attainment. It was designed in Thailand but it’s authors suggest that it can also be used in other South and Southeast Asian countries. However, more valid and reliable tests need to be designed for use with those from different cultures and educational backgrounds.

Conclusion

Although this essay does not cover all factors and ethical issues that arise with a diagnosis of Alzheimer’s disease it indicates the range of difficulties that must be considered as society ages and Alzheimer’s diagnoses become more frequent. It is
important to recognise that emotional wellbeing can be enhanced despite dementia and to insist that human dignity is still respected.

Psychological assessment can make a useful contribution in assessing dementia, but like other methods is not wholly accurate and therefore needs to be considered in the context of other possible indicators. The core of every assessment should be a detailed clinical interview. Amongst the different neuropsychological tests that can be used for assessing dementia, tests of memory offer the best single indicator of the presence of dementia. Individuals should be made aware of the limitations of the tests diagnostic capabilities. However, different assessments will be relevant for different individuals and each individual should have their assessment tailored to their own specific needs.
References


Clare, L. (2002). We’ll fight it as long as we can: Coping with the onset of Alzheimer’s disease. *Aging and Mental Health, 6*, 2, 139 – 148.


CLINICAL DOSSIER

This section of the portfolio contains a brief overview of the experience gained on clinical placements and summaries of five formal case reports conducted during the three years of clinical training.

Placement contracts, supervisor evaluations, clinical logbooks and the full versions of the five case reports are presented in volume 2.

All names and other identifiable information have been removed to ensure confidentiality.
SUMMARY OF CLINICAL EXPERIENCE

This section of the portfolio contains details of experience on six clinical placements, including placement details and summary of clinical skills and expertise obtained.
Adult Mental Health Placement Summary

Placement Details

Dates: October 2003 – March 2004
Supervisor: Dr John Le Lievre
Setting: West Sussex Mental Health Trust
Base: Worthing Community Mental Health Team

Summary of experience

Clinical work for the CMHT consisted mainly of outpatient work with individuals referred from primary care services. Opportunities arose to work with presenting problems of anxiety, depression, anger, etc.

Clinical skills and expertise

Assessment consisted of semi-structured interviews with psychometric measures (i.e. the Beck Anxiety Inventory, the Beck Depression Inventory) and structured psychometric assessments such as the Wechsler Adult Intelligence Scale. The placement provided opportunities for developing therapeutic engagement skills and cognitive-behavioural formulation skills. The main model of therapy used was cognitive behavioural therapy. Clinical work was conducted with individuals from a range of ages presenting with a wide variety of difficulties. Group work for anxiety Management was also conducted. A service related research project (audit) was conducted to measure referral rates within the department.
Adult Mental Health Case Report Summary

The Assessment and Treatment of a Sixty-one Year Old Male Presenting with Panic Disorder and Depression

Referral and Presenting Problem

Mr Tarr was referred by his GP. He was experiencing symptoms of “sweating, nausea, weak trembling legs, racing heart and stomach pains.” These symptoms were accompanied by thoughts that he was experiencing a heart attack and would die. He was avoiding situations similar to those in which he had previously had panic attacks, exercise, travelling spending time alone. He was experiencing high levels of anxiety worrying when the next one might occur. He was also having sleeping difficulties and his problems were impacting on his relationship with his wife.

Background

Mr Tarr was the youngest of three children and was close to both parents. His father had suffered from anxiety although Mr Tarr said that he had not been aware of this. Both parents had died from cancer. Mr Tarr had also recently experienced the losses of others close to him including two friends, his brother and his sister in law. Mr Tarr had been devastated by these events.

Mr Tarr married in 1966 and described enjoying his married life. They emigrated to Australia between 1969 – 1979 but returned to England as Mrs Tarr was homesick. Mr Tarr used to enjoy socialising with his friends but currently avoids most social situations.

Formulation

Mr Tarr presented with Panic Disorder. This was formulated within a cognitive-behavioural model. It appeared that there may have been a predisposition for anxiety
in his familial history. He described being anxious as a child which was compounded by an illness which caused him to miss significant amounts of schooling and let to feeling vulnerable and isolated. He grew up in a protective environment which may have caused him to be more prone to anxiety when faced with stressful events later in life.

Mr Tarr had been under threat of redundancy and had lost many close friends and family members. These events appeared to have triggered his panic attacks. He misinterpreted his anxiety symptoms in a catastrophic way which increased his anxiety resulting in panic attacks. This impacted on his self-esteem and relationship with his wife and resulted in feelings of guilt and depressed mood.

Mr Tarr was maintaining his difficulties by selectively attending to his physiological symptoms and using safety behaviours and avoidance. His withdrawal from socialising with friends and reluctance to discuss his problems with his wife also served to exacerbate his difficulties.

**Action plan**

A cognitive behavioural approach was implemented to examine Mr Tarr’s beliefs about his anxiety and ability to cope. The decision was made on the basis of the formulation and treatments (Roth & Fonagy, 1996).

**Intervention**

Mr Tarr was seen for 12 sessions. Initial sessions consisted of psychoeducation about anxiety and depression, socialisation to the treatment model and goal definition. Cognitive restructuring techniques were utilised to aid Mr Tarr identify his negative automatic thoughts and to challenge them with additional evidence. A graded hierarchy of exposure was collaboratively planned to disconfirm his beliefs about certain situations being dangerous. Mr Tarr identified the safety and avoidance
behaviours that he had been using and decided to discontinue them. He began working through his hierarchy using behavioural experiments. In the final sessions therapy goals were extended and problem solving techniques were utilised to prevent relapse.

Outcome

Mr Tarr completed pre and post measures that assessed his anxiety and depression symptoms (Beck Anxiety Inventory and the Beck Depression Inventory. His score fell from 20 – 9 on the anxiety measure which is classified as within the normal range. His depression score fell from 21 – 11 on the depression measure which is now within the minimal depression range. The therapist also thought that Mr Tarr had made significant progress. He managed to stop many of his avoiding and safety behaviours including resuming sporting activities and travelling, avoiding spending time alone, less visits to his GP and using public transport. Mr Tarr also described feeling less anxious and described an improved social life and relationship with his wife. He recognised the impact that this was having on his mood and that he was increasing in confidence. His final hierarchy item was to manage travelling abroad on holiday which he had booked for the near future.

Critique

Mr Tarr was motivated, attended all sessions and had a positive outlook towards his treatment. The therapist and Mr Tarr formed a good rapport which facilitated therapeutic collaboration. Mr Tarr completed behavioural tasks as in between session assignments and seemed intent on continuing to work on his goals. For continuity and issues of rapport it would have been beneficial for the therapist to have a follow up session with Mr Tarr after discharge to monitor his progress. However, due to time limitations this was conducted by another psychologist within the service.
People with Learning Disabilities Placement Summary

Placement Details

Dates: March 2004 – September 2004
Supervisor: Dr Karen Long
Setting: Kingston PCT
Base: Roselands Clinic, New Malden

Summary of experience

Clinical work for the CMHT consisted mainly of outpatient work with individuals referred from primary care services. Opportunities arose to work with presenting problems of anxiety, depression, psychosis, challenging behaviour, etc.

Clinical skills and expertise

Assessment consisted of semi-structured interviews with psychometric measures (i.e. the Beck Anxiety Inventory, the Beck Depression Inventory) and structured psychometric assessments such as the Rivermead Behavioural Memory Test, the Doors and People Test and the Family Relations Test. The placement provided opportunities for developing assessment skills and working with clients in cognitive-behavioural, behavioural and systemic models. Clinical work was conducted with male and female individuals ranging in ages and cultural diversity. Clients presented with a wide variety of difficulties. The trainee also ran an Autism Training Day for staff working at a Residential Home for people with Learning Disabilities.
People with Learning Disabilities Case Report Summary

A Behavioural Assessment and Intervention of a female presenting with problematic behaviour (wearing multiple layers of sanitary towels)

Referral

Ms Price was referred to the Psychology and Challenging Needs Service for People with Learning Disabilities by the manager of her residential home. The referral described Ms Price as having “an obsession with wearing multiple layers of sanitary towels and incontinence pads.”

Presenting problem

Ms Price constantly wore multiple layers of pads (one incontinence pad, nine sanitary towels and half a roll of toilet paper). This started following her mother scolding her for a stain which appeared on her trousers when she was menstruating seven years ago.

She avoided discussing her pad wearing and when questioned she cried or ran into her room. The behaviour was causing rashes and staff were concerned that Ms Price’s appearance may increase her vulnerability. She was infrequently teased by other residents.

Background

Ms Price had a diagnosis of Downs Syndrome and appeared to be functioning in the mild learning disability range. She had a hearing deficit in one ear and often used her own words as language. Following her father’s death she moved into the residential home as her mother was finding it difficult to care for her. She has a sister and a brother and visited her family weekly. Since moving she worked with staff to increase her independence and was proud of her achievements. Ms Price’s mother had
anxieties about her daughter’s independence and this protectiveness often annoyed Ms Price.

Assessment

The Behavioural Assessment Guide (Institute for Applied Behavioural Analysis, 1993) was used to obtain a functional analysis of the problem and to generate intervention plans. The trainee psychologist met with Ms Price for three hour sessions to conduct the assessment and for eight sessions to implement the intervention. The trainee also met with staff from Ms Price’s residential home and day centre and a Community Nurse who had worked with Ms Price in the past.

Formulation

There are many factors which may have caused Ms Price to be more vulnerable to her difficulties. She had a diagnosis of Downs Syndrome, hearing loss and her verbal language could be difficult to understand particularly initially. Her protective upbringing may have shielded her from experiencing negative events. Moving to the residential home may have been an unsettling experience for her particularly coinciding with her father’s death and may have triggered feelings of vulnerability. Her growing independence increased the likelihood of her receiving negative evaluations from the general public regarding her learning disability. As she experienced her mother’s protective parenting style towards her as criticism this may have contributed to her low self-esteem. She chose not to discuss her difficulties and this lack of social support regarding the problem may have exacerbated her feelings of distress.

The behaviour can be conceptualised within a Behavioural framework. Ms Price previously got a stain on her clothes when she was menstruating. This was responded to in a catastrophic way and Ms Price experienced it as a traumatic event. She coped by wearing multiple layers of sanitary towels. This behaviour became negatively
reinforced by the accident not reoccurring. Ms Price enjoyed social interaction and staff at the residential home were often busy. Conversations that staff have with her to discourage her from pad wearing may have acted as positive reinforcement to maintain the behaviour.

**Intervention**

Initial sessions focused on psychoeducation, socialisation to the model and Ms Price recording her pad wearing in a sticker diary in order to obtain a baseline of the behaviour. The latter was unsuccessful as Ms Price did not record true accounts of her pad wearing. It was agreed with Ms Price that staff could count how many she discarded instead and if this corresponded with her diary records she would receive positive reinforcement such as a video to watch. This was also unsuccessful due to staff sometimes forgetting and Ms Price using an array of techniques that made this difficult for staff to achieve. As it was apparent that Ms Price was not happy with this occurring (although she had consented) this was discontinued.

This failure to obtain a baseline meant that the plan to gradually decrease the pad wearing was changed. It was decided collaboratively to give Ms Price powerful positive reinforcement for only wearing two pads. Ms Price chose to go to a pub with the trainee for a glass of wine. Only positive topics of conversation were discussed so that the interaction could act as paired reinforcement.

**Outcome**

Ms Price went out twice with the trainee. She was anxious leaving the house but soon appeared to enjoy the outings and spoke favourably about them becoming a weekly event. Behavioural guidelines were outlined out for the staff to follow and they began accompanying Ms Price on her outings. This process was monitored monthly by a Clinical Psychologist with a view to extending this to different contexts and for longer time periods. No formal outcome measures were taken. However, staff stated that Ms Price was no longer using toilet roll as extra padding and estimated that her average pad wearing had decreased to approximately four at a time.
Critique

The lack of baseline data was a flaw in the intervention. The behavioural model asserts that the behaviour needs to be defined exactly so that the influence of environmental factors can be considered in the intervention.

Ms Price's favourite member of staff was ill and many regular staff members were on annual leave. Perhaps Ms Price may not have found her diary so difficult if there had been support from regular staff whom she trusted. The staffing situation also helps account for the occasions of lack of baseline recording by staff.

An important part of the intervention was working collaboratively with Ms Price and encouraging her to be the decision maker. The trainee and Ms Price had a good rapport and Ms Price wanted to achieve wearing less pads which were positive factors for the therapeutic process.
Child and family Placement Summary

Placement Details

Dates: October 2004 – March 2005
Supervisor: Dr Olwen Wilson
Setting: Blackwater Valley and Hart PCT
Base: Buryfields Clinic, Guildford

Summary of experience

This placement provided an opportunity to work with infants, primary school aged, middle-school aged and adolescent children with a range of developmental, emotional and behavioural difficulties. Clinical work consisted of individual work with adolescent children with emotional disorders, family therapy work with children and their families, indirect work with parents (e.g. to assist managing challenging behaviours) and facilitating an anger management group. The experience provided the opportunity to gain knowledge about service development, care pathways, case management and team working dynamics. The main psychological models used were cognitive-behavioural, developmental and systemic.

Clinical skills and expertise

The placement provided training regarding Child Protection issues (e.g. risk management) which was invaluable. Assessments included working with children assessing for Attention Deficit and Hyperactivity Disorder (ADHD). Formal assessments used included the Wechsler Intelligence Scale for Children, the Rivermead Behavioural Memory Test, the British Ability Scales and the Bender Visual Motor Gestalt Test. Observation work was conducted in a nursery school and a school for children with autism. Group work for anger management was conducted with six children (aged 10 – 12) and weekly group sessions were also held with their
parents to assist behavioural management. The busy nature of the service also helped to further develop my case management skills.
A Neuropsychological Assessment of an Eleven Year Old male Presenting with Temporal Lobe Epilepsy

Referral

Toby was referred to the Psychology Service by his Consultant Paediatrician for a neuropsychological assessment of his cognitive abilities. Toby suffered from complex partial seizures and received medication for this. He had not had a seizure for the past 18 months. However the Paediatrician thought that to may be beneficial to investigate whether there was any seizure interference with his learning, to identify any areas of specific difficulties and to provide a baseline of his abilities.

Presenting Problem

Toby said that he had difficulty remembering his spellings, handing his homework in and taking his medication. His mother also commented that Toby has difficulty “putting things down in a written format.” She was concerned that he may have memory difficulties as a result of his epilepsy and wanted to ensure that he was given the correct level of support through secondary school.

Background

Toby had recently started secondary school. He had been having a difficult time with his previous teacher and his mother said that this had “knocked his confidence.” Toby had previously been referred to the Psychology Service for his poor sleeping. He attended an anxiety management group which appeared to help the problem.

The trainee met with Toby for five assessment sessions, one session to provide feedback and three sessions for anxiety management.
Psychometric Assessments

The following tests were administered to examine whether Toby’s symptoms were indicative of a neurological difficulty. The Wechsler Intelligence Scale for Children III (Wechsler, 1992), the Wechsler Objective Reading Dimensions (Wechsler, 1993), The Bender Visual Motor Gestalt Test (Clawson, 1992), the Rivermead Behavioural Memory Test (Wilson, Cockburn & Baddeley, 1985) and the Beck Youth Inventories (Beck, Beck & Jolly, 2001).

Literature Review

Seizures can often cause structural damage that can result in cognitive deficits (Motamedi & Meador, 2003). Temporal Lobe epilepsy is often associated with language difficulties, verbal and visual memory problems or postictal psychotic features (Elgar, Helmstaedter & Kurthen, 2004).

However, the other possibility was that Toby’s anxiety may have been impacting on his memory. Children with epilepsy are five times more likely to suffer from behavioural or mental health problems such as anxiety or depression and attentional problems (Motamedi & Meador, 2003). Eyesenk & Calvo (1992) proposed that anxiety impacts on the Central Executive which disrupts verbal and spatial working memory in conditions of anxiety.

Formulation

Results suggested that an organic basis to his difficulties was unlikely. His difficulties appeared to be caused by his levels of anxiety. His experiences at his previous school had resulted in him worrying about school and often being unable to sleep. He provided examples of negative automatic thoughts related to his performance and how his “mind goes blank” when he was anxious. This was consistent with notes from his
previous referral to the department. This was also consistent with his teachers reports as in classes where he described being relaxed he did not have any difficulties. His scores on the Beck Youth Inventories also suggested he had anxiety difficulties.

Toby’s recognition that he was “behind” in literacy has reinforced his belief that he performs at a lower level than his peers. This resulted in him avoiding reading, doing homework or handing it in. These behaviours prevent him from improving and maintain his anxiety. When the formulation was presented to Toby and his mother they both said that it made sense to them. Toby admitted that he had been intentionally choosing not to submit his homework and had not forgotten.

Outcome

The trainee offered Toby three sessions to remind him of anxiety management techniques. His mother agreed to help implement strategies to help Toby such as playing word games such as scrabble and rummikub, taking him to the library to pick appropriate books, reading to him and listening to him reading. His mother agreed to encouraging him to write fun things that had a purpose such as shopping, holiday or Christmas lists or for him to write to friends. She also agreed to reward him for his efforts whilst continually encouraging and praising him to boost his self esteem.

Critique

The trainee did not have a previous assessment to use as a baseline comparison so it was difficult to know whether Toby may have previously performed at a higher level. However, his academic history suggested that this was unlikely. It may have been beneficial for Toby’s father to attend the therapy sessions however work commitments did not allow this. It may have been useful to observe Toby in his school environment but he did not want this to occur.
References


Older Adults Placement Summary

Placement Details

Dates: March 2005 – September 2005
Supervisor: Dr Diana Chanfreau
Setting: Surrey and Borders Partnership
Base: Farnham Road Hospital, Guildford

Summary of experience

Clinical work for the CMHT consisted of outpatient work with individuals referred from primary care services, inpatient work and working with clients in day centres and residential homes. Opportunities arose to work with presenting problems of anxiety, depression, substance abuse, dementia, bereavement, etc.

Clinical skills and expertise

Assessment consisted of semi-structured interviews with psychometric measures (i.e. the Beck Anxiety Inventory, the Beck Depression Inventory, the Hospital Anxiety and Depression Scales, etc.) and structured psychometric assessments such as the Wechsler Adult Intelligence Test, the Wechsler Memory Test, the Behavioural Assessment of the Dysexecutive Syndrome and the National Adult Reading Test. The placement provided opportunities for developing assessment skills and working with clients in cognitive-behavioural, behavioural and narrative models. Clinical work was conducted with male and female individuals ranging in ages and cultural diversity. Clients presented with a wide variety of difficulties. The trainee also ran a ‘Coping With Forgetfulness’ group in an inpatient setting.
Older Adults Case Report Summary

A Therapeutic Intervention with a Seventy-four Year Old Lady Referred for Bereavement Counselling

Referral

Mrs Trip was initially referred to the Psychology Service for a neuropsychological assessment due to frequently experiencing déjà vu symptoms. The Psychiatrist who assessed her concluded that she had “pathological bereavement” and referred her for bereavement counselling.

Presenting Problem

Mrs Trip’s husband had died approximately one year ago from cancer of the pancreas. They had been married for over fifty years and following his death Mrs Trip became depressed and described her feelings of isolation and anxiety at living alone. She had difficulty concentrating, sleeping, making decisions and she had lost three stone in weight. She felt no enjoyment from anything she did, had no motivation and described feelings of depersonalisation. Mrs Trip’s daughter accompanied her to the initial session and said that her mother had previously been an “active and bubbly person” and was now “subdued.” She had also noticed how worried her mother was about the security of her home and had discussed the possibility with her of moving to a warden controlled flat.

Background

Mrs Trip had three daughters and three grandchildren and they all visit her regularly. She had recently suffered the loss of many people whom she was close to including her mother, father and sister. Both parents had a diagnosis of dementia and Mrs Trip had been concerned that her déjà vu symptoms were a sign that she was becoming unwell. Mrs Trip has had serious health complications and her health is currently
reviewed by a cardiologist. She had an extensive network of friends who play an important role in her life and was also involved with the church and a local voluntary organisation.

**Formulation**

Mrs Trip’s difficulties were conceptualised within the cognitive stress theory of bereavement. This theory views bereavement as a major stressor which can impact on mental and physical health. When the appraisal of the bereavement is viewed as stressful this can result in adverse bereavement reactions (Kato & Mann, 1994).

There are several factors which may have contributed to Mrs Trip’s difficulties. She described a protective parenting style particularly from her mother. Bourne (2002) suggested that individuals from sheltered backgrounds can be more prone to psychiatric difficulties in later life when facing stressful life events.

Mrs Trip suffered a succession of losses of close friends and family. She experienced her sister’s death as particularly difficult and her husband’s death from the same illness may have awoken difficult feelings and memories for Mrs Trip.

Bereavement of a spouse is particularly difficult as it often brings with it adverse life events such as the end of a relationship, illness, change of roles and responsibilities and financial difficulties. Bonanno & Kaltman, (2001) argued that new interest and activities can act as coping strategies for dealing with the loss. However although Mrs Trip had increased her social network she had stopped many activities that she used to enjoy.

Having to deal with her own health concerns, her husband’s illness whilst at the same time worrying that she had dementia must have been extremely difficult for Mrs Trip. This may have been exacerbated by her trying to hide her difficulties as this meant that she was unable to share her problems with others or access any practical help.
As the treatment progressed the trainee added to the formulation as it appeared that Mrs Trip's marriage had been rather difficult at times and that she had considered leaving the marriage. Therefore the ambivalence within the relationship may have made the bereavement process more difficult.

**Intervention**

Treatment was implemented based on the cognitive-behavioural model. Initial sessions focused on psychoeducation and socialisation to the model. Sessions also focused on cognitive restructuring and grief therapy (Worden 1982).

Mrs Trip responded well to the cognitive-behavioural model and easily made links between her thoughts, feelings and behaviour. She was excellent at challenging her negative thoughts and this worked particularly well in the area of her worries about the security of being alone at home. Mrs Trip had avoided discussing her husband and seemed to enjoy reminiscing their happy times together. She found it difficult when discussing less positive aspects of their time together as this evoked anger and guilt. However cognitive restructuring and roleplaying techniques seemed to resolve these feelings. Mrs Trip used the 'empty chair method' to say goodbye to Mr Trip. She was encouraged to strengthen her emotional ties with others and to become involved with new activities.

**Outcome**

Mrs Trip reported feeling much better generally and said that she no longer felt as though she was "on automatic pilot." She began to clear out her husband's belongings, was sleeping better and enjoying her food. She also reported having two comforting dreams in which her husband had been cuddling her in bed. Her daughter commented on her improved mood and said that she was "laughing and smiling more" and that she no longer locked the house when going in the back garden which suggested that her anxiety had decreased. The psychiatrist and CPN also commented on her improved mood and Mrs Trip said that she felt pleased that others were noticing the
improvements. She decided not to move into the warden controlled flat and contacted Age Concern to obtain some help for maintaining her house and garden.

Critique

Mrs Trip came to therapy with a positive outlook, was extremely motivated and never missed a session. She formed an excellent rapport with the trainee and put thought and effort into her tasks to complete between sessions. An important part of therapy was Mrs Trip’s admission to herself that she did not always have a happy marriage as this allowed her to integrate her feelings with the knowledge that she loved Mr Trip. It would have been beneficial to have a follow up session with Mrs Trip. However, timing did not allow for this although her CPN continued to support her and monitor her progress.


Specialist Placement Summary (forensic- one year placement)

Placement Details

Supervisor: Dr Anna Manners  
Setting: West London Mental Health Trust  
Base: Boadmoor Hospital, Crowthorne

Summary of experience

Clinical work for the hospital consisted of inpatient work with individuals in a maximum security setting. Opportunities arose to work with presenting problems of psychosis, PTSD, substance abuse, relapse prevention, anxiety, etc. The year long placement provided the opportunity to conduct longer-term work with clients.

Clinical skills and expertise

Assessment consisted of semi-structured interviews with psychometric measures (i.e. the Beck Anxiety Inventory, the Beck Depression Inventory, The Bender Test of Sexual Knowledge). Assessments for risk, substance abuse, admission, and psychosexual issues were conducted with clients. The placement provided opportunities for developing assessment skills and working with clients in cognitive-behavioural and systemic models. Clinical work was conducted with individuals ranging in ages and cultural diversity. Clients presented with a wide variety of difficulties. The trainee also ran an Anxiety Management group and a ‘Making sense of psychosis’ group on a high dependency ward.
Specialist Case Report Summary

Risk Assessment of a Fifty-eight Year Old Male in a High Security Forensic Setting

Referral

Mr Royston was referred for a risk assessment by the consultant psychiatrist linked to his staff team. This was deemed necessary as he had recently been assessed by a Regional Secure Unit (RSU) regarding the possibility of moving on to conditions of lesser security.

Assessment

The trainee met with Mr Royston for eight sessions of one hour each. The trainee’s supervisor observed for two of those sessions. Information was also gathered by interviews with staff, Mr Royston’s case notes, court case transcripts and the Public Inquiry report from Mr Royston’s index offence.

Background

Mr Royston was arrested for murder in 1999. He was deemed mentally unwell and was admitted to a maximum security hospital under the legal classification of mental illness. Mr Royston has a diagnosis of paranoid schizophrenia. He was sentenced to life imprisonment with a tariff of eighteen years. He had previously been admitted to the maximum security hospital twice and had been under supervision in the community at the time of his offence.
Initial formulation

Mr Royston may have been more vulnerable to committing a violent offence by having a diagnosis of schizophrenia and being mentally unwell at the time of the offence. He was also heavily abusing crack cocaine and had become unemployed and was in financial difficulties. His drug abuse had also impacted on his relationships with family members. The social context that he was living in may also have served to increase his risk for violence as he was involved with drugs and crime. He is currently compliant with medication and has responded well to it. However, he denies and minimises much of his past offending, has difficulty taking on the perspectives of others and displays concrete thinking. However, he has attended all therapeutic work he has been offered, engages well in vocational areas of the hospital and has a good support network.

Extended assessment

The HCR-20 (Webster, Douglas, Eaves & Hart, 1997) was used for the main basis of the assessment. The Psychopathy Check List – Short Version (Hart, Cox & Hare, 1995) and the Barratt Impulsiveness Scale (Barratt, 1993) were used to provide more evidence for the items. Mr Royston engaged well although he did appear guarded around the topic of past violence and was often inconsistent in the information that he provided.

HCR-20

The historical items of the HCR-20 were rated as present for previous violence, young age at first incident, relationship instability substance abuse, major mental illness and prior supervision failure. Employment problems and psychopathy were rated as partially present. Personality disorder was rated as not present and early maladjustment was not rated due to lack of information other than Mr Royston’s self-report. For the clinical items lack of insight, negative attitudes and unresponsive to treatment were rated as present and active symptoms of mental illness and impulsivity
were rated as not present. For the risk items plans lack feasibility and exposure to destabilisers were rated as present. Non compliance with remediation, stress and lack of personal support were rated as partially present.

**Interviews with staff**

Staff reported Mr Royston as being compliant with all aspects of his treatment plan and interacting well with staff and patients on the ward. Staff reported that Mr Royston was “practically asymptomatic.” They described Mr Royston’s ex wife and daughter as being extremely supportive and thought that they would continue to support him in the future.

**Conclusions and recommendations**

Within a maximum security setting Mr Royston has presented with no management problems. However, he has a number of static risk factors in his history that would suggest a high level of risk for interpersonal violence in community settings. Although his offending has been low in terms of frequency, when he has offended there have been serious acts of violence resulting in death and serious injuries. Some of these have occurred whilst he has been under the supervision of mental health services. Mr Royston has a tendency to deny involvement or minimise responsibility for his actions. He also presented as keen to portray himself in appositive light and believed that refuting his involvement with past offences would help him move on. It is important that he recognises the need to work on his previous acts of violence rather than denying them.

Further therapeutic work could help Mr Royston address some of the risk areas that were highlighted. These include group work around understanding mental illness, relapse prevention for substance misuse, and group work around violent offending. There are also many risk management considerations that will be needed to be taken into account in the future. His risk may increase with any deterioration in his mental
state, any difficulties in interpersonal relationships or disengagement with those responsible for his care, non-compliance with medication, and use of illegal substances. These will be important to monitor as and when he moves on from conditions of maximum security.

The outcome of whether or not Mr Royston is accepted at the RSU is still awaited. Judgements about risk management in another setting will be best made when plans for transfer from conditions of maximum security have been made explicit. Risk assessment is a dynamic process and Mr Royston’s risk of future violence should be closely monitored and reviewed on a continual basis.
RESEARCH DOSSIER

This section of the portfolio contains evidence of research work conducted throughout the three years on the PsychD course, including a service related project undertaken whilst on the adult mental health placement, a major research project completed in the third year and a record of research experience presented in the form of a research logbook.
Service Related Research Project

The Characteristics of Re-referral to a Psychology Department

Year 1: June 2004
Abstract

Title: An exploratory study of the characteristics of re-referral to a Psychology Department.

Objective: To examine possible predictors of re-referral and ensure that standards set by the Department of Health regarding assessment, engagement and treatment were being met.

Design: This is an exploratory study to examine any differences in the profiles of individuals re-referred or initially referred to a Psychology Service. Information was collected from the files of 100 referrals received over a 6 month period.

Setting: A Psychology Service that receive referrals from primary care sources.

Results: Descriptive statistics, Chi-Square and Kruskal-Wallis tests were performed on the findings. Results suggested that predictors of re-referral are past referral to the Psychology Service, previous non-attendance, non-compliance and psychosis. Socio-economic factors such as unemployment and relationship status also increased the risk.

Conclusions: The results suggest that re-referral is related to characteristics of long term mental illness. The implications were discussed such as alternative ways of dealing with non-attendance. Limitations of the study (e.g. using secondary data, small sample size, etc.) are also discussed.
Introduction

This study was carried out in an inner city Psychology Department that received referrals from primary care sources. Members of staff estimated that the re-referral rate was approximately 20% and were interested in examining the reasons for this. Possible suggestions from staff were that individuals had previously not attended their appointments, had not completed their treatment or been non-compliant, or that there were socio-economic factors that made them less likely to be receptive to the treatment such as substance misuse, relationship difficulties, unemployment difficulties, etc.

The National Service Framework (NSF) (DoH, 1999) standard two states that service users who have mental health problems should have their mental health needs identified, assessed and should then be referred to appropriate specialist services for assessment, treatment and care. Standard four states that “all mental health service users on CPA should receive care which optimises engagement, anticipates or prevents crisis and reduces risk”. It is important to examine reasons why individuals are being re-referred to establish whether it is because areas within these standards are not being offered by this particular service so that improvements can be made.

Within psychiatric services, there are a sub-group of individuals who are often referred to as “revolving door” clients due to their high frequency of re-referral or hospital admissions. These people often require immense input from psychiatric services. Many studies have attempted to examine factors that may increase the chances of re-entering psychiatric services. These have looked at socio-economic factors such as unemployment (Rabinowitz et al, 1995), homelessness (Smoot et al, 1992), marital status (being single, separated or widowed) (Rabinowitz et al, 1995), race (Thomas, Stone, Osborne, Thomas & Fisher, 1993) and age (Arnold et al, 2003). Type of diagnosis (Rabinowitz et al, 1995), substance abuse (Bernado & Forchuk, 2001), violent and criminal behaviour (Haywood at al, 1995) and previous non-compliance (Bernado & Forchuk, 2001) have also been found to increase the chance of frequent service use. However, no clear consensus has been reached within the
literature as to which variables reliably predict future re-referral to services. Re-referral to a Psychology Department could reflect similar factors.

Re-referral could also reflect decision making regarding clients who were not initially accepted or clients who did not attend their previous referral. Killapsy, Banerjee, King and Lloyd (2000) note that non-attendees at outpatient clinics are more unwell than attenders and have a higher risk of subsequent admission. Although this study examined inpatient admission, if non-attendees are more unwell then they may also be more at risk of re-referral to psychology services.

Analysis of all the possible predictors of re-referral is beyond the remit of this audit, which will focus on factors related to the Psychology Service and on certain socio-economic factors. It will examine non attendance, reasons for terminating the first care episode, length of care episode, presenting problem and the number of past referrals. The socio-economic factors it will examine are employment status, relationship status and substance abuse. Findings could have implications for the Service’s policy regarding meeting needs and optimising access and engagement. For example, following up people who do not attend with a home visit or contacting someone by telephone rather than making a repeat appointment or ensuring sufficient long term follow up care.

Exploratory Research Question

Individuals who are re-referred will differ from those who are referred for the first time in demographic variables including age, presenting problem, previous use of services, length of care episode, single or marital status, substance misuse, unemployment.
Method

Design

The study is a between groups comparison of characteristics of individuals re-referred or referred for the first time to a Psychology Department.

Participants

100 referrals from September 2002 to February 2003 were recorded by the researcher from the Psychology Department's referral logbook. Demographic details are presented in tables 1 and 2.

Table 1: Gender and Age of Participants

<table>
<thead>
<tr>
<th></th>
<th>N.</th>
<th>Mean Age</th>
<th>Range</th>
<th>Standard Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>60</td>
<td>34.68</td>
<td>19-64</td>
<td>9.88</td>
</tr>
<tr>
<td>Males</td>
<td>40</td>
<td>33.85</td>
<td>18-54</td>
<td>10.19</td>
</tr>
<tr>
<td>New Referral</td>
<td>50</td>
<td>34.52</td>
<td>18-55</td>
<td>9.45</td>
</tr>
<tr>
<td>Re-referral</td>
<td>50</td>
<td>34.18</td>
<td>19-64</td>
<td>10.55</td>
</tr>
</tbody>
</table>
Table 2: Gender and Age of Different Groups

<table>
<thead>
<tr>
<th>Times Referred</th>
<th>Mean Age</th>
<th>N.</th>
<th>Standard Deviation</th>
<th>N = Male</th>
<th>N = Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>34.52</td>
<td>50</td>
<td>9.44</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>32.19</td>
<td>31</td>
<td>10.09</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>37.27</td>
<td>15</td>
<td>12.10</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>38.67</td>
<td>3</td>
<td>3.21</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>36</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>34.35</td>
<td>100</td>
<td>9.97</td>
<td>40</td>
<td>60</td>
</tr>
</tbody>
</table>

Procedure

The referral logbook was used to identify consecutively fifty first time referrals and fifty re-referrals within the five month period stated above. The referral letter was examined to record the reason for referral. Each individual’s case notes were then examined to record information such as diagnosis or presenting problem, number of times referred, length of care period with the service, number of appointments attended, non-attendance, previous outcomes, substance abuse, employment history and relationship status. These details were then recorded on participant information sheets designed for the audit (Appendix A).

As many individuals did not have a formal diagnosis or if the referral was for more than one difficulty, the main presenting problem was recorded. These were organised into four main groups. These were anxiety, depression, psychosis and ‘other’. Low frequency difficulties were collated into the ‘other’ category. (N =11) These included anger difficulties (N = 3), psychosexual problems (N = 1), social difficulties (N = 2), chronic fatigue (N = 1) and eating disorders ( N = 4).

Outcome and previous outcome were collated into categories of the referral not being accepted, treatment being completed, people not attending their appointments or people not returning their questionnaire form. This latter category refers to a
questionnaire asking about personal information that is sent to each individual with their first appointment invitation. They are asked to complete and return it. Failure to return this form within a certain time period means that they are not confirming their appointment and their time slot may be allotted to someone else. A letter is then sent to the individual and if they do not respond their case is closed.

**Statistical Analysis**

The data was presented using descriptive statistics. It also used chi-squared and Kruskal-Wallis tests due to the categorical nature of the data.

**Feedback**

The author arranged to feedback the results to the Psychology Department (See Appendix B).
Results

The exploratory research question examining whether individuals who are re-referred will have a different profile to those who are initially referred was supported. This section will examine the results of any differences in the characteristics within these two groups.

The study explored whether referrals that were not accepted would be more likely to be re-referred. From the re-referred group 35 individuals had previously been accepted and 15 had not been accepted (see Table 3). Therefore, this raised the question of whether cases which were initially accepted and deemed as appropriate referrals would be more likely to be re-referred than those which were previously not accepted.

Table 3: Referral Outcomes

<table>
<thead>
<tr>
<th>Reason for discharge</th>
<th>Initial Referrals</th>
<th>Re-referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Not returned questionnaire</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Did not attend</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Completed treatment</td>
<td>27</td>
<td>54</td>
</tr>
<tr>
<td>Not accepted</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Accepted</td>
<td>43</td>
<td>86</td>
</tr>
</tbody>
</table>

A Chi-Square analysis found there was a significant association between initial referral decision and re-referral. ($\chi^2(1, n = 50) = 8.00, p = 0.005$) (See table 4).
Table 4: Observed frequencies for initial referral decision and re-referral

<table>
<thead>
<tr>
<th></th>
<th>Re-referrals previously accepted</th>
<th>Re-referrals previously not accepted</th>
<th>Total</th>
<th>Chi-Square</th>
<th>Df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed N</td>
<td>35</td>
<td>15</td>
<td>50</td>
<td>8.00</td>
<td>1</td>
<td>.005</td>
</tr>
<tr>
<td>Expected N</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The study also examined whether clients whose care is terminated by non-attendance would be more likely to be re-referred. Looking at the previous outcome of individuals who had been re-referred those who had completed their treatment had a lower number of mean referrals to the department (2.2) than the other groups (see Table 3).

Table 3 shows that out of the 50 individuals who had been re-referred 9 completed their previous treatment while 14 had not attended and 12 had not returned their questionnaire in order to confirm their first appointment. In the group referred for the first time 27 individuals completed treatment, 8 did not attend and 8 did not return their initial questionnaire. These descriptive statistics suggest that the re-referral group has higher levels of non-compliance and non-attendance than the first time referral group.

A Chi-Square analysis was performed to look at whether individuals who completed their treatment were less likely to be re-referred. The results suggested that there was a significant association ($\chi^2(1, n = 56) = 10.56, p = 0.001$) (see Table 5).
Table 5: Results of the Chi-Square test examining whether individuals who complete treatment are less likely to be re-referred

<table>
<thead>
<tr>
<th></th>
<th>Completed treatment</th>
<th>Not completed treatment</th>
<th>Total</th>
<th>Chi-square</th>
<th>Df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial referral</td>
<td>27</td>
<td>8</td>
<td>35</td>
<td>10.561</td>
<td>1</td>
<td>.001</td>
</tr>
<tr>
<td>Observed N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-referral</td>
<td>7</td>
<td>14</td>
<td>21</td>
<td>10.561</td>
<td>1</td>
<td>.001</td>
</tr>
<tr>
<td>Observed N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The study also examined whether certain presenting problems will increase the likelihood of re-referral (i.e. long term enduring mental illness will be more likely to be re-referred). As can be seen from Table 6, results suggested that long term enduring mental health difficulties such as psychosis were more prevalent in the re-referral group (7 cases in the re-referral group and 4 in the initial referral group).

Table 6: Diagnoses for Initial Referral and Re-referrals

<table>
<thead>
<tr>
<th>Initial Referral.</th>
<th>Presenting Problem.</th>
<th>N</th>
<th>%</th>
<th>Re-referral.</th>
<th>Presenting Problem.</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>19</td>
<td>38</td>
<td></td>
<td>Anxiety</td>
<td>15</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>20</td>
<td>40</td>
<td></td>
<td>Depression</td>
<td>24</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>4</td>
<td>8</td>
<td></td>
<td>Psychosis</td>
<td>7</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>14</td>
<td></td>
<td>Other</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
Individuals who had presented with psychosis as their main presenting problem also had a higher mean number of referrals (3), when compared to individuals who presented with anxiety (2.3), depression (2.5) or the ‘other’ difficulties (2) (see Table 7).

**Table 7: Mean number of referrals for each diagnosis in the re-referral group**

<table>
<thead>
<tr>
<th>Presenting Complaint</th>
<th>Mean number of referrals</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>2.3</td>
<td>0.61</td>
</tr>
<tr>
<td>Depression</td>
<td>2.5</td>
<td>0.66</td>
</tr>
<tr>
<td>Psychosis</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

A Kruskal-Wallis test examined whether having certain types of diagnoses made an individual more likely to be referred. A significant association was not found $\chi^2(3, n = 100) = 2.446, p = 0.485)$. The descriptive statistics for each of these groups can be seen in Table 8.

**Table 8: Results of the Kruskal Wallis Test exploring whether certain diagnoses increase the likelihood of re-referral**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>N</th>
<th>Mean number of referrals</th>
<th>s.d.</th>
<th>Mean Rank</th>
<th>Chi</th>
<th>Df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>34</td>
<td>1.44</td>
<td>.50399</td>
<td>47.56</td>
<td>2.446</td>
<td>3</td>
<td>.485</td>
</tr>
<tr>
<td>Depression</td>
<td>44</td>
<td>1.54</td>
<td>.50369</td>
<td>52.77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>11</td>
<td>1.63</td>
<td>.50452</td>
<td>57.32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>1.33</td>
<td>.50452</td>
<td>43.68</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Individual’s profiles also differed between the initial referral and re-referral groups. The re-referral group had more individuals engaging in substance abuse, less individuals were employed, less were in a stable relationship and mean length of care episode was shorter than in the group who had been referred for the first time (see Table 9).

Table 9: Differences in Characteristics Between Initial Referrals and the Re-referral Group for Accepted Cases

<table>
<thead>
<tr>
<th></th>
<th>Substance Abuse N (%)</th>
<th>Married / co-habiting N (%)</th>
<th>Mean Length of Care Episode (Sd)</th>
<th>Employed N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Referral</strong> N = 50</td>
<td>8 (16)</td>
<td>42 (84)</td>
<td>5.05 months (Sd-2.89)</td>
<td>35 (70)</td>
</tr>
<tr>
<td><strong>Re-referral</strong> N = 50</td>
<td>13 (26)</td>
<td>33 (66)</td>
<td>3.97 months (Sd-3.29)</td>
<td>24 (48)</td>
</tr>
</tbody>
</table>

A Chi-Square test found a significant association between referral group and being in a relationship $\chi^2 (1,n=100) = 4.32$, $p = 0.032$. More individuals in the initial referral group were in a relationship (See Table 10).
Table 10: Chi-Square analysis results examining unemployment in both referral groups

<table>
<thead>
<tr>
<th></th>
<th>Initial referrals in a relationship</th>
<th>Initial referrals not in a relationship</th>
<th>Re-referrals in a relationship</th>
<th>Re-referrals not in a relationship</th>
<th>Total</th>
<th>Chi-Square</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>42</td>
<td>8</td>
<td>33</td>
<td>17</td>
<td>100</td>
<td>4.32</td>
<td>1</td>
<td>.032</td>
</tr>
</tbody>
</table>

No significant association was found between the two referral groups and substance abuse ($\chi^2(1, n = 100) = 1.51, p = 0.220$). (Results in Appendix C).

Table 11: Chi-Square test results examining unemployment and referral group

<table>
<thead>
<tr>
<th></th>
<th>Initial referrals employed</th>
<th>Initial referrals unemployed</th>
<th>Re-referrals employed</th>
<th>Re-referrals unemployed</th>
<th>Total</th>
<th>Chi-Square</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed N</td>
<td>35</td>
<td>15</td>
<td>24</td>
<td>26</td>
<td>100</td>
<td>5.002</td>
<td>1</td>
<td>0.021</td>
</tr>
</tbody>
</table>

A significant association was found between substance abuse and referral group ($\chi^2(1, n = 100) = 5, p = 0.021$) with the re-referral group having significantly more individuals unemployed (Table 11).
Discussion

The results suggest that there are differences in the profiles between first time referrals and re-referrals. Cases which are initially accepted are more likely to be re-referred than referrals that are not accepted. It was found that non-attendance and non-compliance are more likely to be found in the re-referred group.

The main presenting problem also influenced the likelihood of referral. The descriptive statistics suggested that individuals with severe and enduring mental illness such as psychosis, were more likely to be re-referred. However, one must be speculative at drawing conclusions only from descriptive statistics. This was not found to be statistically significant, although this may be because of the small numbers within that sample. Length of care episode was found to be shorter for those who were re-referred. In the first time referral group there were less cases of substance abuse although this was not found to be a significant difference. In the first time referral group more individuals were living in a stable relationship and a higher percentage of them were employed. The results suggest that predictors of re-referral are past re-referral, previous non-attendance and non-compliance. Socio-economic factors such as unemployment and relationship status also seemed to increase the risk.

This supports the findings of Rabinowitz et al (1995), who asserted that unemployment and being single, divorced or widowed increased likelihood of re-referral. It also supported Haywood et al (1996), who proposed that there were higher rates of re-referral amongst individuals who had previously not complied with treatment or who had been misusing substances such as alcohol and drugs. It also supported Killapsy, Banerjee, King and Lloyd’s (2000) study which suggested that non-attenders had a higher rate of re-referral.

The results did not support Arnold and colleagues (2003) previous findings that first time referrals would be younger in age than re-referrals. However, other studies have also failed to find any significant relationship between age and re-referral (Swett, 1995, Pridmore, Hornsby, Hay & Jones, 1994).
These associations among drug/alcohol problems, medical non-compliance, non-attendance and increased likelihood of re-referral have important clinical implications for client education. Increased emphasis on the importance of these factors may be an important preventative intervention to help break the cycle of re-referral.

In relating these findings to the guidelines set out in the National Service Framework (DoH, 1999), the results suggested that perhaps the service was not optimising engagement as well as it could. This was due to the findings that non-attendance and non-compliance were associated with re-referral. Individuals who miss an appointment or do not return their form are at a higher risk of re-referral and clinicians should consider alternative action for non-attendance. It could be speculated that perhaps the service’s policy to these issues could be improved to help meet people’s needs. One option could be to follow up individuals who do not attend with a home visit or a telephone call rather than a repeat appointment.

The relationship that was identified between accepting a referral for care and re-referral may demonstrate that the Psychology service accepts those with genuine need and this predicts future need and thus re-referral. This is most obvious for chronic long term illnesses like schizophrenia. Many studies have found that relapse of psychosis is a strong predictor of readmission (Arnold et al, 2003, Bernado & Forchuck, 2001). This is compatible with the present results suggesting that re-referral is mediated by client related variables rather than service-related variables.

The clinical implications of associations found include consideration of the possible benefits of keeping clients at high risk of re-referral on the caseload on a low support level, rather than discharging them and receiving multiple referrals. This may contain clients and reduce resource use and provide better support in the long term.

Limitations

The associations that have been highlighted may be due to unrecorded variables. For example, the association between accepting the referral and later re-referral may reflect people’s requirements rather than ongoing need, becoming more likely to use
the service for support once they have already done so. Alternatively, referrals may be mediated by GP variables, such as their psychological mindedness rather than the service’s or client variables.

Another potential problem within this study is that there is no way of knowing whether the individuals in the group that have been initially referred will form part of the re-referred group in the future. However, these should only form a minority and therefore should not overly influence the results. Another point is that appointments attended may have been a better reflection of care received than length of time with their case open because frequency of visits varies amongst clients.

Methodological constraints limit the validity of the results. A larger sample size may have improved the reliability and validity of the results. Also due to much of the data being at a nominal level statistical tests used to analyse the data were less powerful than those that could have been used on other types of data.

Primary presenting difficulty was used rather than diagnosis as many of the individuals had not been given a formal diagnosis. Not recording diagnosis has the benefit of reducing assumptions but constrains internal audit and may change perceptions of service use. Neelman and Mikhail (1997) found the absence of a clear diagnosis was a predictor of non attendance in outpatient clinics. The primary presenting difficulty is unlikely to accurately represent the client’s needs and may include other symptoms (for example, anxiety symptoms when labelled as primarily presenting with depression), which may be the real mediator of the referral. Hill, Evers, Thomas and Stevenson (1999) found that 47% of cases referred to an Adult Mental Health Team had three or more referred problems. This suggests that referral reasons are more complex than the current presenting problem label accounts for.

This may also apply in cases where drugs and alcohol abuse are also co-occurring. If staff are predominantly concerned with the treatment of the main presenting psychiatric disorder substance abuse problems may be ignored or inadequately addressed. Perhaps mental health services feel that they are not equipped to deal with these types of problems.
Data recorded was checked from many sources but it is likely that some relevant data was never recorded. Any missing data is likely to bias the results. For example, many individuals may conceal the fact that they are abusing substances. Some people may be aware that if they admit this then they will be referred elsewhere first to deal with those issues rather than the problem that they have presented with.

Although there are benefits to this type of study because of the number of cases that are available for analysis, there can be other problems associated with using secondary data. For example, although efforts were taken to confirm the validity of the data there may have been data recording errors of which the authors were unaware.

Also, generalisability of this study may be limited, since the sample was primarily White British. Generalisability may also be limited because the study was carried out in a single inner city area within a particular service (for example, it only focused on out-patient elements of the service). Most research into factors predicting repeating service has looked at re-admission to acute psychiatric units rather than community settings.

**Future Research**

Future research might overcome these methodological difficulties by using a bigger sample and a prospective design which would have greater control over collecting data (rather than retrospective data) and the option of using parametric tests for analysis which would be more powerful than descriptive statistics. It would also be beneficial to do a study over a longer time period so that it can be seen which of the initial referrals get re-referred and to better examine individual re-referral patterns. Other factors could also be explored such as family involvement, social networks, symptom severity or the sequence of events leading up to hospitalisation. With a larger sample referral sources could also be assessed as mediators of re-referral and GP and assessor labels for client’s presenting problems could be compared.
It would also be interesting to explore whether the attitudes and perceptions of clinical staff play a part in deciding whether clients are re-referred or accepted onto caseloads. Problems may be handled in a cursory manner or overlooked if clients are viewed as constantly returning with familiar or unchanging issues. How these factors effect re-referral have not been adequately examined.

The increasing service pressures on community resources warrants further research to replicate and expand the present findings in outpatient settings. This would facilitate putting research into practice and would have implications for service delivery, resource allocation and meeting client needs.
References


Participant Information Sheet

Subject number:

Dob: Age:

Gender:

Ethnicity:

In a relationship:

Substance abuse:

Current Referral.

Presenting complaint:

Referred by:

Referral date:

Accepted/ not – if not reason:

Return of form for initial appointment:

Duration of time on caseload:

Appointments attended:

DNA’s:

Type of intervention:

Outcome:

Previous Referrals.

Referred to this service before (how many times): 1 2 3 4 5

Presenting complaint:

Referred by:

Referral date:

Accepted/ not – if not reason:
Return of form for initial appointment:

Duration of time on caseload:

Appointments attended:

DNA's:

Type of intervention:

Outcome:
Confirmation letter regarding presentation of results to the Service
Dear Miss Dovey,

Thank you for attending the Psychology Departmental meeting to present the results of your audit. There were some interesting points for us to consider as a service and I am sure there will be a great deal of discussion in the coming weeks when we have had the opportunity to read and consider the whole report. Thank you for the effort that you put into the audit and for taking the time to feedback the results. I wish you all the very best with the remainder of your training.

Yours sincerely

Consultant Clinical Psychologist
Appendix C

Table C: Chi-square test results of substance abuse in initial referrals and re-referrals
### Appendix C

Table C: Chi-square test results of substance abuse in initial referrals and re-referrals

<table>
<thead>
<tr>
<th></th>
<th>Initial referrals - substance abuse</th>
<th>Initial referrals - no substance abuse</th>
<th>Re-referrals - substance abuse</th>
<th>Re-referrals - no substance abuse</th>
<th>Total</th>
<th>Chi-Square</th>
<th>df</th>
<th>Asymp. Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Observed N</strong></td>
<td>8</td>
<td>42</td>
<td>13</td>
<td>37</td>
<td>100</td>
<td>1.51</td>
<td></td>
<td>.220</td>
</tr>
<tr>
<td><strong>Expected N</strong></td>
<td>10.5</td>
<td>39.5</td>
<td>10.5</td>
<td>39.5</td>
<td>100</td>
<td></td>
<td></td>
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</tbody>
</table>
MAJOR RESEARCH PROJECT

Developing a questionnaire to measure disclosure of upsetting material and to examine the relationship between physical and mental health

Year 3: June 2006
ABSTRACT

Objectives: To develop a questionnaire to measure disclosure of distressing material and to explore the relationship between distress disclosure and mental and physical health.

Design: The Disclosure Questionnaire was created using a cross-sectional, opportunity and snowball sampling design. Test-retest data were obtained using a repeated measures opportunity sampling design at two points in time (one week apart).

Participants: Five hundred and forty nine participants took part in the development of the questionnaire. Sixty-nine different participants took part in the test-retest stage of the research.

Materials: Participants completed the Disclosure Questionnaire, the Depression and Anxiety Stress Scale (DASS) (Lovibund & Lovibund, 1995), a demographic information sheet and a measure of physical health. Those who took part in the test-retest part of the research completed these twice (one week apart).

Statistical analysis: Factor analysis was performed on the Disclosure Questionnaire data. The relationship between scores on the Disclosure Questionnaire factors and age were assessed using Spearman's rho. Differences between scores on the Disclosure Questionnaire and gender were assessed using the Mann Whitney U test. Correlations between Disclosure Questionnaire factor scores and mental health (DASS sub-scale scores) and physical health ratings were assessed using Spearman's rho correlations. Multiple regressions were used to identify predictors of scores such as age, gender, DASS sub-scale scores and physical health ratings on each factor of the Disclosure Questionnaire and of total scores.

Results: Factor analysis of the Disclosure Questionnaire identified three factors ('tendency to disclose', 'ease of disclosure' and 'positive beliefs about disclosure').
Significant positive correlations were found between scores of disclosure and physical health and significant negative correlations were found between disclosure and mental health.

Multiple regressions found that older age was a significant predictor of scores on the 'ease of disclosure' factor of the Disclosure Questionnaire. Female gender was a significant predictor of total scores and the 'tendency to disclose' and 'positive beliefs about disclosure' factors of the Disclosure Questionnaire. Physical health was a predictor of scores on all factors and total scores on the Disclosure Questionnaire.

Multiple regressions also examined mental health (sub-scales of the DASS) and found that depression was a significant negative predictor on total scores on the Disclosure Questionnaire and on the 'tendency to disclose' and 'positive beliefs about disclosure' factors. Anxiety was a significant negative predictor on the 'ease of disclosure' factor and stress was a significant negative predictor on the 'ease of disclosure' and the 'positive beliefs about disclosure' factors.
INTRODUCTION

1 What is self-disclosure?

There are many definitions of self-disclosure within the literature with none universally accepted. Derlega, Margulis & Winstead, (1987) defined self-disclosure as the extent to which individuals “reveal to others personal information about themselves, including their thoughts, feelings and experiences” (p.206). This can include any communication referring to the self including personal information, dispositions, events in the past and plans for the future. This is broader than the definition used by Taylor & Altman (1966) who argued that self-disclosure should only describe intimate personal verbal communications. Other researchers argue that individuals also disclose by non-verbal methods such as rolling ones eyes, sighing, drawing, dancing, etc. and that definitions should encompass these non-verbal behaviours in addition to the verbal utterances (Derlega, Margulis & Winstead, 1987).

Definitions have varied depending on whether the researchers view disclosure as a state or trait phenomenon and whether disclosure is deemed a unidimensional or multidimensional construct. Jourard (1971) designed many of the early disclosure studies and viewed disclosure as “the process of making the self known to other persons.” He saw disclosure as a stable personality trait which was associated with positive mental health. However, later research began to examine social-situational factors that impacted on disclosure. Chelune, (1979, p.24) defined disclosure as including five areas including “the amount or breadth of personal information disclosed, the intimacy of the information revealed, duration or rate of disclosure, affective manner of presentation and self-disclosure flexibility” (the ability to modulate disclosure levels according to the demands of the situation).

The diversity in the many definitions of disclosure reflects the many inconsistencies that exist in disclosure research and may serve to explain many of the conflicting findings in disclosure research. This study will explore distress disclosure which is the ability or willingness to openly express negative or unpleasant emotions. This study
only explores verbal self-disclosure of distressing material due to its clinical relevance.

2 What do people disclose?

Researchers have measured self-disclosure in terms of the range of topics discussed and the level of intimacy of the topics that are disclosed. Self-disclosure is considered greater when more topics or more intimate topics are discussed. Studies that have examined topics of self-disclosure found that individuals commonly disclosed information about themselves, relationships with family and friends (Aries & Johnson, 1983), feelings, fears and accomplishments (Rubin, Hill, Peplau & Dunkel-Schetter, 1980) social-emotional topics (Morgan, 1976), cars, work, politics, (Komarovsky, 1967) sports, money, business (Haas, 1979), and strengths (Hacker, 1981).

3 What do people not disclose?

There are certain topics that individuals’ commonly choose not to disclose. Having secrets about ourselves that are deliberately concealed from others seems to be a normal part of human development (Peskin, 1992). Research findings indicate that people often conceal their most painful or traumatic experiences from others. The types of secrets that people tend not to disclose include having HIV (Larson & Chastain, 1990), being gay (Cole, Kemeny, Taylor & Visscher, 1996), grief (Evans, 1976), being raped (Binder, 1981), having been sexually abused as a child (Stark, 1984), sexual practices (Yalom, 1985), drug abuse (Murphy & Irwin, 1992), aggression (Stark, 1984) and family secrets (Karpel, 1980). Most secrets are likely to be about upsetting, negative information that relates to the individual who does not want to disclose it due to fear about how it will be received or of negative consequences that may result from their disclosure (Norton, Feldman & Tafoya, 1974).
4 Functions of disclosure

4.1 Evidence that disclosure impacts on physical health

Research suggests that disclosing distressing material can positively impact on an individual's physical health. Avoiding discussing emotions has been found to be associated with medical problems such as cancer (Cox & McCay, 1982; Jensen, 1987), heart problems (Davies, 1970; Friedman, Hall & Harris, 1985), blood pressure (Davies, 1970) chronic asthma rheumatoid arthritis (Smyth, Stone, Hurewitz and Kaell, 1999) and physical disease rates in general (Blackburn, 1965). Luborsky, Barber & Jones (1992) reviewed psychotherapy outcome studies within medical settings. Luborsky et al (1992) found that patients who received psychotherapy in addition to medical treatment or surgery had better health outcomes than those who relied on the medical treatment alone.

Mumford, Schlesinger & Glass (1983) examined 15 studies exploring the effects of psychotherapy on use of medical services between 1965 and 1980. The researchers concluded that individuals who underwent psychotherapy used medical services 13% less than control participants who were not having psychotherapy. Similar findings were reported by Jones and Vischi (1980).

Pennebaker and his colleagues have conducted many studies highlighting the benefits of disclosure of distressing material and physical health (Pennebaker & Beall, 1986; Richards, Beall & Pennebaker, 2000). For example, Pennebaker & O’Heeron, (1984) administered self-report questionnaires to widows who had lost their spouses as a result of accidental death or suicide approximately one year after their loss. The questionnaires enquired about their coping strategies and physical health. Pennebaker and O’ Heeron found that widows who talked more about their spouse’s death tended to have fewer health problems and ruminated less about the death and circumstances surrounding the event. Pennebaker and O’ Heeron concluded that disclosure appeared to play a central role in the coping and health process.
Pennebaker, Kiecolt-Glaser and Glaser (1988) also investigated the health implications of disclosure by studying immune function. Pennebaker, Kiecolt-Glaser and Glaser randomly assigned participants to write about a personal traumatic event or trivial topics for twenty minutes on four consecutive days. Blood samples were taken the day before the study, on the final day of the study and six weeks later. Health centre records, self reports regarding subjective distress and daily habits, autonomic measures and information regarding possible individual differences were also collected. The results indicated that writing about traumatic experiences had positive effects on the response levels of T-lymphocytes (indicative of improvements in immune function), decreased health centre use and decreased subjective distress in the self-disclosure group.

Cole, Kemeny, Taylor and Visscher, (1996) used objective biological measures of physical health and subjective measures to explore the impact of disclosure on health status. They studied the incidence of infectious and neoplastic (abnormal growths) diseases among men with HIV. Participants completed self report measures, were interviewed and also received a medical examination every six weeks. Men who had not disclosed their homosexual identity experienced increased incidence of cancer and infectious diseases such as tuberculosis, pneumonia and bronchitis over a five year period. Cole et al also found that the incidence of illness increased in direct proportion to the degree that men concealed their homosexual identity. None of these effects were found to be associated with demographic factors (e.g. age, occupation, etc.), depression, anxiety, repressive coping, social desirability response biases or healthy lifestyle patterns.

Results from these studies suggest that disclosure of distressing material can result in individuals experiencing improvements in health. The studies that have examined the biological changes in the body indicate that these results are not simply due to the demand characteristics of self report measures occurring because biological measures can not be affected.
4.2 Evidence that disclosure impacts on psychological health

The literature also suggests that disclosing negative material can have a positive impact on a person’s psychological health. For example, Bolton et al (2003) administered questionnaires to soldiers who had served as peacekeepers in Somalia. The questionnaire included measures of exposure to negative or traumatic situations, reception at returning home, self-disclosure and post-traumatic stress symptoms. They found that higher levels of exposure to stressful events had increased likelihood of experiencing PTSD but that disclosure following these stressful events was associated to lower levels of PTSD severity.

Similarly, Amir, Stafford, Freshman and Foa (1998) found that higher levels of complexity and articulation in rape victim narratives was associated with a lesser degree of PTSD symptoms following the trauma. These findings were consistent with previous findings (Boca, Rime & Acruri, 1992; Joseph, Yule, Williams & Hodgkinson, 1994).

Patterns of self-disclosure seem to have the potential to explain some of the individual differences in the development and continuation of symptoms in certain mental health diagnoses. For example, avoidance is a central feature of many anxiety based disorders such as simple phobias, generalized anxiety disorder, etc. (Wells, 1997). Similarly, individuals with post-traumatic stress disorder (PTSD) often avoid anything associated with the past traumatic event that triggered their trauma reaction (Purves & Erwin, 2004) which often includes disclosing information surrounding the event or discussing topics that remind them of it (DSM-IV). Disclosure can break these patterns of avoidance which can otherwise contribute to maintaining the individual’s difficulties.

Apter et al (2001) argued that limited self-disclosure may act as a risk factor that can serve to increase the likelihood of suicidal behaviour when other risk factors are present such as psychopatholgy, anxiety, depression and hopefulness. The researchers concluded that an inability to self-disclose can lead to increased isolation, loneliness and suffering. They measured this using the Depression, Anxiety and Stress Scale and
concluded that lack of disclosure can affect suicidal behaviour by increasing depression and anxiety which can be important facilitators of suicidal behaviour.

Pennebaker & Susman, (1988) also examined the relationship between distress disclosure and psychological health. Pennebaker and Susman asked undergraduates to write about the most distressing experience in their life for 15 minutes on four consecutive days. The students were assigned to three different conditions. In the trauma fact condition they were asked to write only about the facts of the trauma. Those in the trauma emotion condition wrote about their feelings associated with the trauma rather than the actual facts. The third condition group were asked to write about the facts and their feelings concerning the event. Participants also completed a questionnaire daily exploring their mood and health. Overall, participants in the trauma emotion and trauma combination conditions reported feeling happier, healthier and less anxious at 4 and 6 months following the study. Additionally, those in the trauma combination condition had a significant drop in illness rates as compared to the other groups. The authors concluded that for those individuals who had been “living with” their traumas the experience gave them the opportunity to understand the meaning of the event, resolve what had occurred and explore their role in the event. This study suggests that it is not just the disclosure of the event, but also gaining a new understanding of the event that is beneficial.

Additionally, case reports have linked non-disclosure of past upsetting events to psychotic symptoms in children (Saffer, Sansone & Gentry, 1979) and dysfunction in families (Swanson & Biaggio, 1985).

Thus the findings found that not only can disclosing distressing material have a positive impact on mental health problems, but that individuals who have difficulties with disclosing their distress to others, have an increased likelihood of experiencing psychological problems.
Coates & Winston (1987) argued that there was a curvilinear relationship between self-disclosure and positive benefits. Lack of disclosure can impact on the ability to form relationships with others and often deprives an individual of potentially validating social comparison information (Chelune, Sultan & Williams, 1980). Research has also suggested that too much disclosure may be equally maladaptive. People who disclose too much induce fear and apprehension in others and this can lead to them becoming rejected (Coates, Wortman & Abbey, 1979). Even individuals who may initially help them can often be driven away by them over time (Peters-Golden, 1982).

Kelly and McKillop (1996) reviewed studies and examined the consequences of disclosing a personal secret. Kelly and McKillop aimed to distinguish between situations when revealing was beneficial to when revealing was harmful and proposed a decision making model for revealing secrets. The authors asserted that individuals should disclose a secret if it was troubling them (resulting in ruminations, anxiety, depression, pain or ulcers) if they had a confidant who was discreet, non-judgemental and likely to react positively to the revelations. Kelly and McKillop argued that if this was not possible then they should write the secret down. They posited that eliciting support from others can carry the risk of rejection and threaten individual's self-esteem by making them feel inadequate and unable to cope alone. They found that people who expressed difficulty in coping got more rejection than those who acted as though they were coping well. However, they posited that in many situations non-disclosure can be healthy and play an important role.

Sowell, Seals, Phillips & Julious (2003) explored the decision processes of disclosure in a population of women with HIV. They acknowledged that disclosure was often accompanied by regrets and in some cases led to stigmatization and discrimination rather than to social support. They found that having positive beliefs about others' reactions to their disclosure was crucial to their decision to disclose. A small group of women had not disclosed to anyone. They had appraised the disclosure process to be "too difficult or risky to undertake" and hid their illness from others.
In some circumstances disclosure is not possible for those who may face punishment as a result of their disclosure (e.g. legal proceedings). Additionally, it has also been suggested that individuals who have had experiences that cannot easily be explained will not benefit from disclosing and trying to find meaning from their distressing events. Horowitz (1976) noted that survivors from concentration camps were healthiest if they were able to "put the experience behind them rather than attempt to understand it" if they could not accept the event. Continued thinking and talking about the event could serve to intensify their negative affect.

Studies by Stiles and his colleagues have also concluded that there are no benefits to self-disclosure (McDaniel, Stiles & McGaughey, 1981; Stiles and Shapiro, 1994). However, none of Stiles' studies differentiated between disclosures of distressing or non-distressing content. Frequent disclosures of non-distressing content (e.g. holiday plans) could actually detract from the client's progress particularly if they prevent the client discussing their presenting issues. This suggests that if therapy is not of good quality then the client will not benefit from the experience. These studies also used investigator based methods to measure disclosure and did not actually ask clients whether they had not disclosed information.

The above studies suggest that if certain conditions are not met then disclosure may not be beneficial. These include if the disclosure is met with negative consequences or negative responses from others or if the person is unable to gain meaning and understanding of the event from their disclosure.

6 The importance of disclosure in therapy

The majority of the studies mentioned above emphasise the important role that disclosure can play in alleviating mental and physical health symptoms. Therapy can often provide an opportunity for this. Although disclosure is often difficult because the disclosed material can be negative and potentially distressing, the process of disclosure is viewed as beneficial. This may be either because self-disclosure is considered central to the self-exploration required for symptom alleviation or because
the primary source of some client’s difficulties are seen as stemming from problems in disclosure.

If therapists are not aware of their client’s experiences then they do not know what problems need to be addressed in therapy. Missing information can result in an incomplete formulation and therapy that is poorly targeted or completely misses the issues. Therefore clients withholding information in therapy could be detrimental for their treatment and prognosis. Yalom (1985) found that if clients concealed significant information, they were less involved with the therapy process and less likely to engage and to benefit from the experience. The secrecy and strains that accompany non-disclosure can cause the client to disengage from therapy or to discuss superficial topics.

7 Reasons for non-disclosure in therapy

Although disclosure is seen as important in therapy, there is evidence that many clients do not disclose upsetting material to their therapist. Studies that have examined the rates of non-disclosure whilst in therapy have reported figures ranging from 41 – 46% (Weiner & Schuman, 1984; Hill, Thompson, Cogar & Denman, 1993; Swan & Andrews, 2003). For example, Weiner & Schuman (1984) asked 79 individuals whether they had concealed information from their therapist and 42% of individuals reported that they had done so.

Hook & Andrews (2005) asked clients to provide their reasons for choosing not to self-disclose in therapy. Reasons given were as follows: Lack of trust in therapist (61%), lack of empathy from therapist (61%), fear of negative judgement (56%), fear of rejection (50%), too painful to discuss (56%), too ashamed (78%), too guilty (56%), treatment too short (56%), information not important for treatment (44%) and too private (39%).
8 Clinical and theoretical models of self-disclosure

The material reviewed above demonstrates that disclosure can benefit physical and mental health. There are both clinical and theoretical suggestions as to why this might be the case.

8.1 Clinical Models

Disclosure is an integral part of many psychological therapies with each having techniques that rely solely on disclosure (Stiles & Sultan, 1987). Some examples of how disclosure is used within the different therapy models are presented below, including the cognitive behavioural model, psychodynamic model, systemic model and group therapy model.

In cognitive behavioural therapy, disclosure is used to identify negative automatic thoughts and dysfunctional assumptions. Clients are often encouraged to articulate their feelings to their therapist (Hawton, Salkovskis, Kirk & Clark, 2003). Techniques (such as Socratic questioning) are used to elicit self-disclosure to facilitate cognitive restructuring and provide the client with different meanings to their experiences and beliefs. Dysfunctional assumptions and beliefs form the basis for many mental health difficulties and can also play a large role in maintaining client's problems (Hawton, Salkovskis, Kirk & Clark, 2003). If clients do not disclose information then erroneous beliefs cannot be corrected. Often, these beliefs can be extremely debilitating. For example, a common theme for adults who have been sexually abused as children is to believe that the abuse was their own fault (Saffer, Sansone & Gentry, 1979). Disclosure in therapy allows individuals to question the evidence for their beliefs and can lead to changes in their attitudes and emotions.

Psychodynamic therapy emphasises the importance of catharsis. This model also emphasises the importance of non verbal disclosure through unconscious communication and attends to posture, gestures, silences, etc. It asserts that meaning and unconscious phantasies may be expressed in verbal disclosure through the way the
client speaks rather than what is said. These disclosures can draw the therapist’s attention to transference and countertransference reactions and preconscious attitudes of the client (Lemma, 2003).

Within systemic therapy disclosing beliefs and past experiences can help individuals to reframe each others emotional behaviour so that they are better able to understand it. Identifying patterns and interpretations of emotional behaviour within current interactions can help clients interact in new ways such as disclosing their feelings in less blaming ways (Chelune, 1979).

Yalom (1985) argued that self-disclosure is the mechanism that underlies all therapeutic factors in group therapy. Individuals in group therapy are expected to share private information with group members, express strong emotions, be attentive and empathic to group members, help others in the group to work out their difficulties through altruistic self-disclosure and provide support and honest feedback (Corey & Corey, 1997). All involve self-disclosure (Corey & Corey, 1997). Research has found that disclosure is related to group cohesion (Tschuschke & Dies, 1997) intimate relationships within the group (Benito & Short, 1998) and that limited self-disclosure hinders group progress (Doxsee & Kivlighan, 1994).

8.2 Theoretical Models

In addition to conceptualisations of the benefits of disclosure there are also theories as to why disclosure is helpful. The inhibition theory (Pennebaker & Beall, 1986), the theory of stress and coping (Lazarus & Folkman, 1984) and the Fevr model of disclosure (Stiles, 1987) are outlined below.

Pennebaker and Beall, (1986) proposed a theory of inhibition that outlined the process whereby failure to confront traumatic events resulted in poorer health. They asserted that inhibition of thoughts, feelings and behaviours was an active process requiring physiological work. When individuals chose not to disclose or think about traumatic experiences over long periods of time, cumulative stress was placed on the body
which was associated with lower immunological functioning (Pennebaker, Kiecolt-Glaser & Glaser, 1988) and increased the likelihood of stress related diseases (Cohen & Williamson, 1991). The theory argued that disclosure of past traumatic experiences reduced the likelihood of poor health as it reduced the mental and physical stress experienced by the individual. Pennebaker and Beall (1986) argued that the health benefits of self-disclosure appeared to be most evident following negative personal information that one had not previously disclosed.

Lazarus & Folkman (1984) suggested a theory of stress and coping. They posited that a person’s appraisal of and reaction to an event determined whether the situation was seen as a threat. They argued that this assessment was crucial for how they coped with the situation. They argued that that poorer health was caused by the behavioural inhibition accompanying lack of disclosure and that it also limited the range and frequency of helping behaviours offered by significant others. They asserted that the inability to discuss negative events restricted the range of available coping responses, preventing more active, problem focused responses and leaving primarily emotion focused responses.

Stiles (1987) proposed a fever model of self-disclosure which suggested that disclosure increased with the intensity of a person’s distress. This resulted in disclosure which served to alleviate the distress through catharsis and self-understanding. He argued that the positive effects of disclosure were related more to the depth and extent of the disclosure rather than of the quality of the other persons response, providing it was an accepting one. These clinical and theoretical models of self-disclosure all highlight the positive effects of distress disclosure.

9 Other factors that may impact on disclosure

Evidence suggests that disclosure is often conceptualised as a state and / or a trait. Age, gender and the recipient of the disclosure may also have an impact on levels of disclosure. These factors influencing disclosure will be address in this section.
9.1 Is tendency to disclose to others a state or a trait?

Historically there has been controversy within the study of self-disclosure as to whether it is a state or trait effect. Most of the early self-disclosure studies explored whether individual trait differences impacted on levels of disclosure. Later research began to move away from solely studying individual differences and began to examine the contextual determinants of disclosure.

Many researchers argue that self-disclosure is a state effect (Jourard, 1971). For example, a person may generally be a high self-discloser (trait) but may experience a traumatic event which they can not speak about. When in an emotionally blunted state, people can be cut off from their affective responses and cannot process and express their trauma related feelings (Horowitz, 1976). They may avoid trauma related topics as they do not want to trigger thinking about or re-experiencing the event.

Stile's (1987) also viewed the state of the individual as instrumental to the disclosure process in his fever model. His argued that self-disclosure increased with the intensity of a person's distress and was therefore a state effect. He asserted that by disclosing, individuals could experience the relief of self-disclosure (I've never spoken about this before) and come to terms with the difficulties in their lives by examining the meaning of events and their responses to them.

Other evidence cited for the case of disclosure being a state effect is the argument that mood states seem to impact on self-disclosure. Post, Wittmaier & Radin (1978) found that in conditions of high anxiety, individuals had lower levels of self-disclosure and disclosed less intimately about themselves. Meleshko & Alden (1993) found that socially anxious individuals did not reciprocate disclosure as much as their non anxious counterparts. Alcohol has also been found to elicit higher levels of self disclosure (Chelune, 1979) as have certain drugs such as MDMA (methylenedioxymethamphetamine (Brick & Erickson, 1999). Therefore, psychological difficulties, mood states, substances and particular situations have all been found to impact on disclosure.
However, other researchers assert that levels of disclosure are determined by individual’s personality traits. Previous research has identified individual personality traits that might relate to the tendency to disclose including perfectionism (Kawamura & Frost 2004), self-esteem (Snell & Finney, 1993), introversion (Pederson & Higbee, 1969), defensiveness (Yule, 1999), anxiety (Post, Wittmaier & Radin, 1978) and different attachment styles (Mikulincer & Nachshon, 1991). To discuss all these personality variables is beyond the scope of this study however a few examples have been mentioned.

High levels of private self-consciousness (people who think a great deal about private aspects of themselves) are expected to disclose more because they are more attuned to their personal states and they tend to have a higher need to self-disclose relative to people low in private self-consciousness (Davis & Franzoi, 1987). Perfectionists are less likely to disclose distressing material as they are more sensitive to people knowing that they are struggling with issues or have made mistakes (Kawamura & Frost, 2004). It has been suggested that attachment styles also impact on disclosure with securely attached individuals disclosing more (Shechtman & Rybko, 2004).

Personality characteristics such as alexithymia have been found to result in lower levels of self-disclosure. Individuals with alexithymia experience difficulty recognizing, experiencing, regulating and expressing their emotions. Clinically they show non-verbal signs of emotion and may use words such as sad or angry, yet they are unable to elaborate on these feelings or to connect those words to specific situations where they experienced those emotions (Kennedy-Moore & Watson, 1999). Research suggests that these individuals have a greater risk than the general population of developing both medical and psychiatric disorders (e.g. substance abuse, anxiety disorders, post traumatic stress disorder, somatoform disorders and eating disorders). Unfortunately, their difficulties also reduce the likelihood that they will respond to conventional treatments for their problems.

There is evidence which suggests that individual personality traits may stem partly from genetically based variations in neurophysiological functioning (Kagan, 1994; Suomi, 1991). Kagan (1994) found an association between physiological indexes of
sympathetic and hypothalamic pituitary adrenal activity and an inhibited style of interacting and concluded that this implied the influence of genetic factors. Similarly, introversion and extroversion have been associated with hereditary factors (Kagan 1994).

Therefore, previous research suggests that levels of disclosure may be influenced by either the state or trait of an individual. However, recent research has acknowledged that complex human behaviours such as disclosure are likely to be multiply determined through the interaction of both state and trait factors (Chelune, 1979).

9.2 Age and disclosure

Age appears to impact on patterns of self-disclosure although the findings have been inconsistent. Jourard (1971) examined trends of self disclosure among college students ranging in age from 17 – 55 years. He found that as individuals progressed through adolescence they reduced the amount they confided in their parents and confided more in friends. As they entered into relationships their disclosure levels increased as they confided in their partners. He argued that as romantic relationships tended to be “closer” than that of parental relationships that individual’s self-disclosure increased with age. However, Jourard (1971) recognised that research had not examined the disclosure patterns of those aged above 50 years. He hypothesised that senescence was likely “to be accompanied by a process of disengagement and the self-disclosing patterns should reflect this” (Jourard, 1971, p. 48).

Morikawi (1973) assessed psychological well being and disclosure in individuals ranging in age from 60 – 84 years and found that self-disclosure decreased with age. Moriwaki concluded that age did not relate to psychological well being although higher levels of social support did increase disclosure levels. Morikawi argued that role loss was a more important factor in the psychological well being of the sample than self-disclosure. However, given that it is common for the elderly to suffer multiple bereavements of close friends or spouses this may have impacted on levels of disclosure and was not explored within the study.
Not many studies have examined the impact of age on distress disclosure particularly in older populations. These findings suggest that further investigation is needed to explore the relationship.

### 9.3 Gender and disclosure

The contribution that gender plays in determining self-disclosure has been a well researched area. Jourard (1971) argued that the male sex role inhibits self-disclosure and that this could be explained by gender role expectations. He argued that sex roles within society require men to appear tough, self-assured and emotionally unexpressive and women to be kind, nurturing and comforting. Through social learning these different gender qualities effect communicative styles and influence how much value is placed on expressing feelings and emotions (Maltz & Borker, 1982). These behaviours are modelled and reinforced from early childhood. For example, boys play in groups with hierarchies of leadership and girls play in smaller groups and engage in more talk and more reciprocal interaction (Lever, 1976).

This notion was supported by Hosman’s (1986) findings. Hosman performed a meta-analysis and found that gender differences were greater for studies published between 1960 and 1969 than for studies published between 1970 and 1986. He suggested that gender differences in self-disclosure may be declining due to sex role attitudes and identities changing in the past 40 years.

Dindia & Allen (1992) also examined gender differences in self-disclosure. Dindia and Allen conducted a meta-analysis of over 200 studies and found that women disclosed more than men but concluded that this difference was small. They found that gender differences were more apparent with disclosure to individuals known to the participants rather than in interactions with strangers.

Chesler & Barbarin (1984) examined the role of disclosure in parents whose children had cancer. Mothers in the study were more likely to have a confidant that they talked
to. However, many fathers in the study expressed regret that they did not have this kind of support from their friends. They said that they believed that their male friends would be too uncomfortable discussing those issues. Therefore expectations generated by males or females themselves in the role of the discloser may influence how much they disclose.

Studies that have looked specifically at distress disclosure have also identified differences in distress disclosure between men and women. During the development of the Distress Disclosure Index, Kahn & Hessling (2001) found that women reported as more likely to disclose than men. Nanou, Stewart & Coxell, (2004) found that during the development of the Disclosure Avoidance Scale women also scored significantly higher on scores of disclosure. However, on their final shorter version of the Disclosure Avoidance Scale no significant differences were found between the genders on disclosure scores. These studies support the findings of the previously mentioned research.

Evidence suggests that there are gender differences in both disclosure and distress disclosure (although these seem to be small) with the majority of studies finding that women are more likely to disclose than men. There is a often a distinction made between disclosure and distress disclosure within the research literature. Definitions of both can be viewed in section 1: What is self-disclosure?

9.4 The recipient of the disclosure

The literature on disclosure suggests that people choose specific individuals to reveal things to. The most commonly identified individuals to self-disclose to are same sex or opposite sex friends (Fischer, 1982), close relatives (Tinsley, de St Aubin & Brown, 1982) or a romantic partner (Cramer, 1990). Mental health professionals are also included, however they are identified as the last to be approached (Tinsley, de St Aubin & Brown, 1982). However, O'Kelley & Schuldt (1981) found that self-disclosure can often depend on the reciprocation of self-disclosure by the other person irrespective of gender.
Attractiveness and high status have also been found to be related to higher levels of self-disclosure. Kunin & Rodin, (1982) asked participants to rate therapists on attractiveness and how much they believed they would disclose in hypothetical situations. They also provided information regarding the therapists’ professional status. They found that self-disclosure increased when the therapist was perceived as more attractive and had higher professional qualifications.

10 Summary

Self-disclosure of distressing material is the ability or willingness to openly express negative or unpleasant emotions. The above mentioned studies have suggested that there are certain topics that individuals often find difficult to disclose and that even whilst in therapy clients often conceal information from their therapist that could be clinically relevant. There seem to be many factors that impact on the tendency to disclose distressing material. These include, having certain mental health diagnoses or personality styles, gender differences, age, mood, the context, who one chooses to disclose to, beliefs about how the information will be received and the risks perceived as associated with this.

Psychological therapies from completely different theoretical orientations all view disclosure as having an important role within the process of therapy. Disclosure of distressing information seems to have a variety of functions including catharsis, a means of normalising the experience, gaining practical help and cognitive restructuring through which individuals can gain new insights into the event.

There seem to be mechanisms through which not disclosing significant information may increase the likelihood of experiencing depression, anxiety and physical health symptoms. Pennebaker and Beaall (1986) sought to explain this with their theory of inhibition, Lazarus and Folkman (1984) with their stress and coping model and Stiles (1987) also proposed a fever model for distress disclosure.
The majority of studies highlighted above have supported the notion that self-disclosure has been found to positively impact on mental and physical health. Other studies have suggested that disclosure has no benefits or can have a negative impact particularly if the recipient does not respond in an empathic and validating manner to the disclosure, if there are negative consequences from the disclosure or if the person is unable to gain understanding and meaning from the disclosure (Kelly & McKillop, 1996).

11 Existing measures of disclosure

As self-disclosure is an integral part of psychological therapy it is hardly surprising that there are many existing psychometric measures of self-disclosure. Many of the questionnaires are designed to assess who the targets are for receiving certain topics of disclosure (The Social Accessibility Scale, Rickers-Ovsiankina, 1958; the Jourard Self-disclosure Scale, Jourard & Lasakow, 1958; the Emotional Self-disclosure Scale, Snell, Miller & Belk, 1988; the Self-disclosure Situations Survey, Chelune, 1976; the Self-disclosure Index, Miller, Berg & Archer, 1983; the Masculine and Feminine Self-disclosure Scale, Snell, Belk & Hawkins, 1986; and the Sexual Self-disclosure Scale, Snell, Belk & Papini, 1989). For example, an item from the Self-disclosure Index asks how likely would you be to discuss what is important to you in life to a same sex stranger or a same sex friend. Other disclosure questionnaires have examined general disclosure within specific populations (the Self Disclosure Inventory for Adolescents, West & Zingle, 1969 and the Marital Self-disclosure Questionnaire (Waring, Holden, & Wesley, 1998). However, all these questionnaires pertain to general self-disclosure rather than distress disclosure and enquire about the targets of the disclosure which are not relevant to this study.

The questionnaires that contained items relevant to distress disclosure were reviewed for the purposes of this study. They included the Self-concealment Scale (Larson & Chastain, 1990), the Distress Disclosure Index (Kahn & Hessling, 2001), the Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994), the Distress Disclosure Scale
11.1 The Self-Concealment Scale (Larson & Chastain, 1990)

The Self-concealment Scale has ten items and measures the tendency to conceal personal distressing information from others. Additionally, two of the items relate to fears resulting from disclosing (i.e. embarrassment or the disclosure 'backfiring'). The Self-Concealment Scale was found to have adequate reliability (internal consistency ($\alpha = 0.83$). Test-retest reliability ($r = 0.81$) was assessed using 43 female psychology students over a 4 week period (Larson & Chastain, 1990). Validity of the scale was supported by the distinctness of self-concealment from self-disclosure. Larson & Chastain (1990) found that the Self-Concealment Scale correlated negatively ($r = -0.27$) with the Self-Disclosure Index (Miller, Berg & Archer, 1983).

The sample used for the questionnaire development consisted of 306 psychology undergraduates, individuals on a health psychology mailing list and attendees at a conference. The response rate was 36% and only 29 of the questionnaires returned were from males. Factor analysis was performed on the data and although two factors emerged with eigenvalues greater than 1 the second factor was deemed uninterpretable and was deleted. The remaining factor accounted for 65% of the variance.

Larson and Chastain (1990) also ran a factor analysis to examine whether the Self-Concealment Scale was related to the Self-disclosure Index (Miller, Berg & Archer, 1983). They subjected all items from both of the scales to a maximum likelihood factor analysis which revealed a two factor solution with the Self-disclosure Index items having high loadings on the first factor (.50 -.78) and low loadings on the second factor (.02 -.22). The Self-concealment Scale had high loadings on the second factor (.44 -.70) and low loadings on the first factor (.00 -.15). They concluded from these results that although the Self-concealment Scale was related to self-disclosure it was a distinct construct.
Although the scale was found to have good psychometric properties the sample were mainly female students or health professionals and the results may not generalise to other samples. The emergence of one factor that was found related to disclosure but was deemed a separate entity suggests that although this measure may contain some relevant items that pertain to distress disclosure that this can not be regarded as an assessment that measures all factors involved with distress disclosure.

11.2 Distress Disclosure Index (Kahn & Hessling, 2001)

The Distress Disclosure Index is a twelve item scale which was designed to capture the bipolar nature of disclosure verses concealment. Reliability of the scale was adequate (internal consistency for the scale was $\alpha = 0.94$). Temporal stability was assessed ($r = 0.80$) over a two month period using ninety students (76 female) (Kahn & Hessling, 2001). These participants had also participated in the development of the questionnaire phase. Convergent validity was supported by predicted gender differences (women had a greater tendency to disclose than men), a positive correlation with the Self-Disclosure Index and a significant negative correlation with the Self-Concealment Scale (Kahn & Hessling, 2001).

The Distress Disclosure Index was developed on a sample of 278 undergraduate students with a mean age of 19 years. An exploratory factor analysis suggested the presence of a single factor that was usable although 3 factors initially emerged with eigenvalues above 1. Following the factor analysis the authors deleted 10 items from the questionnaire with factor loadings nearest zero. Due to the remaining items showing similar factor loadings and similar correlations with self-concealment and self-disclosure they concluded that they had one bipolar factor reflecting distress concealment versus distress disclosure.

The number of participants in the sample was low compared to what is recommended for a factor analysis. Costello & Osborne (2005) recommended that a subject to item ratio of 10:1 should be used by researchers to determine their sample size. Additionally, Kahn & Hessling (2001) used only students in their sample and
subsequently one must be cautious in generalising the findings to other populations. The emergence of 3 factors initially suggests that there may be other factors involved in disclosure. Additionally although the questionnaire focuses specifically on distress disclosure it only assesses whether people disclose or conceal upsetting information and does not explore reasons why individuals do not disclose the information such as beliefs, behaviours that surround disclosure (for example, crying), or potential consequences of disclosure.

11.3 The Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994)

This has 20 items to measure alexithymia and has good internal consistency (α = 0.81) as does each of its 3 factors (α = 0.78, α = 0.75 & α = 0.66 respectively) (Bagby, Parker & Taylor, 1994). The scale was reported to have good test-retest reliability (r = 0.77) over a three week period and adequate validity evidenced by comparisons of the 3 factors (Bagby, Parker & Taylor, 1994). Convergent validity was demonstrated by negative correlations with Short Imaginal Processes Inventory (Huba, Singer & Aneshencsel, 1982), the Need for Cognition Scale (Cacioppo & Petty, 1982) and the Psychological Mindedness subscale of the California Psychological Inventory (Gough, 1969) (Taylor, Bagby & Parker, 1992).

Bagby, Parker & Taylor, (1994) administered the questionnaire to outpatient psychiatric patients and concluded that it was replicable across clinical and non-clinical populations. The development of the scale was based on a sample of 965 Canadian undergraduate students. A factor analysis identified 3 factors (difficulty identifying feelings, difficulty describing feelings and externally oriented thinking) which accounted for 31% of the total variance.

Although this questionnaire was not specifically designed to measure distress disclosure it contained items within the difficulty identifying and describing feelings factors that were relevant to distress disclosure. It was thought that these might be reasons for why individuals chose not to disclose. However, only 4 items seemed
relevant to the topic of distress disclosure so that this questionnaire could not be used solely as a measure of self-disclosure.

11.4 Distress Disclosure Scale, (Coates & Winston, 1987)

The Distress Disclosure Scale contains 20 items which measure the extent to which individuals generally reveal their distress to others. The scale has good internal consistency ($\alpha = 0.92$) (Coates & Winston, 1987). However, there are no validity studies. The authors do not specify how they came to formulate the scale and although they administered it to 318 undergraduate psychology students they did not factor analyse the results. The scale was concurrently administered with subjective assessments of physical and mental health and the details of the findings can be viewed below.

The scale enquires specifically about whether people disclose distressing material or not although it additionally contains 2 items relating to the positive consequences of disclosure (e.g. I usually find that talking over my problems with someone is the best way to start solving them). It is difficult to comment on the utility of this scale as it was sampled on a student population, it has not been factor analysed, it has no validity studies and thus seems at a rudimentary stage of development.

11.5 Disclosure Avoidance Scale (Nanou, Stewart & Coxell, 2004)

This measure has 22 items and examines avoidance of disclosing upsetting material. The questionnaire was developed using a sample of 120 university staff and students. The questionnaire was developed by rewriting items from existing distress disclosure questionnaires and developing new items. The Disclosure Avoidance Scale included items about consequences of disclosure (for example, upsetting others, being perceived as weak or mentally ill), two items regarding the use of substances when feeling upset and two items examining beliefs about disclosure (for example, it changes nothing or will make upsetting events seem more real and upsetting).
Factor analysis of the results resulted in the authors selecting one factor for use in the final questionnaire (disclosure avoidance) which accounted for 14% of the variance although thirteen factors were identified with an eigenvalue greater than 1. This suggests that disclosure may be multidimensional. There are no reliability or validity data although details of it’s correlations with mental health can be viewed below.

12 The relationship between distress disclosure questionnaires and physical health

Larson and Chastain (1990) reported correlations of \( r = 0.29 \) for Self-Concealment Scale scores and disclosure and physical symptoms. Coates & Winston (1987) administered their disclosure questionnaire with a measure of Psychological distress (Gurin, Veroff & Field, 1960) which assessed distress related physical symptoms. They reported finding no significant correlation between disclosure and physical health symptoms. Kahn & Hessling (2001) and Nanou, Stewart & Coxell (2004) did not explore the link between disclosure and physical health.

13 The relationship between distress disclosure questionnaires and mental health

13.1 Depression

Larson & Chastain (1990) administered the Self-Concealment Scale with the depression and anxiety scales of the Typology of Psychic Distress Instrument (Melinger, Balter, Manheimer, Cisin & Parry, 1978) and reported significant correlations of \( r = 0.41 \) for disclosure and depression. Nanou, Stewart & Coxell, (2004) administered their disclosure questionnaire with the DASS (21) and reported significant negative correlations of \( r = -0.35 \) for depression. Kahn & Hessling (2001) gave the Distress Disclosure Index and the Centre for Epidemiological Studies Depression Scale (Radloff, 1977) to participants. They found that disclosure negatively correlated with depression \( (r = -0.18) \). Coates and Winston (1987)
administered the Distress Disclosure Questionnaire to participants with the Beck Depression Inventory (Beck, Steer & Brown, 1996) Multiple regressions found a correlation between disclosure and depression ($r = -.25$).

13.2 Anxiety and stress

The same studies also examined associations between disclosure and anxiety. Larson and Chastain (1990) reported correlations of $r = 0.32$. Nanou, Stewart & Coxell (2004) reported $r = 0.38$. Kahn & Hessling (2001) reported that the Distress Disclosure Index failed to correlate with anxiety. Coates and Winston (1987) did not explore the relationship between disclosure and anxiety. Nanou, Stewart & Coxell (2004) also reported significant negative correlations for stress ($r = -0.28$).

14 Rationale for the study

Previous research in the area of self-disclosure has produced many different psychometric assessments. Some of these general disclosure instruments have received criticisms regarding poor reliability and validity (for example, the Social Accessibility Scale, Rickers-Ovsiankina, 1956; the Jourard Self-disclosure Questionnaire, Jourard & Lasakow, 1958; the Self-disclosure Situations Survey, Chelune, 1976). They have also been criticised for measuring individual’s estimates of their future self-disclosure rather than their actual patterns of self disclosure (for example, the Jourard Self-disclosure Questionnaire, the Self-disclosure Situations Survey; the Self-disclosure Index, Miller, Berg & Archer, 1983) and for being outdated (for example, an item on the Social Accessibility Scale is “What is your attitude to the draft?”).

The distress disclosure measurements focus mainly on whether individuals disclose their distress or not and do not actually explore why individuals find it difficult to talk or express their feelings particularly when discussing past upsetting events (for example the Self-concealment Scale, Larson & Chastain, 1990; the Distress
Disclosure Index, Kahn & Hessling, 2001; and the Distress Disclosure Scale, Coates & Winston, 1987). Some of them are at a rudimentary stage of development (the Distress Disclosure Questionnaire, the Self-disclosure Inventory for Adolescents, West & Zingle, 1969) and have little or no validity data (the Distress Disclosure Scale; the Disclosure Avoidance Scale, Nanou, Stewart & Coxell, 2004).

Some of the distress disclosure questionnaires have not been factor analysed (for example the Distress Disclosure Scale, Coates & Winston, 1987) or only contain a single factor. For example, the Self-concealment Scale (Larson & Chastain, 1990), has one factor which only focuses on self concealment. The Distress Disclosure Index (Kahn & Hessling, 2001) has one bipolar factor reflecting distress disclosure versus concealment and the Disclosure Avoidance Scale (Nanou, Stewart & Coxell, 2004) examines disclosure avoidance.

However, research literature suggests that distress disclosure is a multifaceted construct. Thus, this suggests that the more facets that are covered within a single distress disclosure questionnaire the easier it is likely to be to examine the relationship between distress disclosure and physical and mental health. Distress disclosure is currently poorly assessed (Nanou, Stewart & Coxell, 2004). Therefore, this suggests that there is a need to develop a reliable, valid and in depth measure of an individual’s tendency to self-disclose regarding past upsetting events.

As the majority of the studies detailed earlier have demonstrated, self-disclosure of distressing material has been found to be associated with improvements in physical and psychological health. Research has reported that individuals who disclose personal traumas from the past not only report less psychological symptoms such as anxiety, depression, low self-esteem and spend less time ruminating but show biological improvements such as better functioning immune systems, less medical visits and improved health in general. These findings have important clinical implications for therapy highlight the importance of being able to assess this area.

As disclosure of distressing material is such a core feature of psychological therapy it seems essential that there is measure that can be used to assess distress disclosure.
Clinical Psychologists often discuss distressing information with their clients and yet they do not currently measure how or whether they are doing this or routinely assess to examine whether people find it difficult to discuss their problems.

This study aims to develop a reliable and valid instrument using a non-clinical sample that can be used to measure individuals tendency to disclose upsetting material. Concurrent administration of the Depression and Anxiety Stress Scale (DASS) (Lovibund & Lovibund, 1995) and a physical health rating question will also allow an exploration of the relationship between self-disclosure, physical and mental health.
METHOD

The method section is divided on the basis of the research being compromised of three parts including study 1: the development of the questionnaire, study 2: exploring the relationship between the Disclosure Questionnaire and measures of mental and physical health and study 3: the test-retest reliability and internal consistency assessment of the Disclosure Questionnaire.

1 Hypotheses

Study 1: Development of the Questionnaire

*Hypothesis 1:* The disclosure Questionnaire will yield more than one factor and the factors will be related to each other.

Study 2: Exploring the relationship between disclosure and mental and physical health

*Hypothesis 2:* Disclosure will be related to depression, anxiety and stress.

*Hypothesis 3:* Disclosure will be related to physical health.

*Hypothesis 4:* Age, gender, mental health and physical health will predict disclosure.

Study 3: Test-retest reliability assessment of the new version of the Disclosure Questionnaire

*Hypothesis 5:* The Disclosure Questionnaire will have good reliability when it is assessed over two points in time.
2 Study 1: Development of the Questionnaire and study 2: Exploring the relationship between disclosure and mental and physical health

2.1 Design

The Disclosure Questionnaire was created using a cross-sectional design. Data were collected on responses to the Disclosure Questionnaire and measures of mental and physical health simultaneously.

2.2 Participants

Data were obtained from an opportunity sample of participants from a variety of sources. Seven hundred and ninety-eight participants were given information packs via their pigeon holes at their places of work (i.e., government departments, 270) and commercial organisations, 528). The remaining questionnaires were distributed to individuals by the author or by colleagues who had taken additional information packs to distribute.

The intention was to recruit at least 450 participants as this sample size has been recommended as a suitable number for factor analysis (Howell, 1997). Participants were excluded from the study if they:

- Were aged 18 or younger
- Had difficulties understanding written English
- Had a learning disability
- Were currently experiencing a 'difficult life event' such as a bereavement.
- Were engaged in ongoing therapy with a mental health professional

The information sheet contained the exclusion criteria (See Appendix D) so that participants could judge for themselves whether they met the criteria to participate in the study.
2.2.1 Response rate

Six hundred and fourteen (52%) of 1190 questionnaires were returned. Forty-eight questionnaires were incomplete and seventeen arrived too late and were therefore excluded from the study. Thus, data from 549 of 1190 (46%) participants were analysed in this study. Response rates for mail surveys are estimated at 30-40% when there is no follow up and the sample is composed of disinterested non-motivated respondents (Bourque & Fielder, 1995). Therefore, this study had a good response rate when compared to similar types of studies.

2.2.2 Demographic characteristics

Three hundred and thirty three out of the five hundred and forty nine participants in this study were female (61%). The mean age of all participants was 41 years (SD 15.1) with males having a mean age of 42.3 (SD 15.3) and females having a mean age of 39.8 (15). Males ranged in age from 18 to 79 and females ranged in age from 18 to 85.

2.3 Materials

2.3.1 Disclosure Questionnaire

The Disclosure Questionnaire was constructed from new items deemed to be likely related to difficulties in disclosure. The aim was to cover as many aspects of disclosure as possible by including all themes from existing measures of disclosure of negative material and designing new items. Thus methods were used to generate Disclosure Questionnaire items:

A) Discussion/consultation between qualified and unqualified clinical psychologists.
B) Generation of new items based on those in extant measures (Distress Disclosure Index (Kahn & Hessling 2001); Self-Concealment Scale (Larson & Chastain, 1990); Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994); Distress Disclosure Scale (Coates & Winston, 1987); Disclosure Avoidance Scale (Nanou, Stewart & Coxell, 2004), pertaining to disclosure.

Use of methods A and B above resulted in 58 items relating to individual’s tendencies to disclose distressing information (See Appendix G for the Disclosure Questionnaire). The items were organised into different groups encompassing putatively similar aspects of self-disclosure (e.g., fearing the consequences, increasing personal distress, positive appraisal of consequences, physiological reasons such as dry mouth, avoidance, availability of others, difficulty expressing self, wanting to keep things to self, feeling unsure of emotions and beliefs about disclosure (e.g. no use). Each category was designed to contain an equal number of ‘positively’ and ‘negatively’ worded items (See Appendix L for categories and items contained within each one). Positively and negatively worded items were balanced with an equal number of each in the Disclosure Questionnaire.

The phrase ‘Most of the time’ was inserted at the beginning of each item as the questionnaire was intended to measure ‘trait’ rather than ‘state’ disclosure (i.e. respondents’ ‘typical’ pattern of disclosure). The questionnaire was also worded to assess actual disclosure (e.g. ‘I keep what upsets me a secret’) rather than anticipated disclosure (‘I would keep something that upset me a secret’) as this has been a criticism of past questionnaires (Pederson & Higbee, 1969).

A five point Likert scale (strongly disagree, disagree, neither, agree and strongly agree) was used to record participant’s responses. Scoring of the scale was calculated for the positive items with strongly disagree scored as 1, disagree as 2, neither as 3, agree as 4, and strongly agree as 5. Items 3, 8, 12, 20, 21, 25, 29, 32, 35, 39, 43, 44, 49 and 47 were scored this way whilst the remaining items were reverse scored.
The factor analysis suggested that fifteen items should be deleted from the Disclosure Questionnaire. The new version of the questionnaire was used for the test-retest assessment of the Disclosure Questionnaire.

2.3.2 Depression Anxiety Stress Scales (DASS; Lovibund & Lovibund, 1995)

The DASS is a 42 item self-report measure of depression, anxiety, and stress. Each of the 3 scales has 14 items. Participant responses are obtained using 0-3 scale (0 = did not apply to me at all, to 3 = applied to me most of the time). The DASS is commonly in a range of settings and has good convergent and discriminant validity (Lovibund & Lovibund, 1995). The DASS has also been found to have good test-retest reliability (test retest correlations used 20 participants and ranged from 0.71 – 0.81 over a 2 week period evidencing favourable temporal stability, Brown, Chorpita, Korotitsch & Barlow, 1997) and demographic variables such as occupation and education do not influence scores on the questionnaire (Crawford & Henry, 2003).

2.3.3 Demographic details sheet

Participants recorded their age and gender. Additionally, this sheet included a measure of physical health. Participants were asked to rate their current physical health using a (100 mm) visual analogue scale from 0 (extremely unwell) – 10 (extremely well) (See Appendix I for demographic details sheet).

2.3.4 Participant information sheet

The participant information sheet can be viewed in Appendix B.
2.3.5 Mental Health organisations details

A sheet containing details of mental health organisations was included so that individuals could access professional support if they needed to (This can be viewed in Appendix E).

2.4 Procedure

Participants received a pack containing the participant information sheet, details of the exclusion criteria, details of mental health organisations, the Disclosure Questionnaire, the Depression, Anxiety and Stress Scale, the physical health rating scale, the demographic details sheet which included the physical health rating scale and a freepost return envelope.

3 Study 3: Test-retest reliability and internal consistency assessment of the Disclosure Questionnaire.

3.1 Design

Test-retest data were obtained using a repeated measures opportunity sampling design where data on the Disclosure Questionnaire and measures of mental and physical health were obtained from the same participants at two time points (one week apart). Kline (2001) asserted that test-re-test reliability data should be assessed over a time period of at least three months. Unfortunately, this was not possible due to time limitations for completion of this study.

3.2 Participants

Data were obtained from a separate opportunity sample (i.e., none of the participants from the development of the Disclosure Questionnaire sample participated in the test-
retest study) of participants from a variety of locations (recreational groups, commercial organisations, etc).

The intention was to recruit at least 60 participants for this phase of the research as previous research assessing the test retest reliability of disclosure questionnaires has used samples near to this number (e.g., n = 46, Haviland, Warren & Riggs, 2000), n = 72, Bagby, Parker & Taylor, 1994). One hundred and forty pairs of questionnaires were distributed to participants one week apart.

Participants were excluded from the study if they:

- Were aged 18 or younger
- Had difficulties understanding written English
- Had a learning disability
- Were currently experiencing a ‘difficult life event’ such as a bereavement.
- Were engaged in ongoing therapy with a mental health professional

The information sheet contained the exclusion criteria (See Appendix D) so that participants could judge for themselves whether they met the criteria to participate in the study.

3.2.1 Response rate

Sixty-nine pairs of questionnaires were matched up and used for the test-retest of the questionnaire. An additional thirty three questionnaires were returned but could not be matched to a questionnaire with an identical code as these participants had only completed the questionnaires at the one time point. Therefore, the response rate was 61%. As previously mentioned, Bourque and Fielder (1995) suggested that average response rates for mail surveys are generally lower than this, which suggested that this phase of the study also had a good response rate.
3.2.2 Gender

Thirty-five females (51%) took part in the test-retest part of the research.

3.2.3 Age

The mean age of male participants was 40.8 (SD 17.83) and the mean age of female participants was 44.26 (SD 16.37). Male participants ages ranges from 18 to 78 whilst females ranged in age from 21 to 79 years.

3.3 Materials

3.3.1 Disclosure Questionnaire

The factor analysis suggested that fifteen items should be deleted from the Disclosure Questionnaire. The new version of the questionnaire was used for the test-retest assessment of the Disclosure Questionnaire.

3.3.2 Depression Anxiety Stress Scales (DASS; Lovibund & Lovibund, 1995)

The DASS is a 42 item self-report measure of depression, anxiety, and stress.

3.3.3 Demographic details sheet

Participants recorded their age and gender. Additionally, this sheet included a measure of physical health. Participants were asked to rate their current physical health using a
(100 mm) visual analogue scale from 0 (extremely unwell) – 10 (extremely well) (See Appendix J for demographic details sheet).

3.3.4 Participant information sheet

The participant information sheet can be viewed in Appendix C.

3.3.5 Mental Health organisations details (study 1, study 2 and study 3)

A sheet containing details of mental health organisations was included so that individuals could access professional support if they needed to (This can be viewed in Appendix E).

3.4 Procedure

Participants received a pack containing the participant information sheet, details of the exclusion criteria, details of mental health organisations, the new version of the Disclosure Questionnaire (Appendix H), the Depression, Anxiety and Stress Scale, the demographic details sheet which included the health rating scale and a freepost return envelope. One week later participants received an identical pack. Participants were asked to provide a code on the demographic information sheet so that their two questionnaires could be matched together whilst still maintaining anonymity (See Appendix J for the test-retest demographic sheet).

4 Statistical analysis

4.1 Study 1: Development of the Disclosure Questionnaire

Factor analysis of the Disclosure Questionnaire was based on the guidelines in Tabachnik and Fidell (1996). This involved
A) Assessing for normality and linearity, checking for outliers, and assessment of multicollinearity

B) Performing a Principal Components Analysis using varimax rotation to assess for factorability of \( R \)

C) Performing factor analyses using a variety of factor extraction techniques and rotations to derive a ‘solution with the greatest scientific utility, consistency and meaning’ (Tabachnik and Fidell, 1996). The data were subjected to three extraction techniques (principal factors, Image and unweighted least squares with either varimax or oblique rotation) to assess for consistency of the factor structure of the Disclosure Questionnaire.

D) Only factors with more than five items were interpreted as Costello & Osborne (2005) suggest that a factor with fewer than three items is generally weak and unstable and that five or more strongly loading items (.32) or more indicate a solid factor.

E) Only items with loadings of 0.32 or greater were considered to load onto a particular factor (Tabachnick & Fidell, 1996).

4.2 Study 2: Age and gender differences

Differences in Disclosure Questionnaire factor scores according to gender were assessed using the Mann Whitney U Test. The relationship with age and Disclosure Questionnaire scores was assessed using Spearman’s rho correlations following checks for the assumptions of normality. Non-parametric tests were chosen for the analysis due to the data not being normally distributed (negatively skewed).

4.3 Study 2: Relationship between the Disclosure Questionnaire and the Depression, Anxiety and Stress Scale

Correlations between Disclosure Questionnaire factor scores and mental health (DASS scale scores) and physical health were assessed using spearman’s rho
following checks for the assumptions of normality. Histograms showed that the data from the Disclosure Questionnaire were not normally distributed (negatively skewed). Additionally, data from the sub-scales of the DASS were not normally distributed (positively skewed).

4.4 Predictors of disclosure

The disclosure questionnaire factor scores and total scores and the DASS subscales and health were assessed using multiple regression analyses following checks for the assumptions for normality. Although analysis of both the DASS subscales and the Disclosure factor questionnaire scores suggested that the data were not normally distributed Howell (1997), asserted that substantial departures from a normal distribution are tolerable to use within multiple regression analyses due to the robust nature of the tests.

Age and gender were also included as predictor variables within the multiple regressions due to past literature suggesting that these could impact on individual’s levels of disclosure.

Multicollinearity diagnostics were conducted for all multiple regressions. Tolerance figures for all variables in all the regressions were at 0.8 or above, indicating poor relationships between variables and the lack of a requirement to remove any variables from the regression model (Tabachnik & fidell, 1996). The ENTER procedure was used in all regressions.

4.5 Study 3: Test-retest reliability assessment of the Disclosure Questionnaire

Correlations between the Disclosure Questionnaire scores were assessed over two points in time using spearman’s rho following checks for the assumptions of normality. Data were at ordinal level and were in related pairs. The internal consistency of the scale was also assessed by using Cronbach’s alpha.
5 Ethical approval

The study was approved by the University of Surrey Ethics Committee (See Appendix A for letter of ethical approval).
RESULTS

Study 1: Development of the Questionnaire

1 Factor analysis

1.1 Assumptions

1.1.1 Linearity

Visual inspection of the distributions of Disclosure Questionnaire items did not strongly suggest that any item should not enter the principal component and subsequent factor analyses.

1.1.2 Outliers

There were no outliers in the Disclosure Questionnaire data set. For example, there were no cases where only a tiny minority of participants scored at the extremes of the scale.

1.1.3 Multicollinearity and singularity

The lowest tolerance statistic for a Disclosure Questionnaire item was 0.218, well above the tolerance level (0.01) suggested Brace, Kemp and Snelgar (2003) for the exclusion of a variable due to multicollinearity. Accordingly, all Disclosure Questionnaire items were selected by the Principal component and factor analyses.
1.1.4. Factorability of R

The Principal Component Analysis revealed many correlations above 0.3, and a Keiser Meyer Olkin statistic of 0.959 with all individual Keiser Meyer Olkin statistics being above 0.5. Thus, according to Brace et al (2003) the data were factorable, with no need to drop any individual Disclosure Questionnaire item from further factor analyses.

1.2 Factor analysis outcome

After conducting the Principal Component Analysis, the data were analysed using principal factors, Image and unweighted least squares factor extraction techniques with either varimax or oblique rotation. The unweighted least squares and principal axis factors factor extraction techniques (with varimax rotation) yielded almost identical factor structures (with the image factor extraction technique also providing highly consistent results). Overall, the findings of the Unweighted Least Squares technique were considered to provide factors with the most meaning and thus the outcome of this extraction technique was chosen.

The factor analysis identified 13 factors which explained 60% of the variance in Disclosure Questionnaire scores (figure 1). A few items crossloaded onto more than one factor and were subsequently assigned to the factor onto which they were most strongly loaded. Fifteen items failed to load onto the three factors and were deleted from the questionnaire.
Although factors with eigenvalues of greater than one are often retained within factor analysis (Tabachnik & Fidell, 1996), examination of items loading onto factors revealed that only three factors were usable. This was due to the other factors containing less than 5 Disclosure Questionnaire items, or the Disclosure Questionnaire items within those factors loading at less than 0.32 on the given factor (Factor loadings for each item can be viewed in Table 1). The questionnaire items loading onto these factors can also be found in Appendix M. These three factors accounted for 31% of the variance in the Disclosure Questionnaire scores and each factor comprised sets of items that were interpretable and content relevant.
<table>
<thead>
<tr>
<th>Item Brief description of item content.</th>
<th>Factor 1 Tendency to disclose (21 items)</th>
<th>Factor 2 Ease of disclosure (17 items)</th>
<th>Factor 3 Positive beliefs about disclosure (5 items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coming out wrong</td>
<td>.720</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Not discussing things</td>
<td>.788</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Most difficult to discuss</td>
<td>.387</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Becoming tongue tied</td>
<td>.666</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Able to explain feelings</td>
<td>-.400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Become too emotional</td>
<td>.526</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Get things off my chest</td>
<td></td>
<td>.384</td>
<td></td>
</tr>
<tr>
<td>8. Throat tenses up</td>
<td>.344</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Good to share problems</td>
<td></td>
<td>-.482</td>
<td></td>
</tr>
<tr>
<td>10. I do not even want to know</td>
<td></td>
<td>.414</td>
<td></td>
</tr>
<tr>
<td>11. Too embarrassed</td>
<td>.558</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Can't rely on others</td>
<td>.395</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Pretend I have no problems</td>
<td>.537</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Talking is no help</td>
<td>.531</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Go around in circles</td>
<td>.666</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I do not tell the truth.</td>
<td>.476</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I bottle up things</td>
<td>.643</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. I can't find the right words</td>
<td>.598</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. I look for others</td>
<td>-.481</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. I don't want to trouble people</td>
<td>.544</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. I get upsetting thoughts</td>
<td>.523</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Doesn't change my feelings</td>
<td>.426</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. I'm plagued by fears</td>
<td>.513</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. It's not good to talk</td>
<td></td>
<td>.623</td>
<td></td>
</tr>
<tr>
<td>25. Keep it secret</td>
<td>.812</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Factor Loading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I don’t tell others</td>
<td>.779</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. I get upset and cry</td>
<td>.562</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. I avoid</td>
<td>.492</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. I wish I hadn’t told</td>
<td>.461</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. I don’t discuss personal secrets</td>
<td>.567</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. My mouth goes dry</td>
<td>.369</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. It doesn’t change how I think</td>
<td>.449</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Psychological problem</td>
<td>.360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I don’t want to</td>
<td>.473</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Others will think I’m weak</td>
<td>.407</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. I don’t know where to start</td>
<td>.569</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. I prefer to keep quiet</td>
<td>.775</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. I am unwilling</td>
<td>.563</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Talking is useful</td>
<td>-.464</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. I can’t decide whether to</td>
<td>.463</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Things go wrong</td>
<td>.454</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. I’m unsure about my emotions</td>
<td>.320</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. I pretend I’m not bothered</td>
<td>.321</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Factor loadings for each of the items ranged from 0.320 (the lowest score recommended for item inclusion by Tabachnik & Fidell, 1996) to .812 which is considered a more sizeable correlation (Kline, 2001).
2.3 Correlations between factors

Table 2: Correlation between Disclosure Questionnaire factor scores

<table>
<thead>
<tr>
<th></th>
<th>Tendency to disclose</th>
<th>Ease of disclosure</th>
<th>Positive beliefs about disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tendency to disclose</td>
<td>1.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ease of disclosure</td>
<td>0.57**</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Positive beliefs about disclosure</td>
<td>0.72**</td>
<td>0.28**</td>
<td>-</td>
</tr>
</tbody>
</table>

*p < 0.05; **p < 0.01

Although the correlations between the factors were all significantly positively correlated (Table 2) the ‘tendency to disclose’ factor was moderately correlated with the ‘ease of disclosure’ factor and was moderately to strongly correlated with the ‘positive beliefs about disclosure’ factor. The ‘positive beliefs about disclosure’ factor was weakly correlated with the ease of disclosure factor. The strengths of the correlations were classified using guidelines outlined by Coolican (2004).

3 Disclosure Questionnaire scores

3.1 Disclosure Questionnaire factor scores

The Disclosure Questionnaire factor scores for the total sample are presented below in Table 3.
Table 3: Disclosure Questionnaire mean factor scores for the total sample

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of items</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tendency to disclose</td>
<td>21</td>
<td>3.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Ease of disclosure</td>
<td>17</td>
<td>3.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Positive beliefs about disclosure</td>
<td>5</td>
<td>3.9</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Table 3 provides the mean and standard deviation for scores within each of the factors. The mean ranges from 3.3 – 3.9 and further indicates that the Disclosure Questionnaire data on each of the factors are not normally distributed.

3.2 Study 2: Gender differences in Disclosure Questionnaire scores

Men scored significantly lower on the ‘tendency to disclose’ and ‘positive beliefs about disclosure’ factors, while women scored significantly lower on the ‘ease of disclosure’ factor of the Disclosure Questionnaire (Table 4). Mann Whitney U tests indicated that for the three factors the differences in scores were highly significant.
Table 4: Male and female differences on factors of the Disclosure Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Male Mean (SD)</th>
<th>Female Mean (SD)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tendency to disclose</td>
<td>66.50 (14.58)</td>
<td>72.4 (15.31)</td>
<td>z = -4.6 (p&lt;0.00)</td>
</tr>
<tr>
<td>Ease of disclosure</td>
<td>61.03 (10.05)</td>
<td>58.1 (11.39)</td>
<td>z = -2.9 (p&lt;0.01)</td>
</tr>
<tr>
<td>Positive beliefs</td>
<td>18.60 (3.83)</td>
<td>19.9 (3.09)</td>
<td>z = -4.3 (p&lt;0.00)</td>
</tr>
<tr>
<td>about disclosure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure</td>
<td>146.10 (23.60)</td>
<td>150.4 (26.70)</td>
<td>z = -2.2 (p&lt;0.05)</td>
</tr>
<tr>
<td>Questionnaire total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.3 Age differences in Disclosure Questionnaire scores

Spearman’s rho correlations found that older participants scores correlated significantly on the ‘ease of disclosure’ factor (r = 0.16, p<0.01); although this was a weak correlation (Coolican, 2004). Scores on the ‘tendency to disclose’ (r = 0.05, NS) and ‘positive beliefs about disclosure’ factors (r = 0.04, NS) did not correlate significantly with age.

4 Exploring the relationship between disclosure and mental and physical health

4.1 Correlations between Disclosure Questionnaire Factor Scores and physical health

Spearman’s rho analyses found that ‘tendency to disclose’, ‘ease of disclosure’ and ‘positive beliefs about disclosure’ factor scores were all significantly positively correlated with self-rated physical health (Table 5). These were all weak correlations (Coolican, 2004).
Table 5: Correlations between disclosure questionnaire factors and physical health rating

<table>
<thead>
<tr>
<th>Physical health</th>
<th>Tendency to disclose</th>
<th>Ease of disclosure</th>
<th>Positive beliefs about disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.172**</td>
<td>.288**</td>
<td>.123**</td>
</tr>
</tbody>
</table>

*p < 0.05; **p < 0.01

4.2 Correlation between Disclosure Questionnaire factor scores and mental health

'Tendency to disclose' and 'ease of disclosure' factor scores were significantly negatively correlated with all scales scores on the Depression, Anxiety and Stress Scale (Table 6). Correlations on the 'tendency to disclose' factor were weak. Moderate correlations were found on the 'ease of disclosure' factor on all scales of the Depression, Anxiety and Stress Scale.

Table 6: Correlations between disclosure questionnaire factors and Depression, Anxiety, and Stress Scale scores

<table>
<thead>
<tr>
<th>Depression</th>
<th>Tendency to disclose</th>
<th>Ease of disclosure</th>
<th>Positive beliefs about disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-.254**</td>
<td>-.451**</td>
<td>-.087*</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.182**</td>
<td>-.440**</td>
<td>-.053</td>
</tr>
<tr>
<td>Stress</td>
<td>-.217**</td>
<td>-.445**</td>
<td>-.012</td>
</tr>
<tr>
<td>Total</td>
<td>-.234**</td>
<td>-.480**</td>
<td>-.042</td>
</tr>
</tbody>
</table>

*p < 0.05; **p < 0.01

5. Multiple regressions
5.1 Multivariate predictors of total scores on the Disclosure Questionnaire

A standard multiple regression analysis (independent variables were entered at the same time) was used to predict distress disclosure (see Table 7). Variables that were significantly correlated with distress disclosure were used as independent variables to restrict the number of predictors. The correlations between the predictive variables were under .70, ranging from 0.46 to 0.67 and therefore all were included in the regression. The gender, depression and health variables were able to explain 16% of the variance in total scores on the Disclosure Questionnaire, adjusted $R^2 = 0.16$, ($F_{6,548} = 18.5, p<0.00$).

Gender, depression and health were significant predictors of total scores on the Disclosure Questionnaire. More specifically, depression was a significant predictor of lower Disclosure Questionnaire total scores. Female gender and higher ratings of physical health were also significant predictors of higher total Disclosure Questionnaire Scores. However, all these findings were small in significance.

Table 7: Multivariate predictors of total scores on the Disclosure Questionnaire

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>6.55</td>
<td>2.08</td>
<td>0.13</td>
<td>3.16</td>
<td>0.002</td>
</tr>
<tr>
<td>Age</td>
<td>.06</td>
<td>0.07</td>
<td>0.04</td>
<td>0.8</td>
<td>NS</td>
</tr>
<tr>
<td>DASS (depression)</td>
<td>-.65</td>
<td>0.22</td>
<td>-0.19</td>
<td>-2.96</td>
<td>0.003</td>
</tr>
<tr>
<td>DASS (anxiety)</td>
<td>-.30</td>
<td>0.30</td>
<td>-0.06</td>
<td>1.1</td>
<td>NS</td>
</tr>
<tr>
<td>DASS (stress)</td>
<td>-.29</td>
<td>0.23</td>
<td>-0.09</td>
<td>1.2</td>
<td>NS</td>
</tr>
<tr>
<td>Health rating</td>
<td>.21</td>
<td>.06</td>
<td>0.15</td>
<td>3.6</td>
<td>0.000</td>
</tr>
</tbody>
</table>
5.2 Multivariate predictors of the ‘tendency to disclose’ factor score

A standard multiple regression analysis (independent variables were entered at the same time) was used to predict distress disclosure (see Table 8). Variables that were significantly correlated with distress disclosure were used as independent variables to restrict the number of predictors. The correlations between the predictive variables were under .70, ranging from 0.46 to 0.67 and therefore all were included in the regression. The gender, depression and health variables were able to explain 13% of the variance in scores on the ‘tendency to disclose’ factor of the Disclosure Questionnaire, adjusted $R^2 = 0.13$, ($F_{6,548} = 14, \ p<0.00$).

Gender, depression and health were significant predictors of total scores on the Disclosure Questionnaire. More specifically, depression was a significant predictor of lower Disclosure Questionnaire total scores. Female gender and higher ratings of physical health were also significant predictors of higher scores on the ‘tendency to disclose’ factor of the Disclosure Questionnaire. However, all these findings were small in significance.

Table 8: Multivariate predictors of scores on the ‘tendency to disclose’ factor of the Disclosure Questionnaire

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>6.66</td>
<td>1.27</td>
<td>0.2</td>
<td>5.3</td>
<td>0.000</td>
</tr>
<tr>
<td>Age</td>
<td>-0.04</td>
<td>0.04</td>
<td>-0.04</td>
<td>&lt;1</td>
<td>NS</td>
</tr>
<tr>
<td>DASS (depression)</td>
<td>-0.39</td>
<td>0.14</td>
<td>-1.9</td>
<td>-2.9</td>
<td>0.004</td>
</tr>
<tr>
<td>DASS (anxiety)</td>
<td>-0.01</td>
<td>0.18</td>
<td>-0.004</td>
<td>&lt;1</td>
<td>NS</td>
</tr>
<tr>
<td>DASS (stress)</td>
<td>-0.11</td>
<td>0.14</td>
<td>-0.06</td>
<td>-0.8</td>
<td>NS</td>
</tr>
<tr>
<td>Health rating</td>
<td>0.09</td>
<td>0.04</td>
<td>0.12</td>
<td>2.8</td>
<td>0.006</td>
</tr>
</tbody>
</table>
5.3 Multivariate predictors of the 'ease of disclosure' factor score

A standard multiple regression analysis (independent variables were entered at the same time) was used to predict distress disclosure (see Table 9). Variables that were significantly correlated with distress disclosure were used as independent variables to restrict the number of predictors. The correlations between the predictive variables were under .70, ranging from 0.46 to 0.67 and therefore all were included in the regression. The age, anxiety, stress and health variables were able to explain 26% of the variance in scores on the 'ease of disclosure' factor of the Disclosure Questionnaire, adjusted $R^2 = 0.26$, ($F_{6,548} = 32.3$, $p<0.00$).

Age, anxiety, stress and health were significant predictors of total scores on the Disclosure Questionnaire. More specifically, anxiety and stress were significant predictors of lower Disclosure Questionnaire total scores. Female gender and higher ratings of physical health were significant predictors of higher scores on the 'ease of disclosure' factor of the Disclosure Questionnaire. However, all these findings were small in significance.

Table 9: Multivariate predictors of scores on the 'ease of disclosure' factor of the Disclosure Questionnaire

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>-1.55</td>
<td>.83</td>
<td>-0.7</td>
<td>1.8</td>
<td>NS</td>
</tr>
<tr>
<td>Age</td>
<td>.10</td>
<td>.03</td>
<td>0.14</td>
<td>3.8</td>
<td>0.00</td>
</tr>
<tr>
<td>DASS (depression)</td>
<td>-.17</td>
<td>.09</td>
<td>-0.12</td>
<td>-1.9</td>
<td>NS</td>
</tr>
<tr>
<td>DASS (anxiety)</td>
<td>-.24</td>
<td>.12</td>
<td>-1.12</td>
<td>2.0</td>
<td>0.04</td>
</tr>
<tr>
<td>DASS (stress)</td>
<td>-.28</td>
<td>.09</td>
<td>-0.19</td>
<td>-2.9</td>
<td>0.00</td>
</tr>
<tr>
<td>Health rating</td>
<td>.08</td>
<td>.02</td>
<td>0.15</td>
<td>3.6</td>
<td>0.00</td>
</tr>
</tbody>
</table>
5.4 Multivariate predictors of the 'positive beliefs about disclosure' factor score

A standard multiple regression analysis (independent variables were entered at the same time) was used to predict distress disclosure (see Table 10). Variables that were significantly correlated with distress disclosure were used as independent variables to restrict the number of predictors. The correlations between the predictive variables were under .70, ranging from 0.46 to 0.67 and therefore all were included in the regression. The gender, depression, stress and health variables were able to explain 8% of the variance in the scores on the ‘positive beliefs about disclosure’ factor of the Disclosure Questionnaire, adjusted $R^2 = 0.08$, ($F_{6,548} = 8.4$, p<0.00).

Gender, depression, stress and health were significant predictors of total scores on the Disclosure Questionnaire. More specifically, depression and stress were significant predictors of lower Disclosure Questionnaire total scores. Female gender and higher ratings of physical health were significant predictors of higher scores on the ‘positive beliefs about disclosure’ factor. However, all these findings were small in significance.

Table 10: Multivariate predictors of scores on the ‘positive beliefs about disclosure factor’ of the Disclosure Questionnaire

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1.45</td>
<td>.29</td>
<td>0.2</td>
<td>4.9</td>
<td>0.000</td>
</tr>
<tr>
<td>Age</td>
<td>-0.00</td>
<td>.01</td>
<td>-0.12</td>
<td>&lt;1</td>
<td>NS</td>
</tr>
<tr>
<td>DASS (depression)</td>
<td>-0.09</td>
<td>.03</td>
<td>-0.2</td>
<td>-2.9</td>
<td>0.04</td>
</tr>
<tr>
<td>DASS (anxiety)</td>
<td>-0.05</td>
<td>.04</td>
<td>-0.8</td>
<td>-1.2</td>
<td>NS</td>
</tr>
<tr>
<td>DASS (stress)</td>
<td>0.09</td>
<td>.03</td>
<td>-0.2</td>
<td>-2.9</td>
<td>0.003</td>
</tr>
<tr>
<td>Health rating</td>
<td>0.25</td>
<td>.01</td>
<td>0.14</td>
<td>3.1</td>
<td>0.003</td>
</tr>
</tbody>
</table>
6 Study 3: Test-retest Assessment of the Disclosure Questionnaire

6.1 Test-retest reliability

The test-retest coefficients for the individual factors and the disclosure questionnaire were all significant (Table 11). The correlations on the ‘positive beliefs about disclosure’ factor was moderate and correlations on the ‘tendency to disclose’, ‘ease of disclosure’ factors and total score of the Disclosure Questionnaire were high (Coolican, 2004). However, this must be interpreted with caution due to the short period of time in between the test-retest conditions.

Table 11: Correlations between factor scores on the Disclosure Questionnaire at two points in time

<table>
<thead>
<tr>
<th>Tendency to disclose</th>
<th>Ease of disclosure</th>
<th>Positive beliefs about disclosure</th>
<th>Total Disclosure Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>.874**</td>
<td>0.846**</td>
<td>0.698**</td>
<td>0.896**</td>
</tr>
</tbody>
</table>

*p < 0.05; **p < 0.01

7 Cronbach’s alpha coefficient analysis

The internal consistency estimate of Cronbach’s alpha showed $\alpha = 0.95$ for the total Disclosure Questionnaire score, $\alpha = 0.941$ for the ‘tendency to disclose’ factor, $\alpha = 0.895$ for the ‘ease of disclosure’ factor and $\alpha = 0.781$ for the ‘positive beliefs about disclosure’ factor. These Cronbach alpha coefficients are considered high (Coolican, 2004) and suggest that the scale has good internal reliability. When examining the total Disclosure Questionnaire item correlations, no items were deemed necessary to be excluded from the analysis. Tabachnik & Fidell (1996) assert that the criteria for inclusion is that all item correlation coefficients are above 0.4.
8 Summary of the findings

Given the statistical findings of this study, the research hypotheses were addressed as follows:

**Hypothesis 1:**

The disclosure Questionnaire will yield more than one factor and the factors will be related to each other. (study 1)

This hypothesis was accepted as factor analysis of the Disclosure Questionnaire yielded three usable factors.

**Hypothesis 2:**

Disclosure will be related to depression, anxiety and stress. (study 2)

This hypothesis was accepted as significant negative correlations were found with the depression, anxiety and stress sub-scales and total scores of the DASS on the 'tendency to disclose' and 'ease of disclosure factors.' The findings were not significant for the 'positive beliefs about disclosure' factor.

**Hypothesis 3:**

Disclosure will be related to physical health. (study 2)

This hypothesis was accepted. The factor analysis revealed significant positive correlations between scores on all factors of the Disclosure Questionnaire and individual's ratings of their personal health.
Hypothesis 4:

Age, gender, mental health and physical health will predict disclosure. (study 2)

The hypothesis was accepted. Older age was a significant predictor on the ‘tendency to disclose’ factor of the Disclosure Questionnaire. Multiple regressions found that older age was a significant predictor on the ‘ease of disclosure’ factor of the Disclosure Questionnaire. Female gender was a significant predictor of total scores and the ‘tendency to disclose’ and ‘positive beliefs about disclosure’ factors of the Disclosure Questionnaire. Physical health was a predictor of scores on all factors and total scores on the Disclosure Questionnaire.

Depression was a significant negative predictor on total scores on the Disclosure Questionnaire and on the ‘tendency to disclose’ and ‘positive beliefs about disclosure’ factors. Anxiety was a significant negative predictor on the ‘ease of disclosure’ factor. Stress was a significant negative predictor on the ‘ease of disclosure’ and the ‘positive beliefs about disclosure’ factors.

Hypothesis 5:

The Disclosure Questionnaire will have good reliability when it is assessed over two points in time. (study 3)

The hypothesis was accepted. The Disclosure Questionnaire had good reliability when it was assessed over two points in time although this should be interpreted with caution as the reliability was only assessed at one week apart.
DISCUSSION

This section will discuss the main findings of the data analysis, before considering the implications for practice and research. Limitations of the current study will be considered, followed by recommendations for future research in this area.

1 Main findings

1.1 Factor structure

In contrast to other disclosure questionnaires the newly developed questionnaire had three factors which will be discussed in turn. All existing distress disclosure questionnaires have only one factor. The large number of small unusable factors (10) generated from the factor analysis may be due to the items being rewritten from many other questionnaires that examined many different aspects of self disclosure. When the questionnaire was devised the items were divided into common themes although many contained only a few items. Ten groups were identified (These can be viewed in Appendix L). Therefore, it does not seem surprising that so many factors emerged from the analysis but were unusable many due to having less than five items as recommended by Costello and Osborne (2005).

However, the fact that three usable factors emerged from the factor analysis suggested that facets of disclosure included within the other questionnaires had been incorporated into one questionnaire. Thus, the results of this study suggested that disclosure of upsetting material is a multi-faceted concept.

The 'tendency to disclose' factor contained items that examined the bipolar nature of concealment verses disclosure. It contained rewritten items from the Self-Concealment Scale (4), the Distress Disclosure Index (5), the Disclosure Avoidance Scale (7), the Distress Disclosure Questionnaire (2), the Toronto Alexithymia Scale (2) and one new item. Therefore, items within this factor contained items from all the
other questionnaires thought relevant for use within this study as all the questionnaires had items that pertained to whether individual’s tended to disclose or not to.

The ‘ease of disclosure’ factor contained items from the Self-Concealment Scale (2), the Toronto Alexithymia Scale (2), the Disclosure Avoidance Scale (9) and new items (4). Although many items were rewritten from the Disclosure Avoidance Scale the new Disclosure Questionnaire was felt to be distinct from the scale as the Disclosure Avoidance Scale only contained items related to avoiding disclosure. The Toronto Alexithymia Scale (TAS) has three factors (although the reader is reminded that this questionnaire does not assess disclosure). The items that were rewritten from this questionnaire came from the factors ‘difficulty identifying feelings’ and ‘difficulty describing feelings’ factors. The ‘ease of disclosure’ factor seems similar to the ‘difficulty describing feelings’ factor within the TAS as it’s items also inquired about difficulties associated with disclosing (for example, finding the right words, etc.). However, the ‘ease of disclosure’ factor additionally enquired about consequences people experience from their disclosure (for example, things go wrong when I tell others about what upsets me) rather than just measuring whether they had difficulties with disclosing or not.

The positive beliefs factor contained items from the Distress Disclosure Questionnaire (2) and new items (3). Thus, not many of the existing questionnaires contained items exploring beliefs about disclosure.

The new questionnaire did not contain any items about behavioural coping strategies (e.g. substance misuse) for distressing events such as within the Disclosure Avoidance Scale as the author felt that this was a separate area to distress disclosure. Therefore, the new questionnaire differed from previous disclosure questionnaires in having a three factor structure and encapsulating themes from all existing distress disclosure measures into one instrument.
1.2 Gender and disclosure

Men scored significantly higher than women on the 'ease of disclosure' factor although their total scores on the Disclosure Questionnaire were significantly lower than the females. Thus, males did not find it as difficult to disclose as their female counterparts although they still chose to disclose less often. The multiple regressions also found that female gender predicted higher total scores on the Disclosure Questionnaire and higher scores on the 'tendency to disclose' and 'positive beliefs about disclosure' factors.

The findings that males scored significantly lower on the total score of the Disclosure Questionnaire supported previous findings that men score lower on measures of disclosure (Snell, Miller, Belk, Garcia-Falconi & Hernandez-Sanchez, 1989; Nanou, Stuart & Coxell, 2004). This is also consistent with Dindia & Allen’s (1992) meta-analysis results who found that women disclosed more than men but that these differences were small.

The current study also found that women had more positive beliefs regarding disclosure. These results were in accordance with Caldwell & Peplau’s (1982) study which asserted that women placed more emphasis on the value of communicating with friends and spent more time engaged in disclosure.

The finding that men scored lower on total scores of the Disclosure Questionnaire is also consistent with Chesler & Barbarin’s (1984) study which explored disclosure in parents whose children had cancer. Men were found less likely to have a confidant to whom they disclosed. However, some males expressed wanting to discuss issues but thought that their male friends would not be comfortable with it. This suggests that beliefs can play an important role in decisions about disclosure. These findings could partially be explained by Stile’s Fever model of disclosure whereby increasing distress raises the need to disclose.

Sex role attitudes could also partially explain why females reported ease of disclosure more difficult than men (Snell, Miller, Belk, Garcia-Falconi & Hernandez-Sanchez).
In the current study it is difficult to know whether males have responded in a 'bravado' fashion to their questionnaires. Future research in this area could control for socially desirable responding to examine whether these differences remained. Alternatively, it may be because research has suggested that women generally discuss more intimate topics than men (Aries & Johnson, 1983) which may be harder to discuss.

1.3 Age and disclosure

The correlations found that the only factor of the disclosure questionnaire that was significant between the age groups was 'ease of disclosure'. The multiple regressions also found that older age predicted higher scores on the 'ease of disclosure' factor. These results suggested that when older individuals did disclose, they found this easier than their younger counterparts. Research suggests that individuals tend to favour their romantic partner for disclosure (Sollie & Fischer, 1985). As many older individuals may have been with their partners for long periods of time, they may find that disclosing to them is easier. Older individuals may feel more certain about their partner having a positive reaction to their disclosures from past experience. This could partially account for the findings.

1.4 Disclosure and physical health

Previous distress disclosure questionnaires have examined the relationship between distress disclosure and physical health. Scores on the three factors of the disclosure questionnaire were significantly positively correlated with physical health ratings. This suggested that the more participants tended to disclose the less health problems they reported, the easier participants found disclosing the better health they had, and more positive beliefs about disclosure were associated with higher physical health ratings. The current study's correlation is the same as that reported by Larson & Chastain, (1990). Other studies have failed to find significant correlations (for example, Coates and Winston, 1987).
Although the correlation between the 'positive beliefs about disclosure' factor and physical health was statistically significant it was not 'clinically significant' as it accounted for less than one percent of the variance in physical health ratings.

Multiple regressions also found that all factors and total scores of the Disclosure Questionnaire were significant predictors of higher ratings of physical health. These findings were in accordance with studies by Pennebaker & Heeron, (1984) Pennebaker & Beall (1986) Pennebaker, Kiecolt-Glaser & Glaser (1988) who proposed from their findings a theory of inhibition which argued that failure to disclose traumatic events resulted in poorer health through the inhibition placing cumulative stress on the immunological functioning of the body.

The findings also supported the findings of Mumford, Schlesinger & Glass (1983) who found that having psychotherapy decreased the use of medical services and Luborsky, Barber and Jones (1992) who found that psychotherapy improved physical health outcomes. The results were also consistent with Cole, Kemeny, Taylor and Visscher's (1996) findings that men with HIV who concealed their homosexual identity had higher incidence of infectious and neoplastic diseases as compared to those who disclosed their sexual orientation. These findings could also be explained by Lazarus & Folkman’s theory of stress and coping.

1.5 Disclosure and mental health

The findings of the statistical analyses add further weight to the significance of the positive relationship between disclosure and mental health. The results from this study reported larger correlations than previous studies that have examined the relationship between distress disclosure and mental health. This may have occurred due to the three factor structure within the new Disclosure questionnaire which has made it possible to capture additional aspects of distress disclosure.

The correlations suggested that the 'ease of disclosure' and the 'tendency to disclose' factors were the most pertinent factors in the link between disclosure and mental
health. It may be that the material that is most difficult to discuss places the body under increased strain until the issues can be disclosed and resolved. Additionally, if people find disclosure difficult they may avoid it and this inhibition may perpetuate the strain on the body and result in mental health difficulties as proposed by Pennebaker (1989). It may be that those who have scored higher on ‘ease of disclosure’ have an improved capacity for the cognitive emotional processing of their experiences and are able to make better use of disclosure.

Research also suggests that actively concealing personal information appears to be more pathological than the more passive failure to self disclose. Keeping information concealed can be a burden which can be experienced as stressful (Larson & Chastain, 1990). Wegner, Schneider, Carter & White (1987) asked one group of individuals to “try not to think of a white bear” (suppression group) and a different group to “think of a white bear” (expression group) whilst saying their thoughts out loud. Although many participants in the suppression group made distraction plans and managed to think of other things initially it was found that they were unable to suppress thoughts about a white bear for long. Additionally, participants in the suppression group reported more frequent white bear thoughts than those in the expression group. The authors concluded that trying to suppress thoughts can make them more intrusive. Therefore, disclosure of distressing material terminates this process of suppression and can result in less ruminations.

Many studies have highlighted the benefits between self-disclosure and psychological health. An example of why disclosure can be beneficial for mental health can be seen by examining Rachman and Hodgson’s (1980) study that explored ruminating in individuals who had lost their spouse. Rachman and Hodgson found that ruminating was physiologically arousing and caused mental distress. Rachman and Hodgson used physiological measures including heart rate and skin conductance measures. Using the treatment concept of flooding, individuals were asked to talk about their difficulties. The authors found that the more participants talked about their loss the less they experienced physiological signs of arousal and reported less rumination and anxiety.
The correlations found that the ‘positive beliefs about disclosure’ factor was not significantly related to anxiety or stress. This study highlighted a mismatch between individuals’ attitudes and behaviour. However, perhaps this is not surprising given the research that highlights the common discrepancy that often exists between attitudes and behaviour (Miller and Rollnik, 1991). For example, doctors know about the dangerous physical effects of smoking but still engage in the behaviour. This discrepancy may have occurred for a variety of reasons. Individuals may know that disclosure is good for them but they choose not to do it or it may be that they have responded as a result of demand characteristics and responded in a socially desirable way. Alternatively, they may genuinely believe disclosure is beneficial but find it too difficult to do.

The multiple regressions also found that levels of disclosure impacted on mental health. Total scores on the Disclosure Questionnaire and the factors ‘tendency to disclose’ and ‘positive beliefs about disclosure’ were significant negative predictors of depression. Higher scores on the ‘ease of disclosure’ factor were a significant negative predictor of anxiety. Additionally, higher scores on the ‘ease of disclosure’ and ‘positive beliefs about disclosure’ factors were significant negative predictors of stress.

However, in contrast the multiple regressions found that higher scores on the stress sub-scale of the DASS predicted lower scores on the ‘positive beliefs about disclosure’ factor of the Disclosure Questionnaire. Therefore, the less a person believes that disclosure will benefit them, the more stressed that they are. Perhaps they may have disclosed in the past but not in a way that facilitated a better understanding of the event or in way that did not bring them any benefits from the disclosure. Their past experiences may have served to deter them from future disclosures.

Although the multiple regressions found that the ‘positive beliefs about disclosure’ factor was a significant negative predictor of stress and depression this was not found to be significant for the correlations. However, the size of the significance was small and therefore may not be clinically relevant.
Disclosure in therapy can allow information to be provided that can correct existing faulty knowledge. For example, this can be particularly relevant in health anxiety disorders where individuals commonly misattribute their feelings of anxiety to signs of serious ill health such as a heart attack. Education can be a powerful way of normalising individuals’ experiences. For example, individuals with obsessive compulsive disorder can be educated about the normal occurrence of obsessions and directed to appropriate literature to aid their understanding of their behaviours. Discussions which include personal meanings of experiences can be particularly therapeutic as they allow for identification of distorted or inconsistent experiences to awareness where they can be re-evaluated reconciled and accepted by the individual.

Cognitive restructuring allows individuals to view the world in more functional ways. Recent theories of therapeutic change within PTSD have focused on emotional processing with self-disclosure as an important component of this process. There are various theories as to why this seems to help. Discussing the upsetting event may habituate the individual and decrease their arousal and affective reactions (e.g. memories about the event) (Purves & Erwin, 2004). Talking about the event also seems to break the pathological feedback loop of avoidance and rumination and subsequently diminishes rumination and negative affect (Wegner & Erber, 1992). Additionally, verbalising a traumatic experience can help a person make sense of it and to reframe the event. This verbalisation of feelings and thoughts can construct them into a logical narrative and facilitate their integration without which they might otherwise be stored in memory in a disorganised way. The original appraisal of the event can be changed into a more benign evaluation which can be reconstructed as being more controllable and meaningful (Meichenbaum, 1977). This can also allow individual to develop a sense of closure or ‘lay the event to rest’ (Horowitz, 1976).

Pennebaker (1995) has reached similar conclusions from his studies which have highlighted greater benefits from disclosure of upsetting material when the material is disclosed in a way that acknowledges both the distressing event and the person’s emotions. He argued that the concept of making thoughts and feelings concrete facilitated meaning into the event and also counteracted the process of inhibition which could lead to detriments in physical and mental health. He argued that not
disclosing could be more detrimental than the distressing event itself. Pennebaker’s studies have demonstrated the positive effects of disclosure both from writing the material and by verbal disclosure.

The positive relationship this current study found with mental health supported Jourard (1971) who regarded disclosure as necessary for achieving positive mental health. The findings also supported the research of Bolton et al (2003) who found that disclosure resulted in less PTSD symptomatology and Boca, Rime & Acruri (1992) who asserted that disclosure resulted in less ruminations and less anxiety. The results also support Ichiyama et al (1993) who found a relationship between lack of disclosure and depression, anxiety, self esteem and shyness and Apter et al (2001) asserted that lack of disclosure can affect suicidal behaviour by increasing depression and anxiety. All these previous studies concluded that higher levels of disclosure led to better psychological adjustment.

The findings also supported previous studies conducted by Pennebaker and his colleagues (Pennebaker 1995). Pennebaker has explored the possible benefits of disclosure in variety of settings ranging from natural disasters to non-clinical student populations. He also designed laboratory disclosure settings in order to distinguish differences in the process of the disclosure. He concluded that disclosure is most beneficial when done in a way, which facilitates insight and meaning into the event (Pennebaker & Susman, 1988). It may be that when people have positive beliefs about the benefits of disclosure they may be more likely to disclose or that they discuss their distress in a more cathartic manner and gain more benefit from the disclosure experience.

The results of this study supported the findings of Sowell, Seals, Phillips & Julious (2003) who explored the decision processes of disclosure in a population of women with HIV. They found that having positive beliefs about others reactions to their disclosure were crucial to their decision to disclose. In the current study women scored higher on the ‘positive beliefs about disclosure’ factor and scored higher on total scores of the Disclosure Questionnaire than their male counterparts.
The causal direction of the findings from this study is difficult to ascertain. It may be that individuals with higher levels of depression, anxiety and stress find it more difficult to talk about things. Alternatively, it could be that individuals who find it hard to talk about things are more susceptible to the likelihood that they will experience depression, anxiety and stress. However, as the questionnaire was devised to examine individuals general patterns, the results suggested that those who usually tend not to disclose their distressing events have poorer psychological health.

These findings highlight the important role disclosure can play in therapy. If lack of disclosure can lead to mental health problems, or if those with mental health problems disclose less often, then therapy could play a role in alleviating these difficulties and educating individuals about the consequences of how to cope with their distress.

However, the current findings did contrast with some previous findings. A few studies concluded that increased distress disclosure was not always associated with better psychological functioning and better physical health. This study's findings did not support the research by Mc Daniel, Stiles and McGaughey (1981) and Stiles and Shapiro (1994) who concluded that there were no benefits to disclosure. However, these studies have been criticised for their methodological problems. In addition, Kahn and Hessling (2001) argued that many of these discrepancies in the disclosure literature may be due to no distinction being made between self-disclosure and disclosure of distressing material. Kahn and Hessling argued that distress disclosure should be viewed as a subset of self-disclosure which partly overlaps with the subset of self-concealment.

1.6 Reliability

The test-retest correlations indicated that all three factors and total scores on the Disclosure Questionnaire evidenced favourable temporal stability over a time period of at least one week (Table 13). Kline (2000) suggested that test-retest figures above 0.8 were high in reliability. Thus, the test-retest reliability data provided support for the potential utility of this questionnaire. However, this must be interpreted with
caution due to the test-retest period only being one week apart. This study also had the second largest sample size (for the test-retest reliability), used similar numbers of males and females with a wide age range and from a variety of occupational backgrounds. The internal consistency of the scale was also found to be high.

The findings of this study leant support to the Inhibition theory, which argued that long-term non-disclosure of distressing events can lead to lower levels of psychological adjustment due to the stress involved with the active concealment and poorer health due to stress impacting on the body's immune system (Pennebaker, 1989).

As the present study's findings suggested, using disclosure as a coping response may alleviate long-term reactions to distress, such as anxiety and poor health. This also supported Lazarus & Folkman (1984) theory. This argued that disclosure could act as a personality variable which mediated coping responses to distressing events or problems. Lazarus & Folkman (1984) posited that inhibition of the disclosure restricts the range of available coping responses, preventing more active problem solving responses and leaving more emotion focused responses. They stressed the importance of how an event is cognitively appraised by the individual and how they cope with it can affect individual responses to the distress. Disclosure to another can often help the individual create different narratives about an event and appraise the situation differently.

The fever model (Stiles, 1987) argued that the tendency to disclose increased with the intensity of a person's distress resulting in a cathartic reduction of negative feelings and greater understanding of the distress. Although in this study disclosure was associated with improved psychological adjustment it is difficult to determine whether those with greater distress have disclosed and felt benefits or whether generally disclosing results in less likelihood of psychological difficulties. This study examined trait (general) disclosure rather that state disclosure which is central to Stile's model. However, Stile's model is partially supported as increased disclosure within this study has suggested improved psychological and physical wellbeing.
5 Implications for practice and research

Previous research has indicated that people who fail to disclose upsetting material are more likely to be unhappy and unhealthy (Pennebaker, 1995). This association between disclosure and psychological and physical health highlights the importance of knowing how a client’s willingness to disclose could impact on the therapeutic process and outcome. Measures of self-disclosure could play an important role towards better understanding how interventions or therapeutic relationships are experienced differently by individuals who disclose at varying levels and how to facilitate disclosure for the efficacy of therapy. Assessing disclosure could be particularly informative during the assessment phase of interventions as this information could help to formulate interventions and guide subsequent treatment.

If assessments suggest that individuals seem to find distress disclosure difficult then this may dictate a slower pace to the assessment and subsequent intervention. More time may be needed to establish a therapeutic relationship and to gain a good rapport as the individual may be more sceptical about therapy or maintain a more guarded position at the start of therapy. Discussing previous experiences of disclosure, or familial patterns of disclosure may allow the individual to gain some understanding about their own patterns of distress disclosure and to explore whether this impacts on their life. It could also lead to discussions about other coping strategies they use when they are distressed and whether they could gain benefits from utilising any alternative coping strategies.

The model chosen for treatment may also be important for individuals who have difficulty with disclosure. For example, group or family therapy usually involves disclosure to a therapist plus a group of peers or family members which may be perceived as more difficult than disclosure to an individual therapist. Clients may be more likely to disengage from the therapy if they experience it as more threatening reinforcing their beliefs that disclosure is difficult or of no benefit to them. Time limited cognitive-behavioural treatment may also not be appropriate as individuals who find it difficult to disclose may need to go at a slower pace and may not have made many gains after only 8 sessions. Psychodynamic therapy or cognitive
behavioural therapy which is not time limited may provide clients with a less daunting introduction to therapy which can be guided at their own pace.

The correlations suggested that the 'ease of disclosure' was the most robust factor in the Disclosure Questionnaire. This highlights the importance of encouraging clients to talk about their upsetting experiences even if they find this difficult. Discussing upsetting material in therapy may have positive implications for recovery from mental health and physical problems particularly if difficulties associated with disclosure normally results in the individual avoiding disclosure. This highlights the importance of creating a therapeutic relationship and setting which facilitates intimate self-disclosure from the client. Farber, Berano & Capobianco (2004) found that their clients reported that they would welcome an active but gentle pursuit of difficult to disclose material by therapists. Within therapy there should be consideration of these factors and an emphasis on building rapport, trust, confidence and confidentiality (Wells, 1997). If the therapist responds to the disclosure with empathic acceptance then this may facilitate future disclosures to the therapist and may even encourage them to increase disclosure in other relationships outside therapy.

Therapists need to be aware of the different attributes that may result in difficulties with disclosure such as alexithymia, insecure attachments, perfectionism, high levels of anxiety or high levels of guilt or shame. Awareness of the factors that impact on disclosure can help the therapist to examine whether the client has any dysfunctional thoughts that serve to maintain low disclosure patterns (for example, I could not tell anyone about what happened, they would think it was my own fault). Therefore, rather than discuss actual events distressful events, clients could be encouraged to explore what the difficulties or disadvantages might be in having discussions with others about past distressing events.

When the therapist is aware that the client has chosen to actively conceal, behavioural stress management techniques could be used to counteract the stress response of inhibition. They could also be encouraged to write down the event and their emotions surrounding it (Pennebaker, 1989) to reduce their negative mood and to help them
cope more effectively. This may be particularly useful for those who find it difficult to distract themselves from unwanted thoughts.

Individuals who know that they find disclosure difficult may have negative feelings surrounding disclosure or therapy. Research has suggested that certain individuals such as males (Chesler and Barbarin, 1984) or people with certain styles of relating such as alexithymia, (Taylor, Bagby and Parker, 1997) may have less access to disclosure as a supportive mechanism and may benefit from therapy as a means for this. However, they may also be less willing to use disclosure as a means of support. Services need to think of ways to help these individuals access support and to think about ways in which they can make psychological therapy be perceived as less daunting.

6 Limitations

There were also limitations to this study. Some individuals who took part in the study (5) described that they found the Disclosure Questionnaire format of both positive and negative items difficult to answer. It may be that developing a questionnaire containing only positive items may have been easier to follow. Certain items on the Disclosure Questionnaire were in hindsight considered poor items. (For example, I do not talk about what upsets me because my throat tenses up and I just cant speak). This item is making two statements and would have been better split into two separate items. Kline (2000) recommended items for factor analysis avoid using any terms of feeling. However, three items used terms of feeling (e.g. I prefer to keep quiet about the things that upset me) and perhaps the wording of these could have been improved.

Another limitation was that the three factors within the Disclosure Questionnaire only accounted for 30% of the variance. Other unmeasured factors such as trauma incidence, trauma disclosure and social support are also likely to be correlated with predictors of mental and physical health.
There are many options for implementing an exploratory factor analysis. Some researchers argue that the differences between many of the techniques are small (Steiger, 1990; Velicer & Jackson, 1990). However, Costello & Osborne (2005) disagree with this view. They believe that options for choosing which type of factor analysis to use are important in yielding the maximum benefit from the data but that the process for making the best choice is often complex and not well defined. As it appears that there is often disagreement surrounding which type of factor analysis yields the maximum benefit for different types of data, the factor analysis chosen for this study, may be viewed by some researchers as a limitation of this study.

This study relied on individuals using methods of self-report and was therefore liable to inaccuracies. Self-report measures are often subject to retrospective reporting biases.

Due to the ‘positive beliefs about disclosure’ factor not having significant correlations with disclosure and weak findings reported from the multiple regressions, future distress disclosure researchers may not think it necessary to explore this area. However, although the factor did not strongly correlate with mental health, it still provided useful insight into people’s fears about disclosure. This was the smallest factor with only five items and perhaps more items resulting in a stronger factor may have provided more significant results.

Another limitation of this research was that the questionnaires for the test-retest reliability stage of the research were only distributed one week apart. Unfortunately, limited timing to complete the study meant that it was not possible to extend this time frame. However, ideally this time frame could have been longer as it is difficult to know how this shorter time frame impacted on the test-retest reliability findings.

A further limitation of this research is that the sample did not inquire about culture. It was assumed that the majority of the sample was largely white European. This may limit generalisation of the results to other samples. It was decided not to ask respondents to record their race as this may have resulted in a lack of anonymity. However, it may have been interesting to examine whether race affected patterns of
disclosure as this has also been highlighted as a variable that influences self-disclosure in the research (Morrison, & Downey, 2000; Kito, 2005).

It is difficult to know how the findings fully relate to disclosure as this concentrated on general disclosure of distressing material. There may still be pockets of information that people do not disclose or their patterns of disclosure may be representative until a major life event occurs that feels too big to talk about. Even if individuals have had good experiences of disclosing before, they may encounter a problem in life which they have never encountered before. (For example, it may be particularly difficult for a man to disclose having been raped because it is counter to stereotypes about men being victims of sexual offences). It may also be interesting to examine whether those who have a major traumatic event and feel that they cannot disclose it have worse effects from this if they were generally high disclosers before.

The process of disclosure involves complex interpersonal dynamics that need to be viewed in specific situations and relationship contexts. An aim of this research was to examine the general tendency to disclose upsetting information. Therefore, there was no attempt to address the vast array of specific contextual factors that can determine the effects of disclosure on mental and physical health. Similarly, distressing personal information can be kept hidden from oneself. Whilst it is important to recognise that repressed memories can also exert a powerful influence on individual’s behaviour this study only explored conscious aspects of disclosure or non-disclosure.

7 Directions for future research

There seems to be a lack of research literature to determine the role of disclosure before clients enter therapy. This could be a useful area to examine to gain more insight into the process of disclosure.

Current research in self-disclosure has failed to examine the magnitude of the stressor that prompted the self-disclosure. They have looked at the variety of stressors that people have been presented with but have not included measures to assess the
characteristics of the stressor. This is important as some experiences may not need to be shared to promote psychological and physical well-being.

It is still unclear whether non-disclosure leads to mental and physical illness or whether illness led to non-disclosure. Perhaps future research could design a longitudinal study to address this by examining current symptoms and tendency to disclose to assess the cause.

Future research could also focus on the impact of the way that the disclosed information is received. Although it is known that positive reactions to disclosure are related to better psychological adjustment (Bolton et al, 2003) for example does disclosure to an individual who responds in a negative or invalidating manner completely negate the beneficial effects of disclosing the experience? Additionally, does the relationship with the person who reacts negatively to the disclosure effect the impact of the negative experience on the discloser. Future research could also examine how long the positive effects of disclosure last for.

It would be helpful for future studies to examine whether these results would be replicated in a clinical population, which could lead to the development of clinical interventions.
References


Appendix A
Letter of ethical approval
17 February 2006

Ms Laura Dovey
Department of Psychology
School of Human Sciences

Dear Ms Dovey

The development of a questionnaire measuring individuals tendency to disclose upsetting things and the relationship between psychological and physical health (EC/2006/07/Psych)

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 17 February 2006

The list of documents reviewed and approved by the Committee is as follows:-

Document Type: Application
Dated: 11/01/06
Received: 17/01/06

Document Type: Summary of Project
Received: 17/01/06

Document Type: Research Proposal
Received: 17/01/06

Document Type: Information Sheet
Received: 17/01/06

Document Type: Demographic Information
Received: 17/01/06

Document Type: Questionnaire
Received: 17/01/06

Document Type: Insurance Proforma
Received: 17/01/06

Document Type: Your Response to the Committee's Comments
Dated: 06/02/06
Received: 07/02/06
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research, and with the condition set out below:

- That you exclude any participants who are experiencing emotionally upsetting events, e.g. bereavement, regardless of whether they are in therapy or not, and that this is stated in the Protocol's exclusion criteria.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

I would be grateful if you would confirm, in writing, your acceptance of the condition above, forwarding the amended part of the protocol.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr Fiona Warren, Supervisor, Dept of Psychology
Dr A Coxeil, Broadmoor Hospital, Crowthorne
Appendix B
Information Sheet
Development of a questionnaire to measure self-disclosure of upsetting things and the relationship between current psychological and physical health.

You are being invited to take part in a research study.

Before you decide it is important to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you would like to take part. We ask that you do not take part in the study if you meet any of the exclusion criteria (see enclosed sheet – Can I take part in this study?). If there is anything that is not clear or if you would like more information contact details for the researcher can be found on this sheet under the heading ‘Who is organising the study’?

What is the purpose of the study?

The aim of the study is to learn more about when someone tells another person private feelings, thoughts, beliefs or attitudes that upset them (self disclosure). Existing research has enquired about the effects of self-disclosure on health and in mental health settings. This study is aimed at furthering knowledge in these areas. This study will not ask you to reveal any upsetting things or talk about any upsetting things – it is interested only in your experience of disclosing upsetting things to others (e.g. whether you tend to talk to others about things that upset you).

What will I have to do if I take part?

If you agree to take part you will be asked to complete 3 questionnaires. The first asks you to provide basic information about yourself (e.g. gender, age, etc). The second questionnaire asks about your experiences of disclosing upsetting things and the third questionnaire asks about different thoughts and feelings you may be having. Please return the completed questionnaires in the stamped addressed envelope provided within two weeks of receiving them.

Do I have to take part?

No. Taking part in this study is completely voluntary. However, if any of the exclusion criteria detailed on “Can I take part in this study?” apply to you then it is important that you do not take part. This information sheet is yours to keep. If you decide to take part and complete and return the questionnaires, this will be
considered as you providing consent to engage in the study. If you decide that you do not want to take part in the study you will not need to give a reason for this. You can either send the questionnaire back to the researcher in the stamped addressed envelope provided or alternatively you can dispose of it.

How long will it take?

Completing the questionnaires should take approximately 15 minutes.

Is the study confidential?

Yes. All the information that you provide will be anonymous (You do not give your name in this study). The content of the questionnaires will remain confidential to the researchers. All information will be kept in a secure and locked place and will only be used for research purposes. This data will be stored in accordance of the Data Protection Act (1998).

What will happen to the results of the study?

The results will be written up as a Major Research Project as part of a PsychD in Clinical Psychology. The researcher intends to prepare the study for publication in a relevant psychology journal. If you would like a brief summary of the findings, please contact Laura Dovey using the contact details below and this will be sent to you on completion of the study in September 2006.

Who is organising the study?

This study is being conducted by Laura Dovey (Trainee Clinical Psychologist at the University of Surrey). This work is being supervised by Dr Fiona Warren (Lecturer in Psychology at the University of Surrey) and Dr Adrian Coxell (Clinical Psychologist, West London Mental Health Trust).

If you have any questions about the study, please telephone the Clinical Psychology Office on 01483 686887 and leave a message for Laura Dovey with a contact number to return your call. All telephone messages will be replied to as soon as possible. Alternatively, please write to Laura Dovey, C/O University of Surrey, Clinical Psychology Department, Guildford, Surrey, GU2 7LX.

If whilst participating in this study you become aware of thoughts or feelings that are causing you distress, there is an additional sheet that provides contact details for people who may want to talk to someone about these feelings or experiences.

Thank you for taking the time to read and consider this information.

For those of you who decide to take part - Thank-you.

This study has received ethical approval by Surrey University ethics committee.
Appendix C
Information sheet (test-retest participants)
You are being invited to take part in a research study.

Before you decide it is important to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you would like to take part. We ask that you do not take part in the study if you meet any of the exclusion criteria (see enclosed sheet — Can I take part in this study?). If there is anything that is not clear or if you would like more information contact details for the researcher can be found on this sheet under the heading 'Who is organising the study'?

What is the purpose of the study?

The aim of the study is to learn more about when someone tells another person private feelings, thoughts, beliefs or attitudes that upset them (self-disclosure). Existing research has enquired about the effects of self-disclosure on health and in mental health settings. This study is aimed at furthering knowledge in these areas. (This study will not ask you to reveal any upsetting things or talk about any upsetting things – It is interested only in your experience of disclosing upsetting things to others (e.g. whether you tend to talk to others about things that upset you).

What will I have to do if I take part?

This stage of the research aims to assess the reliability of the new questionnaire. If you agree to take part you will be asked to complete 3 questionnaires. You will also be required to complete them again one week later. The first questionnaire asks you to provide basic information about yourself (e.g. gender, age, etc). This questionnaire also asks you to provide a code so that your responses to both sets of questionnaires can be compared without your identity being revealed. The second questionnaire asks about your experiences of disclosing upsetting things and the third questionnaire asks about different thoughts and feelings you may be having. Please return the completed questionnaires in the FREEPOST envelope provided within two weeks of receiving them.
Do I have to take part?

No. Taking part in this study is completely voluntary. However, if any of the exclusion criteria detailed on “Can I take part in this study?” apply to you then it is important that you do not take part. This information sheet is yours to keep. If you decide to take part and complete and return the questionnaires, this will be considered as you providing consent to engage in the study. If you decide that you do not want to take part in the study you will not need to give a reason for this. You can either send the questionnaire back to the researcher in the FREEPOST envelope provided or alternatively you can dispose of it.

How long will it take?

Completing each set of questionnaires should take approximately 15 minutes.

Is the study confidential?

Yes. All the information that you provide will be anonymous (You do not give your name in this study). The content of the questionnaires will remain confidential to the researchers. All information will be kept in a secure and locked place and will only be used for research purposes. This data will be stored in accordance of the Data Protection Act (1998).

What will happen to the results of the study?

The results will be written up as a Major Research Project as part of a PsychD in Clinical Psychology. The researcher intends to prepare the study for publication in a relevant psychology journal. If you would like a brief summary of the findings, please contact Laura Dovey using the contact details below and this will be sent to you on completion of the study in September 2006.

Who is organising the study?

This study is being conducted by Laura Dovey (Trainee Clinical Psychologist at the University of Surrey). This work is being supervised by Dr Fiona Warren (Lecturer in Psychology at the University of Surrey) and Dr Adrian Coxell (Clinical Psychologist, West London Mental Health Trust).

If you have any questions about the study, please telephone the Clinical Psychology Office on 01483 686887 and leave a message for Laura Dovey with a contact number to return your call. All telephone messages will be replied to as soon as possible. Alternatively, please write to Laura Dovey, C/O University of Surrey, Clinical Psychology Department, Guildford, Surrey, GU2 7LX.

If whilst participating in this study you become aware of thoughts or feelings that are causing you distress, there is an additional sheet that provides contact details for people who may want to talk to someone about these feelings or experiences.
Thank you for taking the time to read and consider this information.

For those of you who decide to take part - Thank-you.

This study has received ethical approval by Surrey University ethics committee.
Appendix D

Exclusion Criteria
Can I take part in this study?

We would like to invite you to take part in this study. However you cannot take part if:

- You are below 18 years of age
- You have a learning disability
- You have difficulties understanding written English
- You are currently experiencing an emotionally upsetting event (e.g. a bereavement, etc.)
- We also ask that you do not take part in the study if you are currently receiving any sort of therapy for a mental health problem

If you have answered YES to any of the questions above then you will not be able to take part in this study.

If you are unable to take part please would you return the uncompleted questionnaire using the FREEPOST envelope provided. Alternatively, you may dispose of the envelope and its contents.
Appendix E
Mental Health Organisations
Mental Health Organisations

If you are experiencing feelings of anxiety or depression which are disrupting your life you may find it useful to talk to another person about this. Some people find it helpful to talk to family and friends, but many prefer to talk to a person who has some knowledge (either professional or personal) of the experiences that are causing them distress. You could discuss these difficulties with your GP who would help point you in the right direction to get you the support that you need. Alternatively, below are a list of organisations for people who may want to talk to someone confidentially about their feelings or experiences.

Mind (The Mental Health Charity)
Granta House
15 – 19 Broadway
London
E15 4BQ
Tel: 0208 522 1728
     0845 766 0163 (Outer London)
Email: contact@mind.org.uk

Saneline (Head office)
Cityside House (1st floor)
40, Adler Street
London
E1 1EE
Tel: 0845 767 8000
Email: www.sane.org.uk

Samaritans (Head office)
46 Marshall Street
London
W1F 9BF
Tel: 08457 909090
     01483 505555
Email: www.samaritans.org/cls

Turning Point (Head office)
New Loom House
101 Backchurch Lane
London
E1 1LU
Tel: 0207 702 2300
Email: www.turning-point.co.uk
Appendix F

Depression, Anxiety and Stress Scale (DASS)
The DASS (42)

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week.

Reminder of rating scale:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>I found myself getting upset by quite trivial things 0 1 2 3</td>
</tr>
<tr>
<td>2.</td>
<td>I was aware of dryness of my mouth 0 1 2 3</td>
</tr>
<tr>
<td>3.</td>
<td>I couldn't seem to experience any positive feeling at all 0 1 2 3</td>
</tr>
<tr>
<td>4.</td>
<td>I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion) 0 1 2 3</td>
</tr>
<tr>
<td>5.</td>
<td>I just couldn't seem to get going 0 1 2 3</td>
</tr>
<tr>
<td>6.</td>
<td>I tended to over react to situations 0 1 2 3</td>
</tr>
<tr>
<td>7.</td>
<td>I had a feeling of shakiness (e.g. legs going to give way) 0 1 2 3</td>
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<tr>
<td>8.</td>
<td>I found it difficult to relax 0 1 2 3</td>
</tr>
<tr>
<td>9.</td>
<td>I found myself in situations that made me so anxious I was most relieved when they ended 0 1 2 3</td>
</tr>
<tr>
<td>10.</td>
<td>I felt that I had nothing to look forward to 0 1 2 3</td>
</tr>
<tr>
<td>11.</td>
<td>I found myself getting upset rather easily 0 1 2 3</td>
</tr>
<tr>
<td>12.</td>
<td>I felt that I was using a lot of nervous energy 0 1 2 3</td>
</tr>
<tr>
<td>13.</td>
<td>I felt sad and depressed 0 1 2 3</td>
</tr>
<tr>
<td>14.</td>
<td>I found myself getting rather impatient when I was delayed in any way (e.g. lifts, traffic lights, being kept waiting) 0 1 2 3</td>
</tr>
<tr>
<td>15.</td>
<td>I had a feeling of faintness 0 1 2 3</td>
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<tr>
<td>16.</td>
<td>I felt that I had lost interest in just about everything 0 1 2 3</td>
</tr>
<tr>
<td>17.</td>
<td>I felt I wasn't worth much as a person 0 1 2 3</td>
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<tr>
<td>18. I felt that I was rather touchy</td>
<td>0</td>
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<tr>
<td>19. I perspired noticeably (e.g. hands sweaty) in the absence of high temperatures or physical exertion</td>
<td>0</td>
</tr>
<tr>
<td>20. I felt scared without any good reason</td>
<td>0</td>
</tr>
<tr>
<td>21. I felt that life wasn’t worthwhile</td>
<td>0</td>
</tr>
<tr>
<td>22. I found it hard to wind down</td>
<td>0</td>
</tr>
<tr>
<td>23. I had difficulty in swallowing</td>
<td>0</td>
</tr>
<tr>
<td>24. I couldn’t seem to get any enjoyment out of the things I did</td>
<td>0</td>
</tr>
<tr>
<td>25. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)</td>
<td>0</td>
</tr>
<tr>
<td>26. I felt down hearted and blue</td>
<td>0</td>
</tr>
<tr>
<td>27. I found that I was very irritable</td>
<td>0</td>
</tr>
<tr>
<td>28. I felt I was close to panic</td>
<td>0</td>
</tr>
<tr>
<td>29. I found it hard to calm down after something upset me</td>
<td>0</td>
</tr>
<tr>
<td>30. I feared that I would be “thrown” by some trivial but unfamiliar task</td>
<td>0</td>
</tr>
<tr>
<td>31. I was unable to become enthusiastic about anything</td>
<td>0</td>
</tr>
<tr>
<td>32. I found it difficult to tolerate interruptions to what I was doing</td>
<td>0</td>
</tr>
<tr>
<td>33. I was in a state of nervous tension</td>
<td>0</td>
</tr>
<tr>
<td>34. I felt I was pretty worthless</td>
<td>0</td>
</tr>
<tr>
<td>35. I was intolerant of anything that kept me from getting on with what I was doing</td>
<td>0</td>
</tr>
<tr>
<td>36. I felt terrified</td>
<td>0</td>
</tr>
<tr>
<td>37. I could see nothing in the future to be hopeful about</td>
<td>0</td>
</tr>
<tr>
<td>38. I felt that life was meaningless</td>
<td>0</td>
</tr>
<tr>
<td>39. I found myself getting agitated</td>
<td>0</td>
</tr>
<tr>
<td>40. I was worried about situations in which I might panic and make a fool of myself</td>
<td>0</td>
</tr>
<tr>
<td>41. I experienced trembling (e.g. in the hands)</td>
<td>0</td>
</tr>
<tr>
<td>42. I found it difficult to work up the initiative to do things</td>
<td>0</td>
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Appendix G

Disclosure Questionnaire (58 items)
Everybody experiences upsetting things sometimes. This questionnaire is designed to help you tell us about your experience of, and attitudes toward, disclosing upsetting things.

If you strongly disagree with a statement circle SD
If you disagree with a statement circle D
If you neither agree nor disagree with a statement circle N
If you agree with a statement circle A
If you strongly agree with a statement circle SA

There are no right or wrong answers. When answering the questions please try to be honest with yourself.

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<tr>
<th>Most of the time....</th>
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<tbody>
<tr>
<td>1. I think that if I told anyone about what upsets me they would think that I had a psychological problem.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>2. I do not think that the things that upset me seem better when I talk about them.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>3. I think that it is helpful to get the things that upset me off my chest.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>4. I do not want to trouble anybody by talking about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
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<th>Most of the time....</th>
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<tr>
<td>5. I act as if I am not bothered about the things that upset me the most.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>6. I do not think that it is good to talk about what upsets you.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>7. I worry that people will think I am weak if I talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>8. I do not worry that I will accidentally let slip what is upsetting me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
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<th>Most of the time....</th>
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<tr>
<td>9. I wish that I had not told anyone about the things that upset me</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>10. I do not even 'want to know' about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>11. I keep busy and try to forget what is upsetting me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>12. I do not lie if someone asks me about something secret that upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
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<th>Most of the time....</th>
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264
13. When I try to talk about what upset me it comes out wrong.  
14. I **cannot** find anyone to talk with about what upsets me.  
15. Things go wrong when I tell others what upsets me.  
16. Talking about what upsets me **does not** change the way I feel.  

*Most of the time*....

17. I am too embarrassed to tell people about what upsets me.  
18. I **do not** talk about what upsets me because my throat tenses up and I just can’t speak.  
19. It is the things that have upset me the most that are hardest to talk about.  
20. I **do not** worry that people will like me less if I talk about what upsets me.  

*Most of the time*....

21. I think that talking about what upsets me is useful.  
22. I **am not** willing to tell anyone about what upsets me.  
23. My mouth goes really dry when I talk about what upsets me.  
24. I **cannot** decide whether or not to talk about what upsets me.  

*Most of the time*....

25. I think that a problem shared is a problem halved.  
26. I **do not** tell others upsetting secrets about myself.  
27. I get upset and cry when I talk about what upsets me.  
28. I **cannot** find the right words to describe what upsets me.  

*Most of the time*....

29. I look for others to talk with about what upsets me.  
30. I **do not** talk about what upsets me because I get too emotional.  
31. I prefer to keep quiet about the things that upset me.  
32. I **do not** get upsetting images in my mind when I talk about what upsets me.
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<td><strong>Most of the time.....</strong></td>
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<tr>
<td>33. When I talk about what upsets me I just ‘go around in circles’.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>34. I do not want to talk about the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>35. I have someone to talk with about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>36. I do not feel that I can rely on others to keep secret what upsets me.</td>
<td>SD</td>
<td>D</td>
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<td>SA</td>
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<td><strong>Most of the time.....</strong></td>
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<td>37. I avoid thinking about the things that upset me and hope that they go away.</td>
<td>SD</td>
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<td>SA</td>
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<td>38. I do not tell others about the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>39. I try to understand what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>40. I do not ‘stick my head in the sand’ when things upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td><strong>Most of the time.....</strong></td>
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<tr>
<td>41. I bottle up the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>42. I avoid talking about the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>43. What upsets me are someone else’s secrets or problems.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>44. I do not think that people will laugh if I tell them about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td><strong>Most of the time.....</strong></td>
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<tr>
<td>45. When I talk about what upsets me I get upsetting thoughts.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>46. I do not know what is going on inside me when I am upset.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>47. I am plagued by fears of talking about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>48. I do not tell the truth if someone asks me why I am upset.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td><strong>Most of the time.....</strong></td>
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<tr>
<td>49. I know why I am upset.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>50. I do not know where to start when I try to talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>51. I keep what upsets me a secret.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>52. I do not discuss things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<td><strong>Most of the time....</strong></td>
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</tr>
<tr>
<td>53. I end up tongue-tied when I try to talk about what upsets me.</td>
<td>SD D N A SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54. I do not think that it helps to talk about what upsets me.</td>
<td>SD D N A SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55. I act like the things that upset me do not exist.</td>
<td>SD D N A SA</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>56. I do not think that talking about what upsets me changes how I think about it.</td>
<td>SD D N A SA</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Most of the time....</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>57. I can say how I feel when something upsets me.</td>
<td>SD D N A SA</td>
</tr>
<tr>
<td>58. I do not think that others would care if I talked about what upsets me.</td>
<td>SD D N A SA</td>
</tr>
</tbody>
</table>
Appendix H

Disclosure Questionnaire following factor analysis (43 items)
Everybody experiences upsetting things sometimes. This questionnaire is designed to help you tell us about your experience of, and attitudes toward, disclosing upsetting things.

If you strongly disagree with a statement circle SD
If you disagree with a statement circle D
If you neither agree nor disagree with a statement circle N
If you agree with a statement circle A
If you strongly agree with a statement circle SA

There are no right or wrong answers. When answering the questions please try to be honest with yourself.

<table>
<thead>
<tr>
<th>Most of the time....</th>
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</thead>
<tbody>
<tr>
<td>1. When I try to talk about what upsets me it comes out wrong.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>2. I do not discuss things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>3. It is the things that have upset me the most that are the hardest to talk about.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>4. I end up tongue-tied when I try to talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>Most of the time....</td>
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<tr>
<td>5. I can say how I feel when something upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>6. I do not talk about what upsets me because I get too emotional.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>7. I think that it is helpful to get the things that upset me off my chest.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>8. I do not talk about what upsets me because my throat tenses up and I just can’t speak.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<td>Most of the time....</td>
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<tr>
<td>9. I think that a problem shared is a problem halved.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
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<td>SA</td>
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<tr>
<td>10. I do not even ‘want to know’ about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>11. I am too embarrassed to tell people about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>12. I do not feel that I can rely on others to keep secret what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<td>Most of the time ....</td>
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<tr>
<td>13. I act like the things that upset me do not exist.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>14. I do not think that it helps to talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>15. When I talk about what upsets me I just ‘go around in circles’.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>16. I do not tell the truth if someone asks me why I am upset.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<td>Most of the time ....</td>
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<tr>
<td>17. I bottle up the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>18. I can not find the right words to describe what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>19. I look for others to talk with about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>20. I do not want to trouble anybody by talking about what upsets me.</td>
<td>SD</td>
<td>D</td>
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<td>A</td>
<td>SA</td>
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<td>Most of the time ....</td>
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<tr>
<td>21. When I talk about what upsets me I get upsetting thoughts.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>22. Talking about what upsets me does not change the way I feel.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>23. I am plagued by fears of talking about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>24. I do not think it is good to talk about what upsets you.</td>
<td>SD</td>
<td>D</td>
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<td>SA</td>
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<td>Most of the time ....</td>
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<tr>
<td>25. I keep what upsets me a secret.</td>
<td>SD</td>
<td>D</td>
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<td>A</td>
<td>SA</td>
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<tr>
<td>26. I do not tell others about the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>27. I get upset and cry when I talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>28. I avoid talking about the things that upset me.</td>
<td>SD</td>
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<td>SA</td>
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<td>Most of the time ....</td>
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<tr>
<td>29. I wish that I had not told anyone about the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>30. I do not tell others upsetting secrets about myself.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>31. My mouth goes really dry when I talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>32. I do not think that talking about what upsets me changes how I think about it.</td>
<td>SD</td>
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<td>SA</td>
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<tr>
<td>33. I think that if I told anyone about what upsets me they would think that I had a psychological problem.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>34. I do not want to talk about the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>35. I worry that people will think I am weak if I talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>36. I do not know where to start when I try to talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>Most of the time....</td>
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<tr>
<td>37. I prefer to keep quiet about the things that upset me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>38. I am not willing to tell anyone about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>39. I think that talking about what upsets me is useful.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>40. I can not decide whether or not to talk about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<tr>
<td>Most of the time....</td>
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</tr>
<tr>
<td>41. Things go wrong when I tell others about what upsets me.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>42. I do not know what is going on inside me when I am upset.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>43. I act as if I am not bothered about the things that upset me the most.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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Appendix I
Demographic Information Sheet
Demographic Information

Please fill in the following questions and return this sheet with the other 2 questionnaires.

Gender- Male / Female

Age -

Code - (if the researcher has asked you to provide one)

Please rate how healthy you feel physically by making a mark on the following line with 0 representing extremely unwell and 10 representing extremely well.

0---------------------------------------------------------------10
Appendix J
Demographic Information Sheet (test-retest sample)
Demographic Information

Please fill in the following questions and return this sheet with the other 2 questionnaires.

Gender- Male / Female

Age - ____________

Code - ____________ (Please write your shoe size and third letter of your mother's maiden name)

Please rate how healthy you feel physically by making a mark on the following line with 0 representing extremely unwell and 10 representing extremely well.

0---------------------------------------------------------------10
Appendix K

Origin of items on the Disclosure Questionnaire
<table>
<thead>
<tr>
<th>Items on newly developed Self-disclosure Scale</th>
<th>Item origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I think that if I told anyone about what upsets me they would think that I had a psychological problem.</td>
<td>If I talked about what upsets me people would think that I am mentally ill (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>2. I <strong>do not</strong> think that the things that upset me seem better when I talk about them.</td>
<td>Talking about upsetting things changes nothing (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>3. I think that it is helpful to get the things that upset me off my chest.</td>
<td>When I'm feeling down and depressed, I feel better if I talk over my problems with someone (Distress Disclosure Scale, Coates &amp; Winston, 1987)</td>
</tr>
<tr>
<td>4. I <strong>do not</strong> want to trouble anybody by talking about what upsets me.</td>
<td>New</td>
</tr>
<tr>
<td>5. I act as if I am not bothered about the things that upset me the most.</td>
<td>I try to act cheerful and pleasant with others even if I'm feeling down and depressed (Distress Disclosure Scale, Coates &amp; Winston, 1987)</td>
</tr>
<tr>
<td>6. I <strong>do not</strong> think that it is good to talk about what upsets you.</td>
<td>New</td>
</tr>
<tr>
<td>7. I worry that people will think I am weak if I talk about what upsets me.</td>
<td>People will think I am weak if I talk with them about upsetting things (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>8. I <strong>do not</strong> worry that I will accidentally let slip what is upsetting me.</td>
<td>I'm often afraid I'll reveal something that I don't want to (Self-Concealment scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>9. I wish that I had not told anyone about the things that upset me</td>
<td>Things can go badly wrong when you tell others about upsetting secrets (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
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</tr>
<tr>
<td>10. <strong>I do not</strong> even ‘want to know’ about what upsets me.</td>
<td></td>
</tr>
<tr>
<td>11. I keep busy and try to forget what is upsetting me.</td>
<td>When I am upset I keep busy and hope the upset goes away (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>12. <strong>I do not</strong> lie if someone asks me about something secret that upsets me.</td>
<td>I have a secret that is so private I would lie if anyone asked me about it (Self-Concealment Scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>13. When I try to talk about what upsets me it comes out wrong.</td>
<td></td>
</tr>
<tr>
<td>14. <strong>I can not</strong> find anyone to talk with about what upsets me.</td>
<td>I try to find people to talk with about my problems (Distress disclosure Index, Kahn &amp; Hessling, 2001)</td>
</tr>
<tr>
<td>15. Things go wrong when I tell others what upsets me.</td>
<td>Telling a secret often backfires and I wish I hadn’t told it (Self-Concealment Scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>16. Talking about what upsets me <strong>does not</strong> change the way I feel.</td>
<td>Talking about upsetting things changes nothing (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>17. I am too embarrassed to tell people about what upsets me.</td>
<td>My secrets are too embarrassing to share with others (Self-Concealment Scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>18. <strong>I do not</strong> talk about what upsets me because my throat tenses up and I just can’t speak.</td>
<td>My throat gets tense and I just can’t speak properly if I talk about what upsets me (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>19. It is the things that have upset me the most that are hardest to talk about.</td>
<td></td>
</tr>
<tr>
<td>20. <strong>I do not</strong> worry that people will like me less if I talk about what upsets me.</td>
<td>If I shared all my secrets with my friends, they would like me less (Self-</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Statement</th>
<th>Scale/Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. I think that talking about what upsets me is useful.</td>
<td>I usually find that talking over my problems is a good way to solve them (Distress Disclosure Scale, Coates &amp; Winston, 1987)</td>
</tr>
<tr>
<td>22. I am not willing to tell anyone about what upsets me.</td>
<td>I keep my troubles to myself rather than sharing them with others (Distress Disclosure Scale, Coates &amp; Winston, 1987)</td>
</tr>
<tr>
<td>23. My mouth goes really dry when I talk about what upsets me.</td>
<td>New</td>
</tr>
<tr>
<td>24. I can not decide whether or not to talk about what upsets me.</td>
<td>I switch between wanting and not wanting to talk about what upsets me (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>25. I think that a problem shared is a problem halved.</td>
<td>New</td>
</tr>
<tr>
<td>26. I do not tell others upsetting secrets about myself.</td>
<td>There are lots of things about me that I keep to myself (Self-Concealment Scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>27. I get upset and cry when I talk about what upsets me.</td>
<td>I can’t talk about things that upset me because if I do I’ll cry (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>28. I can not find the right words to describe what upsets me.</td>
<td>It’s difficult for me to find the right words for my feelings (Toronto Alexithymia Scale, Bagby, Parker &amp; Taylor, 1994)</td>
</tr>
<tr>
<td>29. I look for others to talk with about what upsets me.</td>
<td>When something unpleasant happens to me I often look for someone to talk to (Distress Disclosure Index, Kahn &amp;</td>
</tr>
<tr>
<td>30. <strong>I do not</strong> talk about what upsets me because I get too emotional.</td>
<td>I can’t talk about the things that upset me because if I do I cry (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>31. I prefer to keep quiet about the things that upset me</td>
<td>When something bad happens to me I tend to keep it to myself (Self-Concealment Scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>32. <strong>I do not</strong> get upsetting images in my mind when I talk about what upsets me.</td>
<td>New</td>
</tr>
<tr>
<td>33. When I talk about what upsets me I just ‘go around in circles’.</td>
<td>When I talk about what upsets me I just end up going round in circles and getting nowhere (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>34. <strong>I do not</strong> want to talk about the things that upset me.</td>
<td>I prefer not to talk about my problems (Distress Disclosure Index, Kahn &amp; Hessling, 2001)</td>
</tr>
<tr>
<td>35. I have someone to talk with about what upsets me.</td>
<td>When I am in a bad mood I talk about it with my friends (Distress Disclosure Index, Kahn &amp; Hessling, 2001)</td>
</tr>
<tr>
<td>36. <strong>I do not</strong> feel that I can rely on others to keep secret what upsets me.</td>
<td>Things can go badly wrong when you tell others about upsetting secrets (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>37. I avoid thinking about the things that upset me and hope that they go away.</td>
<td>When I am upset I just keep busy and hope that the upset goes away (Disclosure Avoidance Scale, Nanou, Stewart &amp; Cox, 2004)</td>
</tr>
<tr>
<td>38. <strong>I do not</strong> tell others about the things that upset me</td>
<td>I typically don’t discuss the things that upset me (Distress Disclosure Index, Kahn &amp; Hessling, 2001)</td>
</tr>
<tr>
<td>39. I try to understand what upsets me.</td>
<td>I try to understand why I am feeling upset (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>40. I do not ‘stick my head in the sand’ when things upset me.</td>
<td>Sometimes I just pretend what upsets me does not exist (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>41. I bottle up the things that upset me.</td>
<td>It’s difficult for me to reveal my innermost feelings even to close friends (Toronto Alexithymia Scale, Bagby, Parker &amp; Taylor, 1994)</td>
</tr>
<tr>
<td>42. I avoid talking about the things that upset me.</td>
<td>I just could not speak about my biggest fears (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>43. What upsets me are someone else’s secrets or problems.</td>
<td>New</td>
</tr>
<tr>
<td>44. I do not think that people will laugh if I tell them about what upsets me.</td>
<td>New</td>
</tr>
<tr>
<td>45. When I talk about what upsets me I get upsetting thoughts.</td>
<td>New</td>
</tr>
<tr>
<td>46. I do not know what is going on inside me when I am upset.</td>
<td>I don’t know what is going on inside me (Toronto Alexithymia Scale, Bagby, Parker &amp; Taylor, 1994)</td>
</tr>
<tr>
<td>47. I am plagued by fears of talking about what upsets me.</td>
<td>Some of my secrets have really tormented me (Self-Concealment Scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>48. I do not tell the truth if someone asks me why I am upset.</td>
<td>I am willing to tell others my distressing thoughts (Distress Disclosure Index, Kahn &amp; Hessling, 2001)</td>
</tr>
<tr>
<td>49. I know why I am upset.</td>
<td>I always understand why I am feeling upset (Distress Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>50. I do not know where to start when I I would like to talk about what upsets me</td>
<td></td>
</tr>
<tr>
<td>Try to talk about what upsets me.</td>
<td>but I would not know where to start (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004).</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>51. I keep what upsets me a secret.</td>
<td>I have an important secret that I haven’t shared with anyone (Self-Concealment Scale, Larson &amp; Chastain, 1990)</td>
</tr>
<tr>
<td>52. I <strong>do not</strong> discuss things that upset me.</td>
<td>When I’m distressed I don’t tell anyone (Distress Disclosure Index, Kahn &amp; Hessling, 2001)</td>
</tr>
<tr>
<td>53. I end up tongue-tied when I try to talk about what upsets me.</td>
<td>My throat gets tense and I just can’t speak properly if I talk about what really upsets me (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>54. I <strong>do not</strong> think that it helps to talk about what upsets me.</td>
<td>Talking about upsetting things changes nothing (Disclosure Avoidance Scale, Nanou, Stewart &amp; Cox, 2004)</td>
</tr>
<tr>
<td>55. I act like the things that upset me do not exist.</td>
<td>Sometimes I just pretend that what upsets me does not exist (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>56. I <strong>do not</strong> think that talking about what upsets me changes how I think about it.</td>
<td>Talking about upsetting things changes nothing (Disclosure Avoidance Scale, Nanou, Stewart &amp; Coxell, 2004)</td>
</tr>
<tr>
<td>57. I can say how I feel when something upsets me.</td>
<td>I am able to describe my feelings easily (Toronto Alexithymia Scale, Bagby, Parker &amp; Taylor, 1994)</td>
</tr>
<tr>
<td>58. I <strong>do not</strong> think that others would care if I talked about what upsets me.</td>
<td>New</td>
</tr>
</tbody>
</table>
Appendix L

The different facets of disclosure within the questionnaire
Table to show the different facets of disclosure within the questionnaire

<table>
<thead>
<tr>
<th>Themes</th>
<th>Number of Positive items</th>
<th>Number of Negative items</th>
<th>Total items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of consequences</td>
<td>4 (Items 1,7,15,17)</td>
<td>4 (Items 4,20,36,44)</td>
<td>8</td>
</tr>
<tr>
<td>Positive consequences</td>
<td>2 (Items 3,25)</td>
<td>2 (Items 6,29)</td>
<td>4</td>
</tr>
<tr>
<td>Increased distress</td>
<td>3 (Items 27,32,45)</td>
<td>3 (Items 2,9,57)</td>
<td>6</td>
</tr>
<tr>
<td>Physiological reasons</td>
<td>2 (Items 23,53)</td>
<td>1 (Item 18)</td>
<td>3</td>
</tr>
<tr>
<td>Avoidance</td>
<td>6 (Items 11,19,37,42,47,55)</td>
<td>6 (Item 5,6,8,10,12,48)</td>
<td>12</td>
</tr>
<tr>
<td>No efficacy</td>
<td>3 (Items 16,33,21)</td>
<td>2 (Item 56,54)</td>
<td>5</td>
</tr>
<tr>
<td>Availability of others</td>
<td>2 (Items 29,35)</td>
<td>1 (Item 14)</td>
<td>3</td>
</tr>
<tr>
<td>Unsure of feelings</td>
<td>2 (Items 39,49)</td>
<td>3 (Items 24,46 &amp; 57)</td>
<td>5</td>
</tr>
<tr>
<td>Keeping things to self</td>
<td>4 (Items 31,41,43,51)</td>
<td>5 (Items 22,26,34,38,52)</td>
<td>8</td>
</tr>
<tr>
<td>Difficulty expressing self</td>
<td>1 (Item 13)</td>
<td>2 (Items 28,50)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>29</td>
<td>58</td>
</tr>
</tbody>
</table>
Appendix M

Items within each factor as a result of Unweighted Least Squares factor analysis
Factor 1 – Tendency to disclose (21)

I do not want to trouble anybody by talking about what upsets me
I act as if I am not bothered about the things that upset me the most
I wish that I had not told anyone about the things that upset me
Talking about what upsets me does not change the way I feel
I am too embarrassed to tell people about what upsets me
I am not willing to tell anyone about what upsets me
I do not tell others upsetting secrets about myself
I look for others to talk with about what upsets me
I prefer to keep quiet about the things that upset me
I do not want to talk about the things that upset me
I do not feel that I can rely on others to keep secret what upsets me
I do not tell others about the things that upset me
I bottle up the things that upset me
I avoid talking about the things that upset me
I do not tell the truth if someone asks me why I am upset
I keep what upsets me a secret
I do not discuss the things that upset me
I do not think it helps to talk about what upsets me
I act like the things that upset me do not exist
I do not think that talking about what upsets me changes how I think about it
I can say how I feel when something upsets me

Factor 2 – Ease of disclosure (18)

I think that if I told anyone about what upsets me they would think that I had a psychological problem
I worry that people will think I am weak if I talk about what upsets me
When I talk about what upsets me it comes out wrong
Things go wrong when I tell others what upsets me
I do not talk about what upsets me because my throat tenses up and I just can’t speak. It is the things that have upset me the most that are hardest to talk about. My mouth goes dry when I talk about what upsets me. I can not decide whether or not to talk about what upsets me. I get upset and cry when I talk about what upsets me. I can not find the right words to describe what upsets me. I do not talk about what upsets me because I get too emotional. When I talk about what upsets me I just ‘go around in circles’. When I talk about what upsets me I get upsetting thoughts. I do not know what is going on inside me when I am upset. I am plagued by fears of talking about what upsets me. I do not know where to start when I try to talk about what upsets me. I end up tongue-tied when I try to talk about what upsets me.

Factor 3 – Positive beliefs about disclosure (5)

I think that it is helpful to get the things that upset me off my chest. I do not think that it is good to talk about what upsets you. I do not even ‘want to know’ about what upsets me. I think that talking about what upsets me is useful. I think that a problem shared is a problem halved.

Number of items within each factor rewritten from the existing questionnaires

Factor 1

(4) Self-Concealment Scale (Larson & Chastain, 1990)
(5) Distress Disclosure Index (Kahn & Hessling, 2001)
(2) Distress Disclosure Scale (Coates & Winston, 1987)
(7) Disclosure Avoidance Scale (Nanou, Stewart & Coxell, 2004)
(2) Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994)
(1) New

**Factor 2**

(2) Self-Concealment Scale (Larson & Chastain, 1990)
(0) Distress Disclosure Index (Kahn & Hessling, 2001)
(0) Distress Disclosure Scale (Coates & Winston, 1987)
(9) Disclosure Avoidance Scale (Nanou, Stewart & Coxell, 2004)
(2) Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994)
(4) New

**Factor 3**

(0) Self-Concealment Scale (Larson & Chastain, 1990)
(0) Distress Disclosure Index (Kahn & Hessling, 2001)
(2) Distress Disclosure Scale (Coates & Winston, 1987)
(0) Disclosure Avoidance Scale (Nanou, Stewart & Coxell, 2004)
(0) Toronto Alexithymia Scale (Bagby, Parker & Taylor, 1994)
### Research Log Checklist

<table>
<thead>
<tr>
<th></th>
<th>Formulating and testing hypotheses and research questions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
<td></td>
</tr>
</tbody>
</table>