BIBLIOTHERAPY FOR GENERALISED ANXIETY DISORDER: A CONTROLLED TRIAL COMPARISON AND EXPLORATION OF FACTORS RELATED TO OUTCOME

Thesis submitted for the degree of

Doctor of Clinical Psychology

at the University of Leicester

by

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September, 2001

2002

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Bibliotherapy for Generalised Anxiety Disorder – A controlled Trial Comparison and Exploration of Factors Related to Outcome.

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ABSTRACT

The pilot study served to develop and initially evaluate a cognitive behavioural bibliotherapy programme for use in treating Generalised Anxiety Disorder. Administered during 16 one hour appointments with a Psychologist, the programme was associated with significant improvements in anxiety, depression and problem severity.

The finalized programme comprised two components – information about anxiety and cognitive behavioural anxiety management guidance. In the main study 46 patients with a primary diagnosis of Generalised Anxiety Disorder were randomly allocated to one of two treatment conditions – receipt of the full programme or only the information component – or a waiting list control condition. Psychologist administration of the programme took 10 minutes.

Patients in receipt of the full programme experienced significantly greater gains than those in the waiting list condition in self assessed anxiety, depression, quality of life, and stress. There were no other between condition differences, but a trend in pre to post changes favouring the full programme. The presence of other co-morbid anxiety or depression conditions did not affect outcome.

Clinical improvements in both treatment conditions were associated with improvements in anxiety related health attitudes including self-efficacy. Additionally, clinical improvements in patients in the full programme condition were associated with improvements in coping skills and compliance with the programme. The potential inter-relationship between clinical, attitudinal and coping skills change, and programme compliance were discussed.

ACKNOWLEDGEMENTS

With thanks to my supervisors, Dr. Celia McCrea and Professor Ed Miller, for their guidance and advice; the individuals who took part in the research project and co-operated so helpfully with me; Janet Morris who showed almost superhuman patience in persisting with my handwriting to type the thesis; and my wife, Hilary, who looked after the children whilst I wrote it.

DEDICATION

To my parents to whom education was always an important end
in itself and who always encouraged my education over the years.

CONTENTS

CHAPTER 1

ANXIETY AND BIBLIOTHERAPY – A REVIEW

1.1 GENERALISED ANXIETY

1.1.1 What is it?

Prior to 1980, in DSM II (American Psychiatric Association, (APA) 1968) there was a category known as anxiety neurosis, defined as excessive anxiety over a prolonged period of time without marked phobic avoidance. It was a diagnostic category employed for people otherwise described as chronically anxious or suffering from free-floating anxiety (Marks and Lader, 1973; Wolpe, 1958) and tended to be a category used as a catch-all for people suffering from anxiety for whom it was not possible to ascribe a primary diagnosis of Panic Disorder (PD), agoraphobia (AP), Social Phobia (SP) or Obsessive-Compulsive Disorder (OCD).

In 1980, DSM III (APA, 1980) criteria were defined which set Generalised Anxiety Disorder (GAD) aside as a separate category defined in its own right. However, problems with the criteria were subsequently identified, most notably the requirement that the condition was present for only one month and the lack of an operational definition of what constituted worry

(DiNardo et al, 1983; Riskind et al, 1987). Such criticisms led to a redefinition in DSM III - R (APA, 1987) in which the duration criterion was increased to a minimum of six months, thus reducing the probability that the category was ascribed to transitory, reactive anxiety. Further, the nature of worry was further defined with a central criterion of pervasive worry focused on two or more life circumstances. Also, the diagnosis of GAD could be awarded as an additional diagnosis rather than as a category ascribed in the absence of other conditions.

The only two studies to examine the validity of the DSM III-R category of GAD reported promising but slightly conflicting results (DiNardo et al, 1989; Mannuzza et al, 1989;). In large part the conflict may have been due to their use of two different diagnostic interviews which emphasised different aspects of the DSM III-R criteria. The study by DiNardo et al (1989) used the ADIS-R interview format (DiNardo & Barlow, 1988) in which the criteria relating to worry are central (as intended within DSM III – R), and revealed the strongest support for GAD as a valid category which can be reliably diagnosed as separate from other anxiety disorders.

Whilst there is some further evidence supporting the view that GAD is different from Panic Disorder (PD) and Dysthymia (Ryskind et al, 1991), there is also evidence of considerable commonalities and overlap between the different anxiety

disorders (Barlow et al, 1986; Turner et al, 1986). Further, GAD is often found to co-exist with other disorders (Brauman-Mintzer & Lydard, 1996), especially social phobias (Rapee et al, 1988; Sanderson & Barlow, 1990).

The tendency to worry has also been shown to be highly correlated with trait anxiety (Borkovec et al, 1993) but not state anxiety (Eysenck, 1992). Worry can be seen as a normal aspect of human functioning and the content of 'normal' worries has been found to be similar to that reported by sufferers of GAD (Craske et al, 1989). Such findings led Rapee (1991) to conclude that GAD is akin to trait anxiety and should perhaps be viewed as the basic anxiety disorder, a condition which can co-exist with other, more specific types of anxiety. He also proposes that therapies which focus on GAD could have a broader impact, helping perhaps not just GAD sufferers but also people with more specific anxiety disorders with successful treatment of GAD resulting in dramatic improvements in co-morbid conditions (Borkovec, Abel & Newman, 1993). Tyrer et al (1993) broadens the potential central role of GAD, suggesting it is a central part of the disposition to neurotic disorder. Support for such views comes from the work of Borkovec et al (1995) who found successful treatment of GAD was associated with significant reductions in a range of comorbid anxiety disorders and dysthmia.

1.1.2 Epidemiology of GAD

While early studies put the lifetime prevalence of GAD as high as 45% (Breslau, 1985), this was done using the looser criteria from DSM III. Imposing the more stringent criterion of a duration of at least 6 months caused prevalence estimates to drop to between 4% (Barlow, 1988) and 9% (Breslau & Davis 1985). Such figures are considerably higher than equivalent prevalence rates for PD or OCD (Regier et al, 1988), indicating that GAD is one of the more common anxiety disorders in the general population. Such findings are in stark contrast to the finding that GAD is one of the least common anxiety disorders to present to Mental Health Centres accounting for only 10% of referrals to one specialist anxiety clinic (Barlow 1988). This may reflect the aforementioned close link between "normal" worry which may discourage sufferers from seeing it as a disorder. Indeed, Rapee, (1985) found that sufferers from GAD were more likely to seek help from alternative sources such as acupuncturists or self-help books rather than from conventional health professionals. Hence, the efficacy of self-help approaches is particularly salient to sufferers of this disorder, an issue given added emphasis by its relatively high prevalence rate.

1.1.3 Therapy for GAD

Unfortunately, the early research into the treatment of generalised anxiety was severely limited by the pre DSM III

difficulties in diagnosing it reliably and validly. The result was that many studies contained heterogeneous patient populations in which general anxiety was confused with hypochondriasis, mild personality disorder, agoraphobia or social phobia (Butler & Booth, 1991). Given Barlow's (1988) finding that GAD is infrequently presented to specialist clinics, the likelihood is that the majority of patients in such studies had anxiety diagnoses other than GAD.

Another limitation when interpreting the results of early studies is their general tendency to use analogue populations, typically university students. Hence, the results may not generalise readily to clinical populations.

These qualifications aside, treatments found to be of some efficacy in the treatment of generalised anxiety included relaxation training (Hutchins et al, 1980; Lebouef & Lodge, 1980; Lewis et al, 1978; Raskin et al, 1980), EMG feedback (Lebouef & Lodge, 1980; Raskin et al, 1980) and transcendental meditation (Raskin et al, 1980) The study by Lebouef and Lodge (1980) was the only one to use a clinical population. It reported the gains obtained using relaxation training or EMG to be so limited as to be of questionable use as a sole treatment for generalised anxiety.

Whilst there appears to be a recent increase in studies focussing on GAD, it is still relatively understudied compared with other anxiety conditions (Norton et al, 1995). More recent research has used clinical populations defined via the DSM-III or DSM-III-R criteria, thus improving the identification of patients suffering from GAD. Promisingly, conclusions from this literature may generalise to GAD as defined by DSM-IV, given clients who meet GAD criteria for DSM-III-R routinely also meet DSM-IV criteria (Abel & Borkovec, 1995).

Perhaps reflecting the central role of worry in GAD, reviews of randomised clinical trials suggest that cognitive or cognitive behavioural therapy can bring about significant improvements in GAD (e.g. Borkovec & Wiseman, 1996; Chambless & Gillis, 1993; Fisher & Durham, 1999).

Cognitive behavioural therapy in the studies reviewed can vary in its content considerably. It can range from Meichenbaum's (1976) Stress Innoculation Training (e.g. Ost, 1985), or Suinn and Richardson's (1971) Anxiety Management Training (e.g. Jannoun et al, 1982), across to the more complex, detailed cognitive therapy based on the work of Beck (eg Beck et al, 1985) (e.g. Butler et al, 1991).

Results indicate that individual cognitive behavioural therapy is more effective than a waiting list control (Barlow et al, 1984; Blowers et al, 1987; Butler et al, 1987, 1991; Jannoun et al, 1982; Ost, 1985; Power et al, 1990; Rapee & Barlow, 1986). White et al (1992, 1995) also showed that cognitive therapy in a group psycho-educational format was superior to a waiting list control.

In comparison with other therapies, the picture is less clear cut. Cognitive behavioural therapy has been shown to be superior to pharmacotherapy (Lindsey et al, 1987; Power et al, 1990) or inferior (Biswas & Chattopadhyoy, 1985). However, the latter study contained a very small and restricted sample of 16 males aged 25 – 35 years and the superiority of pharmacotherapy was lost at 4 month follow-up.

Compared with behaviour therapy, cognitive behaviour therapy has been shown to be superior (Butler et al, 1991; Durham & Turvey, 1987; Durham et al, 1994, 1999) or equivalent (Borkovec & Costello, 1993; Lindsey et al, 1984; White et al, 1992, 1995; White, 1998).

The equivalence in the latter five studies may be ascribed at least in part to non specific aspects of therapy (e.g. White, 1992). In the psychotherapy literature more generally, equivalence between different therapies is a frequent finding (Stiles et al,

1986). This has led some to hypothesise the importance of non-specific effects of therapy, effects common to most if not all therapeutic approaches. Such processes potentially active in the treatment of anxiety might include the provision of a credible explanation of anxiety (Borkovec & Mathews, 1988; White et al, 1992) or the installation of hope or the expectation of positive change and/or the provision of an increased sense of control (Barlow , 1988). Unfortunately, evidence in direct support of such ideas does not yet exist.

Another potential explanation of the equivalence in outcome reported above is the presence of between condition overlaps in content in two of the studies (Borkovec & Costello, 1993; Lindsey et al, 1987). In particular, the cognitive behavioural and behavioural conditions in both studies contained relaxation components, a treatment shown to be of use in its own right in the treatment of generalised anxiety (Hutchins et al, 1980; Leboef & Lodge, 1980; Lewis et al, 1978; Raskin et al, 1980).

Whilst the White et al study (1992, 1995) clearly distinguished in content terms between the cognitive and behavioural conditions, another potential explanation of their finding of equivalence is the nature of the large group therapy format employed. On average, 20-24 patients took part in 6 therapy group sessions which were described as didactic in nature. It is possible that such a format

is better suited to a behavioural approach, relying as it can on instruction and guidance. In contrast, cognitive therapy relies on active questioning of belief structures, potentially initially between therapist and client. This may be less readily achieved in a brief, didactic, large group context, thus reducing the efficacy of the cognitive therapy.

Moving on to comparisons between cognitive behavioural therapy and other forms of psychotherapy, Durham et al (1994, 1999) found that cognitive therapy was superior to analytical psychotherapy, both forms of therapy effecting significant changes pre to post .

When compared with non-directive therapy, the relative efficacy of cognitive behaviour therapy is once again promising but not conclusively so. Borkovec et al (1987) found cognitive restructuring (see Beck & Emery, 1979, 1985) plus relaxation was therapeutically equivalent to 'non-specific' therapy plus relaxation when judged by independent assessors' ratings. However the cognitive therapy condition was superior on the client's subjective measures. The 'non-specific' therapy was described in terms similar to Rogerian counselling. Similarly mixed results were obtained by Blowers et al (1987). They found cognitive therapy superior to Rogerian non-directive therapy on only two measures. However, whereas the cognitive therapy condition was

significantly superior to the wait list condition on all measures, the Rogerian condition was not. In contrast, a subsequent study by Borkovec and Matthews (1988) found significant and equal gains produced by each of three therapy conditions: cognitive restructuring plus relaxation, non-specific therapy plus relaxation, or imaginal systematic desensitisation plus relaxation. They argued that the partial contradiction to their previous study (Borkovec et al, 1987) may have been in part due to the presence in the earlier study of a more severe and chronic client group which emphasised differences between the treatment conditions.

The inclusion of relaxation therapy as a common component of each treatment condition in the Borkovec et al (1987) and Borkovec and Matthews (1988) again makes it impossible to draw clear conclusions about the conditions' differential effectiveness.

Given the often chronic and relapsing nature of GAD (Rickels & Schweizer, 1990), it is important to note that the gains found with cognitive behavioural therapy have generally maintained at follow-up (eg Blower et al, 1987; Borkovec & Matthews, 1988; Butler et al, 1987; Rapee & Barlow, 1988). Indeed, the gains have maintained up to one (Borkovec & Castello, 1993; Durham et al, 1999) to two years (White, 1998). Further, in Durham et

al's (1999) study, patients in the cognitive therapy condition had continued to improve.

Taken together, the studies reported above indicate that cognitive behavioural therapy can be an effective treatment for GAD, with gains that maintain up to two years. In some cases, it may be superior to other forms of therapy such as pharmacotherapy (Lindsey et al, 1987; Power et al, 1990), behaviour therapy (Butler et al 1991; Durham & Turvey, 1986; Durham et al, 1994, 1999), analytical therapy (Durham et al, 1994, 1999) or non directive therapy (Blower et al, 1987)

However, in all the studies reporting the relevant data, it appears that even with significant gains following cognitive behavioural therapy, a significant percentage of patients can remain significantly distressed. The review by Chambless and Gillis (1993) reported the percentage of patients left as clinical cases to vary between 27 and 68%. In their more recent review, Fisher and Durham (1999) report that whilst about 60% of patients will show some significant improvement, only about 40% will have recovered. They conclude that this indicates that whilst cognitive behavioural therapy has promise, GAD is a difficult condition to treat.

As such, it is perhaps important to continue developing the model of GAD and relatedly, the best form of therapy. For example, Borkovec and Newman (1998) suggest the importance of extending the cognitive behavioural model of GAD to encompass elements of attachment theory (Bowlby, 1982), a theory arising from the psychodynamic literature. As a corollary, they suggest effective therapy for GAD may need to be multi-component including cognitive, behavioural and interpersonal elements.

Such an integration of cognitive, behavioural and interpersonal models has been proposed to be more generally appropriate by Ryle (1991). In part, he argues from the premise that no one model of therapy has been shown conclusively to be the most effective, referring to the outcome equivalence paradox (Stiles, 1985). Certainly the review of GAD outcome literature above indicated that non cognitive therapies may be of at least some benefit to GAD sufferers, eg relaxation therapy (Hutchins et al, 1980; Lebouef & Lodge, 1980; Lewis et al, 1978; Raskin et al, 1980); EMG feedback (Lebouef & Lodge, 1980; Raskin et al, 1980); behaviour therapy (Butler et al, 1991; White et al, 1992, 1995); analytical psychotherapy (Durham et al, 1994, 1999) and non directive therapy (Borkovec & Matthews, 1988).

1.1.4 Therapy For GAD – The Format

The above review indicates that cognitive behavioural therapy for GAD is currently the most effective treatment available.

Given that the current study intends to evaluate such a treatment approach within a self-help bibliotherapy format, consideration needs also to be given to the role of format in determining treatment efficacy. More specifically, the role of the amount of therapist contact in determining outcome.

Studies reporting positive outcomes with cognitive behavioural therapy have reported a wide range of levels of therapist contact. These include only 6 hours (Jannoun et al, 1981), 8.7 hours (Butler et al, 1987), 18 hours over 14 weeks (Barlow et al, 1984) up to 20 hours over 6 months (Durham et al, 1994).

Unfortunately, firm conclusions from such comparisons are difficult to make given the therapies differ between the studies, as too do the patient groups. For example, in contrast to Barlow et al (1984) and Durham et al (1994), Butler et al (1987) excluded patients whose condition had lasted more than 2 years. As there is evidence that severity and chronicity are highly correlated (Breslau & Davies, 1985), it is possible Butler et al's (1987) shorter therapy was offered to a less severe clinical population. Barlow et al (1984) and Durham et al (1994) also based their work on Beck and Emery's (1979, 1985) cognitive behaviour therapy. In contrast, Butler et al (1987) based their cognitive therapy on the arguably simpler to assimilate Anxiety Management Training of Suinn and Richardson (1971). Hence it

is possible that Butler et al's (1987) very low level of therapist contact was achieved because a simpler therapy was offered to less severely disturbed patients.

Further indirect support for the premise that reductions in therapy time can be achieved comes from the findings that the gains noted during therapy were made by the mid point of cognitive therapy, i.e. after only 13.5 hours in the Durham and Turvey (1987) study and after only 8 hours in the Lindsey et al (1987) study. Similar findings are again noted in the broader psychotherapy literature (Howard et al, 1986). However, what is unclear in these studies is the importance of subsequent sessions in facilitating maintenance of such gains.

In this regard, Durham et al (1994, 1999) systematically varied the amount of therapist contact within a given treatment modality with equivalent patient samples. Patients received either an average of 15.4 or 8.5 hours of cognitive behavioural therapy. They found that despite no differences between high and low contact conditions at follow-up, there were significant differences at 1 year follow-up. The high contact condition had continued to improve whereas the low contact condition had deteriorated. Despite this deterioration, the cognitive behavioural low contact condition was still superior to the two other treatment conditions

employed at similar levels of therapist contact, i.e. analytical and anxiety management therapies.

The potential for less therapist contact resulting in lower treatment efficacy was proposed earlier as being one potential reason why White et al (1992, 1995) failed to find differential outcomes between treatments. In similar vein, Butler and Booth (1991) have suggested that some forms of cognitive behavioural therapy may be so complex as to overload patients if insufficient time is given during therapy.

The above research offers some indirect and direct support for the belief that the amount of therapist contact can be greatly reduced during cognitive therapy for GAD whilst still achieving clinical improvements (e.g. Butler et al, 1987; Durham et al, 1994; Jannoun et al, 1981). However there is the possibility that the effectiveness of the therapy is reduced (Butler & Booth, 1991; Durham et al, 1999).

1.1.5 Summary and Conclusions from the GAD Literature.

Before turning to look at the literature relating to Bibliotherapy, summarised below are the key conclusions drawn from the above review of research into GAD which are relevant to the proposed study.

In recent years, GAD has been recognised as a condition separate from other AXIS I anxiety conditions but with a considerable degree of overlap (APA, 1968, 1987). Indeed it has been suggested that GAD is akin to trait anxiety and should perhaps be viewed as the basic anxiety disorder, a condition that will often co-exist with other, more specific types of anxiety (Rapee, 1991). This is important given much of the literature to date has focused on the treatment of specific anxieties and yet GAD is not only more common (Regier et al, 1988), it also presents less frequently to mental health centres (Barlow, 1988). Hence, effective treatments for GAD need to be found and it has been suggested these may also have relevance for the sufferers of specific anxiety disorders (Rapee, 1991).

The evidence from the literature to date regarding treatment of GAD indicates that cognitive behavioural therapy is the most effective therapy currently available (Borkovec & Whisman, 1996; Chambless & Gillis, 1993; Fisher & Durham, 1999). That said, after therapy the majority of patients may continue to experience clinical levels of GAD (Chambless & Gillis, 1993; Fisher & Durham, 1999).

Less effective but still potentially of value are other forms of therapy including relaxation therapy (e.g. Lebouef & Lodge, 1980), behaviour therapy (Butler et al, 1991; White et al, 1992,

1995; White, 1998), analytical psychotherapy (Durham et al, 1994,1999) and non-directive therapy (Borkovec & Matthews, 1988).

It has been proposed that effective therapy for GAD needs to be multimodal in nature, containing cognitive, behavioural and interpersonal components (Borkovec & Newman, 1998).

There is also evidence indicating that effective cognitive behavioural treatment of GAD can occur with relatively low levels of therapist contact (Butler et al, 1987; Jannoun et al, 1981; White, 1992, 1995; White, 1998). However, this may be at the expense of a lower level of efficacy (Durham et al, 1999).

It may be speculated that less complex forms of cognitive behavioural therapy can be transmitted with lower levels of therapist contact (e.g. Butler et al, 1987). More therapist contact may facilitate the transmission of more complex forms of therapy (Butler & Booth, 1991) and potentially relatedly, facilitate maintenance of therapy gains, as found by Durham et al (1999).

The suggested non specific aspects of therapy may contribute to positive outcomes, perhaps independent to some degree of the amount of therapist contact. In relation to GAD, these aspects include the provision of a credible explanation of anxiety

(Borkovec & Matthews, 1988; White et al, 1992) and the instillation of hope, the expectation of positive change and/or the provision of an increased sense of control (Barlow, 1988).

1.2. BIBLIOTHERAPY

1.2.1 The Efficacy of Bibliotherapy – a General Review

As already noted, the studies by Jannoun et al (1982) and Butler et al (1987) showed that GAD could be successfully treated by therapies which offered considerably less time with a therapist than other comparable studies. Interestingly, both these studies made use of educational booklets supplied to clients during therapy. These booklets provided clients with information on the nature and causes of anxiety and background material as to the ways of dealing with it. Although it can be speculated that such booklets helped bring about the noted savings in therapist's time, the impact of the booklets was not separately assessed.

Such savings in therapist time, perhaps to the extent of removing therapist contact completely, is currently an important issue for the NHS. Faced by the perhaps inevitable short-fall between the level of demand for mental health services and the resources available, in the author's experience mental health and primary care services are increasingly considering the use of

bibliotherapy or CD-rom therapy programmes as an alternative to at least some therapist based care. In such circumstances, it is important to test the efficacy of such programmes.

There is a large body of research showing that the use of such educational booklets with or without therapist contact can achieve important clinical gains in a wide range of clinical conditions (see Glasgow & Rosen, 1978, 1982; Gould & Clum, 1993; or Marrs, 1995, for fuller reviews of this literature). Gains with bibliotherapy with varying degrees of therapist contact have been noted in the treatment of disorders or problems as diverse as headaches (e.g. Blanchard et al, 1990), smoking cessation (e.g. Pederson et al, 1981), drinking reduction (e.g. Heather, 1986), social skills deficits (e.g. Dalton et al, 1992), sexual dysfunction (e.g. van Lankveld, 1998), parent and child training (e.g. Rakos et al, 1985), depression (e.g. Cuijpers, 1997), insomnia (e.g. Alperson & Biglan, 1979), phobias (e.g. Gould et al, 1993), agoraphobia (e.g. Lelliot et al, 1987) and eating disorders (e.g. Carter & Fairburn, 1998).

Generally such programmes are based on behavioural principles which presumably may be readily operationalised in written format and are also of clinical relevance to disorders readily analysed in behavioural terms, e.g. habit disorders such as smoking or drinking, or phobic disorders. Indeed, Gould and

Clum's (1993) effect size analysis of bibliotherapy treatments identified that bibliotherapy was more effective with conditions such as social skills deficits or fear reduction, although this may have been a function of the ease of operationalising outcome in such treatment which increased the likelihood of effective measurement.

Gains achieved by bibliotherapy have generally been shown to maintain, perhaps reflecting one positive advantage of bibliotherapy which is that clients have the materials to keep and refer back to, thus facilitating both maintenance of therapeutic gains and potentially providing them with a source of new ideas should new problems occur in the future.

Perhaps somewhat surprisingly, both Gould and Clum (1993) and Marrs (1995) conclude that bibliotherapy can be as effective as therapist-led programmes. However, they also conclude from their review that the bibliotherapy's effectiveness was generally enhanced for some types of disorder such as anxiety by the addition of therapist contact. The effect sizes obtained by bibliotherapy compared favourably with those found in reviews of the psychotherapy literature (eg Shapiro and Shapiro, 1983). However, given the effect size is greater for bibliotherapy approaches to conditions which may be construed as less

complex than those typically addressed by a psychotherapy, such equivalence may be artificial.

Intuitively, one might expect drop outs to be a significant problem for self-help approaches, an expectation apparently confirmed in Glasgow and Rosen's reviews (1978, 1982) where rates as high as 50% were reported. Somewhat in contrast, Gould and Clum's (1993) more recent review reported drop out rates which averaged only 9.7%, a figure comparable to untreated controls (8.6%), and a level very similar to those reported in the psychotherapy literature (Shapiro & Shapiro, 1983).

Gaps identified in the bibliotherapy literature include evaluation of the role of moderator variables such as personality type, reading ability and education level (Marrs, 1995).

1.2.2 The Efficacy of Bibliotherapy for Anxiety Conditions

There is an extensive literature showing bibliotherapy to be effective in phobic fear reduction. The early studies whilst very positive in their findings (e.g. Baker et al, 1973; Marshall, 1976) typically used analogue populations, thus limiting their results' generalisability. More recent studies using clinical populations have confirmed bibliotherapy's efficacy in aiding phobic fear reduction (e.g. Alkubaisy et al, 1992; Ghosh et al, 1988; Gould et al, 1993).

The contents of the bibliotherapy programmes tested have all been based on systematic desensitisation principles, a technique well established and effective for the treatment of phobic disorders (Blanchard et al, 1985) but with far less relevance to generalised anxiety. As suggested above, bibliotherapy may be particularly suited to the administration of a highly structured but in principle relatively simple form of therapy such as systematic desensitisation. It could be suggested that bibliotherapy may be of less use as a medium for the transmission of more complicated and multi-faceted treatment protocols as might be necessary in the treatment of more complicated forms of anxiety, e.g. agoraphobia, panic disorder or GAD disorder.

There is as yet relatively little research evaluating bibliotherapy for such conditions. Taking agoraphobia first, there is research indicating that therapist's contact time can be significantly reduced by the use of home-based treatment programmes which make use of the patient's spouse plus a self-treatment manual (Jannoun et al, 1980; Matthews et al, 1977). Average therapist's time was 6.9 hours (excluding follow-up) in the Matthews et al (1977) study and this was subsequently reduced successfully to 3.5 hours (also excluding follow-up) in the Jannoun et al (1980) study which used the same booklets as Matthews et al.

Neither of these studies controlled for the effect of the manuals on their own but in a subsequent study, Matthews et al (1981), obtained favourable findings when using the manuals with no therapist contact. Similarly favourable findings were obtained by Weeks (1973) in an uncontrolled consumer survey of readers of her books on agoraphobia. Less favourable results were obtained in a study by Holden et al (1983). Using chronic agoraphobics who could not get to the clinic for treatment, Holden et al found the use of manuals to be totally ineffective when therapist contact comprised one hour during which the manual was introduced to the patient with, subsequently, contact being limited to weekly 10 minute telephone calls during which the therapist attempted to motivate patients to continue with the programme and answered any queries they may have. Holden concluded that the self-help phase to the treatment did not work due to problems of compliance with the instructions to engage in the exposure component of therapy. In the subsequent stage of the study, 4 of the 6 patients involved showed at least moderate improvement following weekly sessions with a therapist of approximately 2 hours duration each over a period between 4 to 8 weeks. Holden et al ascribes his initially poor results to the use of a more chronic population who were also potentially less motivated than those in either the Matthews et al (1981) or the Weeks (1973) studies.

It is also perhaps worth noting that Matthews et al (1981) excluded from their trial clients whose partner refused to participate in the exposure component of therapy. Given the proposal (eg Goldstein & Chambliss, 1978) of a relational component in the aetiology of at least some agoraphobia, Matthews et al (1981) may have inadvertently excluded more severely disturbed clients. It may also be the case that the programme used differed significantly between studies. The problem of compliance identified by Holden et al (1983) is one which is a very common finding in the wider self-help literature relating to the treatment of anxiety. For example, Rosen et al (1976) found approximately 50% of snake phobics failed to complete their programme in the self-help condition and subsequent improvement was correlated with the degree of compliance shown.

In another controlled trial of agoraphobics, Lelliot et al (1987) found equivalent results between therapist aided and unaided bibliotherapy, with gains that maintained at 5 year follow-up. The therapist contact only amounted to three to six 45 minute sessions of therapist accompanied exposure. This relatively low level of contact may have been insufficient to assess the potential benefits of therapist contact.

The literature to date for panic disorder (P. D) is unfortunately just as sparse. The four studies the author is aware of indicate that cognitive behavioural bibliotherapy can be of help in the treatment of panic disorder (Gould et al, 1993; Gould & Clum, 1995; Hecker et al, 1996; Lidren et al, 1994). It has proved more effective than waiting list conditions (Gould et al, 1993; Gould & Clum, 1995; Lidren et al, 1994) and of equivalent effectiveness to individual cognitive behavioural treatment (Gould et al, 1993; Hecker et al, 1994) or group cognitive behavioural therapy (Lidren et al, 1994).

Favourable findings of a limited nature for bibliotherapy have been reported in the eight studies the author is aware of that have focussed on more general anxiety (Donnan et al, 1990; Finch et al, 2000; Holdsworth et al, 1996; Kiely & McPherson, 1986; Kupshik & Fisher, 1999; Milne & Covitz, 1988; Sorby et al, 1991; White, 1995). These studies will be reported on in some detail here given their direct relevance to the current study.

Each of the studies is hampered by design problems, many of them quite significantly so. These include the absence of pre measures (Finch et al, 2000; Kiely & McPherson, 1986); poorly defined selection criteria (Donnan et al, 1990; Finch et al, 2000; Holdsworth et al, 1996, Milne & Covitz, 1988); the inclusion of a broad range of anxiety conditions within each study (Donnan et

al, 1990; Finch et al, 2000; Holdsworth et al, 1996; Kiely & McPherson, 1986; Kupshik & Fisher, 1999; Milne & Covitz, 1988; Sorby et al, 1991; White, 1995); the absence of compliance measures (Donnan et al, 1990; Finch et al, 2000; Holdsworth et al, 1996; Milne & Covitz, 1988; Sorby et al, 1991; White, 1995); the lack of independent checks on patient suitability (Finch et al, 2000; Holdsworth et al, 1996; Kupshik & Fisher, 1999; Milne & Covitz, 1988; White, 1995); the absence of an adequate control condition (Finch et al, 2000; Kupshik & Fisher, 1999); poorly defined or controlled comparison conditions (Donnan et al, 1990; Holdsworth et al, 1996); and the absence of a definition of how much therapist contact was offered in the different bibliotherapy conditions (Kupshik & Fisher, 1999).

Comparison between studies is also made difficult due to a number of factors. These include the use of anxiety populations which potentially varied considerably between studies in the nature of anxiety disorders included. Further, clarification of this issue is hampered by the wide range of diagnostic criteria used to define the samples chosen. The populations chosen and criteria used to do so included anxiety neurosis and allied conditions using the Royal College of General Practitioner Codes (RCGP, 1984) (Kiely & McPherson, 1986); GP diagnoses of anxiety, unspecified (Donnan et al, 1990; Milne & Covitz, 1988); GP diagnoses of anxiety, depression or both, again unspecified

(Holdsworth et al, 1996); a range of anxiety disorders including GAD, using DSM-III (Sorby et al, 1991) or DSM-III-R (White, 1995) criteria; mild to moderate anxiety defined using the Zung Anxiety Scale (Zung, 1971) combined with the exclusion of any co-morbid conditions (Kupshik & Fisher, 1999); and self-diagnosed chronic anxiety (Finch et al, 2000). No study exclusively focussed on GAD despite its relatively high prevalence rate (Regier et al, 1988) and proposed role as central to other anxiety conditions (Rapee, 1991).

A second difficulty when comparing between studies is the variation in the nature of the bibliotherapy condition. Bibliotherapy included a 14 page information only leaflet (Kiely & McPherson, 1986); 27 – 67 page treatment manuals (Holdsworth et al, 1996; Milne & Covitz, 1988; White, 1995); or a combination of audio and video tapes (Finch et al, 2000). The content where defined was generic information only (Kiely & McPherson, 1986); behavioural (Milne & Covitz, 1988), or cognitive behavioural (Donnan et al, 1990; Finch et al, 2000; Holdsworth et al, 1996; Kupshik & Fisher, 1999; Sorby et al, 1991; White, 1995). There were varying degrees of therapist contact associated with the bibliotherapy, ranging from totally self-administered (Donnan et al, 1990; Finch et al, 2000; Holdsworth et al, 1996; Milne & Covitz, 1988); GP administered taking about 5 minutes (Kiely & McPherson, 1986); therapist administered taking 30 minutes

(White, 1995); or nurse administered with three levels of contact ranging from telephone contacts of unspecified frequency or duration up to weekly face to face contacts of unspecified duration (Kupshik & Fisher, 1999).

Bearing in mind these design limitations and differences, each of the study's results are summarised below, taking them in chronological order.

Kiely and McPherson (1986) evaluated GP administered information only leaflets, with no coping advice, describing the causes and consequences of stress. The content followed from a range of psychological and medical models of stress. GPs spent up to 5 minutes administering the leaflets to patients. Compared with GP treatment as usual at the 3 month point, the bibliotherapy condition led to superior improvements in general symptom level and GP consulting rates for psychological reasons. There were no drop-outs from either condition.

Milne and Covitz (1988) compared three conditions: two forms of behavioural bibliotherapy (a comprehensive manual including relaxation instructions, or a two page leaflet containing information and coping advice) and a GP treatment as usual control group. Only one within group improvement was reported, an increase at 6 months in knowledge of anxiety management within the leaflet condition. No between group comparisons were reported. There were trends indicating the potential superiority of

the bibliotherapy conditions. The lack of statistically significant differences were ascribed by the authors as being potentially related to the very small sample sizes in the three conditions, the total sample size being only 18. There was a 16% drop-out rate overall, across all 3 conditions.

Donnan et al (1990) compared patients receiving a range of treatments as normal including counselling with or without the addition of a self-administered cognitive behavioural manual including a relaxation tape. They reported significantly better outcomes on anxiety and depression measures for those in the bibliotherapy condition at 6 weeks, but by 3 months the superiority was only shown on the depression measure. There was a 41% drop-out rate overall at 3 months, with a rate of 43% in the bibliotherapy condition.

Sorby et al (1991) reported modest short-term gains in anxiety symptoms for patients receiving a cognitive behavioural manual when compared with those receiving GP treatment as usual. Patients receiving the manual improved more quickly but apparently both groups were equally improved after 8 weeks. The analysis reported did not include post hoc tests to clarify the meaning of an Analysis of Variance time x condition interaction. There were no drop-outs from the manual group.

White (1995) compared patients receiving a therapist administered cognitive behavioural manual, a therapist advice session lasting 30 minutes; or GP treatment as usual. At 3 months, the bibliotherapy condition was superior to the other two on a range of anxiety, depression and general symptoms measures. All patients in the study were subsequently offered the option of individual cognitive behavioural therapy. 44% of those in the bibliotherapy condition declined because they felt sufficiently improved, compared with 5% in the advice only and 0% in the GP treatment conditions. After receiving this individual therapy, patients in all 3 conditions had significantly improved but those in the bibliotherapy condition continued to improve at a greater rate. These gains and the superiority of the bibliotherapy condition maintained at 1 year (White, 1995) and 3 year (White, 1998) follow-ups. Patients in this condition also required significantly fewer individual therapy appointments. In terms of the clinical significance of the gains found, White (1998) reported 3 year follow-up anxiety caseness levels of 22%, 62% and 58% in the bibliotherapy, advice only and GP treatment conditions respectively, compared with 3 month levels of 62%, 90% and 95% respectively. Seemingly then the provision of bibliotherapy before individual therapy enhances its effectiveness. White (1995) also reports findings which indicate that bibliotherapy on its own is less effective than individual therapy. There were no drop-outs in the bibliotherapy condition.

Holdsworth et al's (1998) comparison of a cognitive behavioural manual with GP treatment as usual revealed no significant between group differences at the 3 month point. There were significant improvements in anxiety and depression within both conditions, with a non significant trend for better results in the bibliotherapy condition. It is possible that any between group differences were reduced by uncontrolled for changes in the GP treatment as usual condition. At least some of these GPs had received a manual of their own, advising them as to the psychological treatment of anxiety. There was a 44% drop-out rate in the bibliotherapy condition.

Kupshik and Fisher (1999), in a poorly reported study, found patients receiving a cognitive behavioural manual plus weekly appointments of unspecified length with a nurse over 6 weeks were significantly improved in their anxiety at the 6 week point compared with those receiving the manual plus an unspecified number of telephone contacts of unspecified duration. By 3 month follow up, 50% of the patients had dropped out; the differential drop-out rate across conditions was not reported. There was a degree of maintenance of post therapy gains, with 69% of those who had initially made a clinically significant change retaining this. In the low contact, telephone only condition, 43% of patients were reported as clinically improved at

6 weeks, the absence of a no treatment control preventing ascription of this to the bibliotherapy.

Finally, Finch et al (2000) found patients receiving an extensive 16 tape audio and video cognitive behavioural programme improved significantly after only 6 weeks. The absence of any comparison group prevents ascription of these changes to the programme. However, the authors argue that their sample were chronically anxious, making unlikely rapid change due to time alone. The population sampled was poorly defined, on the basis of self diagnosis with 'the majority' suffering anxiety for 5 – 10 years. Two thirds of their sample had dropped out by the 6 week stage.

In the above studies, there was a limited degree of exploration of the processes within conditions that may influence outcome. Increased knowledge about anxiety management following bibliotherapy was found but it was not linked with outcome (Milne & Covitz, 1988). In contrast, Kiely and McPherson (1986) found no increase in knowledge about stress following bibliotherapy, despite the clinical superiority of this condition. Nor did they find it resulted in changes in coping behaviour, perhaps not surprisingly given the bibliotherapy programme evaluated contained no advice on coping. Holdsworth et al (1996) did find bibliotherapy resulted in increased cognitive coping and reduced

avoidance coping but there was no link with outcome. Kupshik and Fisher (1999) found a significant relationship existed between the degree of programme compliance and degree of therapist contact, with a trend indicating compliance was linked positively with outcome. This paralleled their finding of a significant positive relationship between outcome and degree of therapist contact. Kiely and McPherson (1986) found no such relationships, they argued potentially due to the high level of compliance in their bibliotherapy condition creating a threshold effect.

Patient characteristics linked with improvement on the basis of non significant trends are a lower level of formal education (Finch et al, 2000; Kupshik & Fisher, 1999) and younger age (Finch et al, 2000). No consideration was made in the 8 studies reviewed of the role of condition severity or chronicity.

Other processes speculated to be linked with improvement included a reduction in patients' anxiety about their condition following information about stress (Kiely & McPherson, 1986). This study employed detailed post intervention interviews and identified patients as feeling reassured by the bibliotherapy, viewing their symptoms in less catastrophic terms. This is a view similar to that expressed by Gould et al (1993) who found reductions in panic frequency were unrelated to changes in coping behaviour. Instead, they speculated that improvements in

panic severity and frequency were linked in some way with the parallel large changes noted in self-efficacy (Bandura, 1977). This, they reasoned, reflected an increased sense of competence in patients and a reduced tendency to catastrophise their panic symptoms. Hence, even if panics occurred, they were likely to be less severe, as follows from Clark's (1986, 1996) cognitive model of panic attacks. In similar vein, Borden et al (1991) hypothesised that a sense of control was an important determinant in coping better with panic attacks. Further, White (1995) suggested that bibliotherapy increased a patient's sense of responsibility for the change process, an ascription of responsibility which might be expected to enhance self-efficacy. The potential importance of self-efficacy as a factor in the process of therapeutic change is a topic which is returned to later in this review.

Another process potentially at work in improvements achieved via bibliotherapy more generally is the potential for increased retention of information when compared with standard psychotherapy (cf Ley, 1977). This potential is perhaps borne out by White's' (1995) finding that the bibliotherapy condition showed the greatest gains at the 12 month follow-up point, even after patients had received individual cognitive therapy. The bibliotherapy condition may have both helped prepare patients

for individual therapy and also to retain the information thereby obtained.

These are issues returned to later in Section 1.4 when discussion focuses on the design of the current study.

1.2.3 Summary and conclusions from the bibliotherapy literature

Before turning to a discussion of self-efficacy, summarised below are the main conclusions to be drawn from the above reviews of the general and anxiety bibliotherapy literatures.

There is now considerable evidence supporting the efficacy of bibliotherapy in the treatment of a wide range of non-anxiety and anxiety based disorders (Glasgow and Rosen, 1978; Gould and Clum, 1993; Marrs, 1995). For some disorders, it is possible that its efficacy is equivalent to individual or group cognitive behavioural therapy - e.g. panic disorder (Gould et al, 1993; Hecker et al, 1996; Lidren et al, 1994). Such a possibility has yet to be explored with respect to GAD.

The effectiveness of bibliotherapy for anxiety is an important issue given the author's experience of an increasing expectation in primary care and mental health services that such programmes will help deal with the large short-fall between resources and the level of demand for mental health services.

There is evidence showing that significant reductions in therapist time can be achieved during effective individual cognitive behavioural therapy for GAD (Butler et al, 1987; Jannoun et al, 1986). Further, that bibliotherapy can effectively treat a wide range of anxiety disorders as compared with GP treatment as usual (Donnan et al, 1990; Kiely & McPherson, 1986; Milne & Covitz, 1988; White, 1995). The results are not unequivocal though with the gains either being very limited (Donnan et al, 1990; Milne & Covitz, 1988) or sometimes only equivalent to GP treatment as usual (Holdsworth et al, 1996). Drop-out rates for bibliotherapy used to treat general anxiety varies from 0% (Kiely & McPherson, 1986; Sorby et al, 1991; White, 1995) upto 66% (Finch et al, 2000).

From the general bibliotherapy literature, there is evidence that bibliotherapy's effectiveness can be enhanced by the addition of therapist contact (Gould & Clum, 1993), perhaps particularly for disorders such as anxiety (Marrs, 1995). There is very limited direct support for this to date arising from the one study the author is aware of that examines bibliotherapy at different levels of therapist contact for a range of anxiety disorders (Kupshik & Fisher, 1999). Some indirect supportive evidence comes from White (1995) who found the effect size for patients who received individual cognitive behavioural therapy after a 3 month waiting

period was substantially greater than that shown by patients who had originally received bibliotherapy.

The effect sizes obtained by bibliotherapy in general compare favourably to those found in reviews of the broader psychotherapy literature (e.g. Shapiro & Shapiro, 1983). However, given the effect size is greater for bibliotherapy approaches to disorders which may be construed as less complex than those typically addressed by psychotherapy, such equivalence may be artificial. As regards anxiety conditions, up to 62% of patients with a range of anxiety disorders may remain clinical cases after bibliotherapy (White, 1995). This figure corresponds to the level of clinically significant change identified in cognitive behavioural psychotherapy for GAD (Fisher & Durham, 1999).

Additional benefits of bibliotherapy for a range of anxiety disorders include reductions in psychotropic use and GP consulting rates (Kiely & McPherson, 1986) and the need for subsequent psychotherapy (White, 1995). Bibliotherapy may also enhance the latter when it occurs (White, 1995, 1998).

The process by which bibliotherapy can reduce general anxiety disorders remain only tentatively explored and poorly defined. Improvements have been noted in knowledge about anxiety

management (Milne & Covitz, 1988) and coping skills (Holdsworth et al, 1996), changes not correlated to outcome. Compliance can be a large problem for bibliotherapy generally (Glasgow & Rosen, 1982), including as applied to general anxiety disorders (Finch et al, 2000; Kupshik & Fisher, 1999). A trend has been noted between compliance and improvement (Kupshik & Fisher, 1999). Compliance in this latter study was significantly positively related to the degree of therapist contact.

A lower level of education (Finch et al, 2000; Kupshik & Finch, 1999) and a younger age (Finch et al, 2000) may be linked with positive outcome. So too may reductions in catastrophic thoughts about anxiety (Kiely & McPherson, 1986), enhanced self-efficacy (Gould et al, 1993), an increased sense of self-control (Borden et al, 1991), an increased sense of ascription of responsibility for change (White, 1995), or the increased retention of information (cf Ley, 1977).

1.3 SOCIAL COGNITIVE THEORY

Bandura's (1977, 1986, 1997) social cognitive theory may be useful within the context of the current project because it provides a framework in which to try to understand the change process during therapy. It does this in two main ways.

Firstly, its views on the cognitive processes involved in anxiety may be of relevance to the hypothesis that anxiety levels have been reduced following the use of bibliotherapy due to changes in the way the anxiety has been perceived by the sufferer (Gould & Clum, 1993; Kiely & McPherson, 1986;). This possibility is discussed in the next section (1.3.1).

Secondly, the model is being increasingly used to explain how behaviour change occurs during therapy or health promotion programmes. Hence, it may help us predict how bibliotherapy will be used by clients. This point is returned to in section 1.3.3

1.3.1 Cognitive Processes in Anxiety and Stress

Social cognitive theory perceives stress and anxiety reactions in terms of an individual's self-perceived efficacy to exercise control over potentially aversive situations.

Related aspects of the social cognitive theory are the dimensions of situational and outcome expectations. Situational expectancy refers to the degree to which an individual sees situations as salient and threatening to him/herself. The outcome expectation relates to a belief about whether anything can be done to deal with the situation to reduce its threat value. Self-efficacy relates to the individual's belief that he/she can carry out the required action to reduce the threat.

Bandura (1977, 1986, 1997) also proposes a subdivision of self-efficacy along the dimensions of magnitude - an estimate of an individual's best possible performance; strength - the confidence in this estimate of strength; and generality - the number of situations over which the performance can be successfully performed. The dimension of strength is generally taken as the most important dimension, certainly in terms of predicting subsequent behaviour (Schwarzer, 1992).

Stress and anxiety are said to arise when a situation is perceived as threatening and personally salient. The degree of distress is also a function of the outcome expectation that the situation is controllable, and, most crucially according to Bandura (1977, 1986,1997), that the individual can effect this control. Further, Bandura suggests that the level of self-efficacy affects not only the intention to change the risk situation, but also the effort expended to do so, and the persistence to continue striving in spite of barriers and set backs that could serve to undermine motivation.

In certain respects, social cognitive theory corresponds closely to other models relevant to an understanding of anxiety and stress. For example, Lazarus and Folkman's (1984) transactional model of emotions describes anxiety and stress as the result of two interrelated processes. Firstly, there needs to be a primary appraisal of threat, a concept seemingly similar to Bandura's

(1977, 1986, 1996) situational expectancy. Where threat is present, a secondary appraisal process can be prompted although this can occur independently and involves an evaluation by the individual of his/her capacity to cope with the threat. The secondary appraisal process seems to subsume Bandura's outcome and self-efficacy expectations.

From the clinical literature on anxiety, Beck's (eg 1976) anxiogenic triad proposes that anxiety is a result of three cognitive processing errors: an overestimate of the probability of an aversive event; the magnification of the consequences of this event; and, thirdly, an underestimate of the individual's capacity to cope should the event occur. The first two of these appear to relate closely to Bandura's (1977, 1988, 1997) situational expectation and the third appears to integrate once again his outcome and self-efficacy expectations.

For the current purpose, it is perhaps most salient to note that the main similarities between the different models is that they each propose that an individual's experience of anxiety or stress is mediated in some way by cognitive processes. These include both the degree to which a situation is perceived as aversive and is manageable or controllable.

While there is a growing body of research evidence which supports the above aspects of social cognitive theory, it is important to note that the theory is not without its critics. One

primary criticism made by Eastman & Marzillier (1984) is that Bandura (1977) overstates the importance of self-efficacy. Other criticisms of social cognitive theory include the apparent difficulty in differentiating between self-efficacy beliefs and outcome expectations. (e.g. Borkovec, 1978), and concerns about the methodology used in many of Bandura's studies and the conclusions drawn there from (Eastman & Marzillier, 1984).

In terms of difficulties clearly differentiating between self-efficacy beliefs and outcome expectations, the concepts can be viewed as closely interlinked and hence difficult to separate operationally. The resultant difficulties in measurement have contributed to confusion in some of the research literature (Yalow & Collins, 1987).

There may also be some validity to the view that Bandura over-emphasises the role of self-efficacy beliefs at the expense of outcome expectations. As Eastman and Marzillier (1984) point out, outcome expectations can play a very important role in many people's experience of anxiety. For example, the person with agoraphobia may be at least as concerned about the consequences of losing control in public as his/her subsequent ability to cope with this. Such a view fits well with Beck's (1976) anxiogenic triad. Certainly, as the review below of evidence supporting Bandura's social cognitive theory indicates, researchers looking at its role in explaining the processes

involved in the experience of stress and anxiety have focussed almost exclusively on self-efficacy beliefs to the exclusion of outcome expectations. Perhaps this is a matter of emphasis which needs redressing in the research, especially since outcome expectations are still part of social cognitive theory. Interestingly, in the health risk behaviour research literature reviewed in section 1.3.3, the differential roles of self-efficacy beliefs and outcome expectations are more fully explored. The conclusions there include that both can play a role, dependent on the stage of change being examined, e.g. intention formation vs action stages, and the individuals' level of knowledge regarding the behaviour under consideration.

The third aspect of the critique of social cognitive theory rested on concerns about Bandura and colleagues research methodology and consequently the conclusions drawn from this research. Certainly, there do seem to be problems with the research methodology, primarily in its measurement of self-efficacy (Yalow & Collins, 1987). Another difficulty is that inferences are drawn on the basis of correlational data. In large part this difficulty relates to a cause-effect dilemma, ie. is self-efficacy simply a measure of actual level of competence? There seems some growing agreement that whilst both self-efficancy beliefs and actual competence are independent to some degree, they also interact to influence each other (Smith, 1989). It makes intuitive sense that a person's belief in their competence to

perform an action may be at least occasionally at odds with their actual competence, and this potential discrepancy between assumption and reality lies at the centre of cognitive therapy. Further, what a person can actually achieve may influence what they believe and reciprocally what they believe they can achieve may influence what they attempt to do.

With these reservations or criticisms of the theory in mind, there is evidence from direct and indirect sources in support of the value of social cognitive theory to an improved understanding of the experience of anxiety and stress. This evidence is briefly reviewed below.

From the self-efficacy literature, subjects with high self-efficacy have been shown to tolerate more pain (Litt, 1988; Manning & Wright 1983) indicating they experienced less distress, apparently because their higher self-efficacy levels reflected a greater belief in their ability to cope (cf Lazarus & Folkman's 1984 secondary appraisal or Beck's 1976 third dimension of the anxiogenic triad). In similar vein, self-efficacy level has been shown to influence positively blood pressure, heart rate and serum catecholomine levels in threatening situations (eg Bandura et al, 1988). Higher levels of stress coping self-efficacy have been associated with better psychological adjustment to highly stressful events such as abortion (Mueller & Major, 1989),

physical assault (Ozer & Bandura, 1990) or natural disaster (Benight et al, 1997).

Lower levels of self-efficacy have been predictive of higher levels of anxiety and general emotional distress (Alden et al, 1994). Among panic disorder patients, self-efficacy has been found to be a more important predictor of panic attacks than catastrophic cognitions (Williams & Flabo, 1996) despite the central role ascribed to these by Clark (1986). Bouchard and colleagues (1994) reported that changes in self-efficacy in panic disorder patients preceded changes in catastropic beliefs and mediated treatment outcome.

As already described, Gould & Clum (1993) ascribed clinical gains in PD clients not to improved coping behaviour but to increased levels of self-efficacy with respect to controlling panic symptoms. In the area of phobic anxiety and consequent avoidance behaviour, Bandura and Adams (1977) and Bandura et al (1980) found that self-efficacy beliefs were better predictors of subsequent approach behaviour on higher order tasks not yet attempted than was previous actual approach behaviour on tasks lower in the hierarchy.

In the treatment of agoraphobia, perceived self-efficacy accurately predicted treatment outcome independently of other factors such as the initial level of anxiety and previous avoidance behaviour. (Williams et al, 1989). In people experiencing the

early stages of psychosis, Macdonald and colleagues (1998) found a significant association between the use of adaptive coping responses and level of self-efficacy regarding symptom coping, both in turn being related to lower symptoms levels. Solomon and Draine (1995) found that the experience of stress in carers due to caring for a chronically mentally ill relative was significantly related to their self-efficacy regarding management of the illness. There is now a strong theme in the treatment literature indicating that self-efficacy is a key component in the process of recovery from psychological disorders (Carpinello, 2000).

More generally, research from different perspectives has underscored the influential role of perceived control in stress reactions. For example, in situations in which the opportunity to wield control over physically aversive stimuli exists but is unexercised, it is the self-knowledge that one could exercise such control which serves to reduce the stress reaction (Glass et al, 1971). A similar finding was made when the aversive stimulus was dysfunctional thoughts. Kent and Gibbons (1987) concluded that perceived inefficacy to control dysfunctional thoughts appeared more distressing than the actual thoughts themselves. Pointing to the independence of self-efficacy from actual ability, perceived control over aversive stimuli which is artificially high, i.e. not based on actual ability, has also been found to reduce stress reactions (Geer et al, 1970; Glass et al, 1973).

This last finding is important given the apparent cause-effect dilemma with respect to actual competence and level of self-efficacy. As illustrated above, Bandura and his colleagues have conducted a number of studies with phobic subjects (Bandura et al, 1974, 1979, 1980, 1982, 1985, 1988). These studies reveal close links between self-efficacy beliefs and levels of phobic fear and avoidance behaviour. Correlational in nature, these links are only suggestive. They do not conclusively resolve the question of whether the change in fear level and avoidance behaviour is reflected in a change in self-efficacy belief, or whether the latter mediates the former changes in some way.

As Bandura (1977, 1986, 1997) states, the actual capacity to perform a task is one route to increased self-efficacy. It is likely in turn that increased self-efficacy might result in changes in behaviour, e.g. the more confident phobic is more likely to attempt to approach the feared stimulus which may well break the self-efficacy loop of avoidance.

Additional evidence in support of the independence of actual capacity and self-efficacy comes from a number of sources. In addition to that mentioned earlier (Geer et al, 1970; Glass et al, 1973), research based on attribution theory found that actual failure to control aversive stimuli does not produce a stress reaction if the failure can be ascribed to situational factors rather than personal incapability (Wortman et al, 1976). Further, in the

field of health behaviour change, it has been shown that actual capacity to perform behavioural tasks such as physical exercise can be widely divergent from self-perceptions of capability (Ewart et al, 1983).

Further evidence comes from the field of pain control. Numerous studies have revealed that self-efficacy beliefs about the controllability of pain can be altered independently of the actual ability to do so. For example, Litt (1988) found that false feedback about pain tolerance levels led to corresponding changes in self-efficacy beliefs regarding pain management. Those in turn were associated with actual pain tolerance and the actual experience of pain. A similar finding was made by Reese (1983) who showed that cognitive techniques, self relaxation training and placebos all increased self-efficacy beliefs related in turn to higher pain thresholds and lower experiences of pain. Interestingly from the perspective of anxiety management, Holroyd and colleagues (1984) manipulated self-efficacy levels by providing tension headache sufferers with false EMG feedback. This was used to raise or lower artificially the individual's beliefs that he/she could control muscular tension, and hence control tension headaches. The investigators found that perceived self-efficacy beliefs were more closely related to reductions in tension headaches than was the actual ability to relax the relevant muscles. A similar finding was made in a study which identified the role of artificially enhanced self-efficacy in

reducing emotional distress during endoscopy (Gattuso et al, 1992).

Finally, taking a developmental perspective to illustrate the independence of actual ability and perceived ability, research using infant monkeys found that the early experience of being able to control access to food in some way insulated monkeys against the stressful effects of subsequent exposure to uncontrollable aversive stimuli (Mineka et al, 1986). It might be hypothesised that the mediating process involved some internalised sense of controllability instilled via the earlier control experiences.

1.3.2 Summary and Conclusions of the Relevance of Social Cognitive Theory to Bibliotherapy for Anxiety

Bandura's (1977, 1986, 1997) social cognitive theory proposes that the emotional impact of stimuli or situations is a function of an individual's situational and outcome expectancies and his/her level of self-efficacy. There is some evidence supporting the importance of self-efficacy in determining the level of stress or anxiety experienced. There is also evidence that an individual's level of self-efficacy is independent to some degree of their actual level of competence in controlling an aversive stimulus or situation.

Bandura (1991) proposes four routes whereby self-efficacy is influenced : direct or mastery experiences; indirect or vicarious experiences ; verbal persuasion or symbolic experience; and changes in autonomic or emotional arousal. For example, Bandura presents evidence to indicate that an individual's perception of heightened arousal is taken to signify personal weakness or an inability to cope, i.e it serves to lower self-efficacy.

From the perspective of bibliotherapy, social cognitive theory may be a model which helps explain the process of clinical change. In section 1.2 Gould et al (1993) and Kiely and McPherson (1986) were reported as finding clinical improvements in anxiety conditions without related coping behaviour change. Kiely and McPherson (1986) suggested the improvements were due to a reassurance process. The provision of information about anxiety was linked with reductions in worry about the symptoms, causes and consequences of anxiety. In social cognitive theory terms, this could be formulated as an improvement in the situational expectation, eg headaches do not mean brain tumours; the outcome expectancy, eg anxiety is normal and can be coped with; and thirdly, the individual's self-efficacy level, eg anxiety symptoms are not a sign I can't cope and some simple strategies I already possess such as relaxation can help me cope.

In similar vein, Gould et al (1993) found reductions in panic attack frequency and severity were associated with increases in self-efficacy. They suggested that an individual's increased sense of competence in controlling panic attacks led to a reduced tendency to catastrophize his/her panic symptoms. Such a view fits well with the cognitive model of panic proposed by Clark (1986). This model describes how panic attacks may be made more likely or intense due to the increase in arousal caused by the expectation of a panic attack, potentially itself triggered by an increase in autonomic or emotional arousal.

It is possible then that bibliotherapy may produce improvements in anxiety by directly altering an individual's perception of his/her condition, via provision of information alone. Such information may change situational expectancies, outcome expectancies and/or self-efficacy beliefs. It would do this via the routes of indirect or vicarious experience (eg case vignettes of individuals successfully managing anxiety) and/or verbal persuasion (eg by providing alternative, less catastrophic explanations of anxiety symptoms).

In addition, bibliotherapy has the potential to directly influence self-efficacy by providing advice on coping behaviour. Such behaviour, if adopted, would be expected to directly increase self-efficacy levels. Finally, referring to Bandura's fourth route to self-efficacy enhancement, any consequent improvements in

autonomic or emotional arousal may further serve to improve self-efficacy levels.

1.3.3 Cognitive Processes in Health Related Behaviour Change

The discussion above described how self-efficacy and related processes can mediate in the experience of anxiety and stress. In this section, social cognitive theory is discussed from the perspective of health related behaviour change, including the use of bibliotherapy programmes.

This is a key and growing use of the social cognitive model. In his review, Schwarzer (1992) concluded that research has shown self-efficacy to be a very powerful determinant of health related behaviour change. He describes how self-efficacy level determines the appraisal of one's personal resources in stressful encounters and plays a key role in the forming of behavioural intentions. The stronger the self-efficacy beliefs, the higher are the goals people set for themselves and the firmer their commitment to engage in the intended behaviour, even if failures mount.

Schwarzer (1992) reviews evidence indicating that in the intention formation phase of health related behaviour change, self-efficacy and outcome expectancies are the major predictors of intention. This said, there presumably must be some basal level of situational expectation, i.e. that the situation is

threatening and personally salient, otherwise the other two dimensions are irrelevant and people will not contemplate the benefits of possible action and their competence to actually perform these. Subsequently, in the action stage of change, Schwarzer argues that outcome expectancy becomes less important whilst self-efficacy level remains important, assuming a primary role.

Evidence is growing in support of the role of self-efficacy in health related behaviour change. For example, self-efficacy has been shown to be a better predictor of actual exercise behaviour than actual competence in the behaviour (e.g. Ewart et al, 1986). In the management of heart disease, Clark and Dodge (1999) found self-efficacy beliefs to be predictive of the appropriate use of medication, getting adequate exercise, managing stress and following a reasonable diet. Self-efficacy has been generally found to be more highly correlated with subsequent behaviour than the intention to carry out the behaviour, the situational expectation or the outcome expectation, e.g. breast self-examination (Seydel, Taal & Wegman, 1990), use of contraceptives (Levinson, 1982), use of clean needles by drug addicts (Kok, et al, 1990), smoking cessation (De Vries, Dijkstia & Kuhlman, 1988), and physical exercise in heart disease management (Kaplan, Atkins & Reinsch, 1984).

Returning to the theme developed in section 1.3.1, further evidence supporting the independence of self-efficacy from behavioural competence comes from Reynolds et al (1982) who found that the number of previous attempts to quit smoking was unrelated to self-efficacy levels. The latter has also been shown to be a more accurate predictor of relapse after smoking cessation programmes than length of smoking history, number of past attempts to stop, length of prior abstinence and level of physical dependency on nicotine (e.g. Barrios, 1985; Haaga 1989). In research involving competitive physical exercise, self-efficacy levels regarding competence was artificially manipulated, i.e. independently of actual competence (Weinberg, 1979, 1980, 1981). The high self-efficacy group consistently pushed themselves further during the physical exercise task than the low self-efficacy group. This evidence also provides support for the notion that self-efficacy influences effort and persistence.

In comparative studies, domain specific self-efficacy scales have typically been shown to predict changes in behaviour better than general measures of self-efficacy (Bandura, 1991). For example, Di Clemente et al, (1985) found that self-efficacy in the area of over eating was only very weakly correlated with that for smoking. Such a finding parallels evidence in the related field of locus of control (e.g. Lefcourt, 1984; Rotter, 1966) which highlighted the need to define locus of control in domain specific

terms if it was to have any predictive or explanatory power, e.g. the health locus of control (e.g. Wallston et al, 1976).

Bandura's (1977) self-efficacy dimension of generalisability leads him to suggest that if different classes of activity require similar functions and subskills, self-efficacy ratings relating to one activity may generalise to the related activities. In the field of anxiety, given many cognitive behavioural therapy techniques or coping responses can be used in a multitude of situations, one may predict some generalisability of the efficacy of coping skills across the different types of anxiety disorder. This would correspond in turn in the case of GAD with the view that it is the basic anxiety condition (Rapee, 1991). Hence, a sense of self-efficacy with respect to managing GAD might be expected to generalise to other anxiety conditions. To date, no self-efficacy measures relating to GAD exists. Gould and Clum (1993) have developed one which is specific to coping with the symptoms of P.D. Unfortunately, this measure reflects the specific, focussed nature of P.D and as such is unlikely to be of use when considering GAD.

With regard to the interrelationship between outcome expectation and self-efficacy, there is evidence to indicate that outcome expectations may play a more important role in determining intention to change and actual action when individuals have no experience with the behaviour under consideration (Schwarzer,

1992). Only after a sufficient level of experience is attained does self-efficacy account for the majority of the intention variance. This indicates that where new behaviours are contemplated, individuals need to be informed of what is entailed if self-efficacy ratings are to be accurate. Interestingly, in Bandura and Adams's (1977) early research with snake phobias, which revealed the predictive power of self-efficacy levels, the researchers specified just what behaviour changes were required via behavioural desensitization hierarchies. It is likely that the inter relationship between self-efficacy, outcome expectations and actual behavioural experience is complex (Clark & Dogge, 1999).

1.3.4 Summary and Conclusions of the Relevance of Social Cognitive Theory to the Use of Bibliotherapy

Bandura's (1977, 1986, 1997) social cognitive theory proposes that behaviour change or action is a function of situational expectancy, outcome expectancy and self-efficacy beliefs. There is growing evidence in the field of changing health risk behaviours to support the view that self-efficacy and outcome expectancy beliefs are important determinants of both the intention to change and actual behavioural change. Further, self-efficacy beliefs may be more important than outcome expectancy beliefs in determining actual behavioural change when the individual is relatively familiar with the behaviour in question.

The measurement of self-efficacy beliefs needs to attend to the degree of domain specificity present in the abilities under examination. It has been suggested that the abilities required to successfully manage GAD may be generalisable to other types or domains of anxiety diagnosis.

For the current project, there is a variety of skills or abilities which may be of relevance from a self-efficacy perspective. One set is that required to use the bibliotherapy programme, e.g. reading, writing, setting aside time, intellectual ability. These abilities will probably pre-exist in most patients and consequently self-efficacy beliefs with respect to their application to the programme should be accurate - assuming clients are made aware in some way of the ability requirements when using the programme.

Probably less accurately understood by clients prior to therapy and to some degree the focus of any therapy programme for anxiety are the skills required to manage anxiety, e.g. relaxation, communication of distress, cognitive change. Clients may already possess these prior to the bibliotherapy but be unaware of their relevance to their current condition. For example, they may be suffering tension headaches and be unaware that they are say, caused by difficulties at home. Instead, they may ascribe them to a brain tumour. Consequently, they may fail to use pre-existing communication or problem solving skills to address the difficulties at home.

Alternatively, the skills of anxiety management may be very new to clients, e.g. relaxation exercises or cognitive restructuring. Whether the skills are unknown or seen as irrelevant to their condition, it is unlikely that a self-efficacy rating prior to therapy will be based on an accurate understanding of what is required. Hence, it is possible that while pre-therapy ratings of self-efficacy with respect to using the pack are a useful predictor of subsequent behaviour, those for use of coping skills may not be. Instead, outcome expectations may play a stronger predictive role in relation to the trying out of new coping skills.

It might also be predicted that self-efficacy ratings of coping skills use will become a more accurate predictor of subsequent behaviour by the post-therapy point. By this point clients would have a greater understanding of the skills. Indeed, there is evidence from the addictions field that pre-therapy self-efficacy ratings are less predictive than those at post-therapy of post-therapy relapse (e.g. Colletti, et al, 1985).

1.4 RATIONALE TO THE CURRENT STUDY

1.4.1 Background

The empirical research for the current study began in 1995 and was based on the literature available up to that point. The study had four aims. The first was to develop an effective bibliotherapy

programme for the treatment of GAD. This was seen as necessary for a number of reasons.

As discussed earlier, there is a very high prevalence of GAD in the population (Barlow, 1988; Breslau & Davies, 1985) and correspondingly high rates of presentation in Primary Care (Goldberg & Huxley, 1993; Regier et al, 1988).

Finding effective treatments for such patients could then be seen as very important. In recent years, there has been much concern about the over prescribing and potential negative consequences of anxiolytics (e.g. Hoehn-Saric, 1998). Hence, a psychological treatment adjunct or alternative would be of value.

Focussing on the literature available up to 1995, the earlier review indicated that cognitive behavioural treatments for GAD could be effective (e.g. Barlow, 1984; Blower et al, 1987; Butler et al, 1987, 1991; Durham et al, 1994). However, it is increasingly recognised that the provision of clinicians skilled in such approaches is unlikely in the forseeable future to match the level of need from patients (Department Of Health, 1999). Hence NHS services are looking for alternative methods of delivering therapy which require little or no therapist time. The development of effective, potentially self-administered treatment programmes via bibliotherapy would obviously help in this respect. Additionally, such programmes could potentially be readily administered by primary care clinicians, including GPs. This would be particularly

relevant given approximately 90% of mental health problems that present in the NHS, including GAD, are currently treated solely in primary care (Goldberg & Huxley, 1992). This mirrors the finding discussed earlier that GAD is one of the least common anxiety disorders to present to specialist mental health centres, despite it being one of the more commonly occurring anxiety disorders (Barlow, 1988).

The programme developed and evaluated by the current study was based on the cognitive behavioural treatment model. This was decided on given its potential superiority in treating GAD to no treatment (eg Blower et al, 1987; Butler et al, 1987, 1991; Power et al, 1990) and behaviour therapy (eg Butler et al, 1991; Durham et al, 1994).

The model's applicability within a bibliotherapy format had up to 1995 only received very limited examination. Two studies found only limited and short term gains (Donnan et al, 1990; Sorby et al, 1991). Both these studies made use of patients suffering a wide range of anxiety disorders, including GAD. The current study chose to focus on GAD as the primary presenting condition.

The second aim of the current study was to evaluate whether an effective bibliotherapy programme needed to be cognitive behavioural in content. Kiely & McPherson's (1986) study reported earlier found clinical gains for anxious patients using a

non-cognitive behavioural programme. Instead, the evaluated programme consisted purely of educational information as to the nature and consequences of anxiety and stress. Both programmes evaluated by Donnan et al (1990) and Sorby et al (1991) combined such advice with further sections on cognitive behavioural anxiety management techniques. Hence, it is possible the effectiveness of their programmes were due at least in part to educational information.

The content of an effective programme is both a clinical and pragmatic issue. Pragmatically, an education only programme will be potentially much shorter, taking less patient time and effort. For the NHS, the saving would be in production costs.

Clinically, it was speculated on above that psychotherapy might sometimes overload patients with information and change requirements (Butler & Booth, 1991). This possibility could be used to explain findings in the broader psychotherapy literature for GAD which indicates that large reductions in therapy time can be achieved apparently without corresponding reductions in efficacy (e.g. Butler et al, 1987; Jannoun et al, 1980). The possible negative impact of overloading might be particularly relevant when trying to operationalise in a bibliotherapy format, a complicated multi-component treatment protocol such as a cognitive behavioural approach to GAD. It was commented on earlier that there is some evidence indicating bibliotherapy may

be more effective with conditions where there is a clearly identified behaviour to change via a purely behavioural bibliotherapy programme (Gould & Clum, 1993).

It might be expected that an information only programme would be of some help to sufferers of GAD. Further, that the information only programme may be less effective than a programme comprised of both information and guidance as to the development of cognitive behavioural coping skills. Hence, in the current study two bibliotherapy programmes were developed and evaluated: an information only programme and an information plus cognitive behavioural coping programme.

The third aim of the study relates to exploring how, if effective, a bibliotherapy programme contributes to clinical improvement. The processes by which bibliotherapy can reduce anxiety remains tentatively explored and poorly defined.

The limited amount of relevant bibliotherapy research to date has speculated on the potential role of reassurance in helping anxiety sufferers (Kiely & McPherson, 1986) or the role of an increased sense of increased control or self-efficacy for people experiencing panic disorders (Borden et al, 1991; Gould et al, 1993). In the current study, these potential processes have been conceptualised within a social cognitive therapy framework.

As reviewed above, the theory proposes with some experimental support that the degree of stress and anxiety experienced in a situation is a function of three factors: the degree of perceived threat and personal salience (situational expectation), the strength of belief the situation is controllable (outcome expectation) and the strength of belief the individual can effect this control (self-efficacy) (Bandura, 1977, 1986, 1997).

Improvements on all three dimensions could occur via information alone in the absence of behaviour change (Bandura, 1991). It has been suggested above that information about anxiety results in anxiety sufferers feeling reassured or less threatened by their condition (situational expectancy), more confident that anxiety is a treatable condition (outcome expectancy) and that they have or can learn the relevant anxiety management skills (self-efficacy). Using the model, an examination can occur as to the degree of association between clinical outcome and changes along these dimensions. Given both bibliotherapy programmes contain the information on anxiety, such associations could be relevant to both.

It might also be expected in the programme focussing on the development of cognitive behavioural coping skills that clinical improvements may be linked with coping skills acquisition. Whilst such a link was not found by Kiely and McPherson (1986), they were not surprised given the bibliotherapy programme

tested provided no guidance as to skills development. More surprising was Gould et al's (1993) failure to find a link. This may have been a function of problems with their measurement of coping and a high degree of variance in a small sample on the relevant coping measure. Additionally, it could be a result of the aforementioned potential difficulties operationalizing cognitive therapy into a bibliotherapy format, including the danger of overloading clients with information.

The third variable which may be linked with successful outcome is the degree of compliance with the programme. The only study the author was aware of in the anxiety literature up to 1995 which examined this found such a link for a behavioural programme used by snake phobics (Rosen et al, 1976). Given the potentially high level of non compliance with bibliotherapy programmes both generally (e.g. Glasgow & Rosen, 1978, 1982), and in the treatment of anxiety (Donnan et al, 1990), perhaps especially with more complex programmes, exploration of the link between compliance and outcome was seen as relevant for the cognitive behavioural programme. It was thought compliance would not be a problem for the education only programme given its shortness.

The fourth aim of the current study was to explore potential predictors of non-compliance. If these can be identified, GPs could target programme administration more effectively. To do so could reduce the likelihood of potential pitfalls that could cause

patients additional distress and/or reduce the chances of them accessing appropriate care.

As already commented on, compliance rates with bibliotherapy can be relatively low, both in general (e.g. Glasgow & Rosen, 1978, 1982) and in the treatment of anxiety (eg Donnan et al, 1990; Holden et al, 1983; Rosen et al, 1976). Consequently, one potential problem might be a GP administers the programme, a client does not complete it and the GP may conclude the client is not motivated to help themselves. A corollary might be that the GP is more reluctant to refer the client on for more specialist help.

Additionally, from the client's perspective, their non completion of the programme could reduce their outcome expectancy regarding therapy more generally. It could also lower their sense of self-efficacy regarding their ability to manage their condition. Such reductions could simultaneously increase their level of distress while also discouraging them from seeking further help.

Given such potential pitfalls, it would be helpful to identify potential predictors of non- compliance. If these can be identified, this would reduce the likelihood of the potential pitfalls whilst also reducing the wasted cost to both patients and the NHS. Patients for whom bibliotherapy was predicted to be unsuitable could then be considered for referral on to more specialist mental health services. Given compliance is expected

to be uniformly high with the information only programme, potential predictor variables have no relevance. Variables with potential predictive power for the use of the cognitive behavioural programme include patients' expectations regarding the programme, the severity of their anxiety, their reading ability and their level of education.

As reviewed earlier, the uptake of health related behaviour change has been shown to be associated with situational expectancy, outcome expectancy and self-efficacy (Schwarzer, 1992). Further, self-efficacy has been shown to be the most important variable where the behaviour in question is familiar whereas outcome expectancy is more important when the behaviour is unfamiliar. For current purposes, one set of behaviours are likely to be familiar, i.e. the general and reading use of the bibliotherapy programme using skills such as reading, setting aside time, saying "no' to interruptions. For the use of these, self-efficacy beliefs may be the better predictor. Outcome expectancy beliefs may be a better predictor of the use of the relatively unfamiliar coping behaviours.

The relevance for compliance of the initial severity of symptoms arises from research such as Holden et al (1983). He found that patients with more severe agoraphobia failed to comply with the bibliotherapy programme until they had the support of therapist contact. This was in contrast to the more favourable findings with

less severe populations (Mathews et al, 1981; Weeks, 1973). Similar differential outcomes between populations of differing severity were reported in a review of the cognitive behavioural psychotherapy literature for GAD (Durham & Allan, 1993). Intuitively it makes sense that a higher level of anxiety may, by its very nature, interfere with both a person's ability to concentrate on and persist with a written programme. This said, an argument in the opposite direction could also be made i.e. those with more severe anxiety may be more motivated to adhere to a treatment programme. Given the relatively weak evidence base and the possibility of a relationship in either direction, any prediction may be viewed as very speculative.

Finally, with regard to potential predictor variables, reading ability may be expected to facilitate a person's use of a written treatment programme and hence their compliance with it. Relatedly, educational attainment has often been linked with more successful outcome in psychotherapy (Garfield, 1994).

The hypothesized inter-relationship between the different variables under consideration and outcome is shown below in Figure 1 for the information only programme and in Figure 2 for the information plus coping skills programme.

FIGURE 1 FACTORS POTENTIALLY INFLUENCING OUTCOME DURING BIBLIOTHERAPY FOR GAD WITH INFORMATION ONLY PROGRAMME

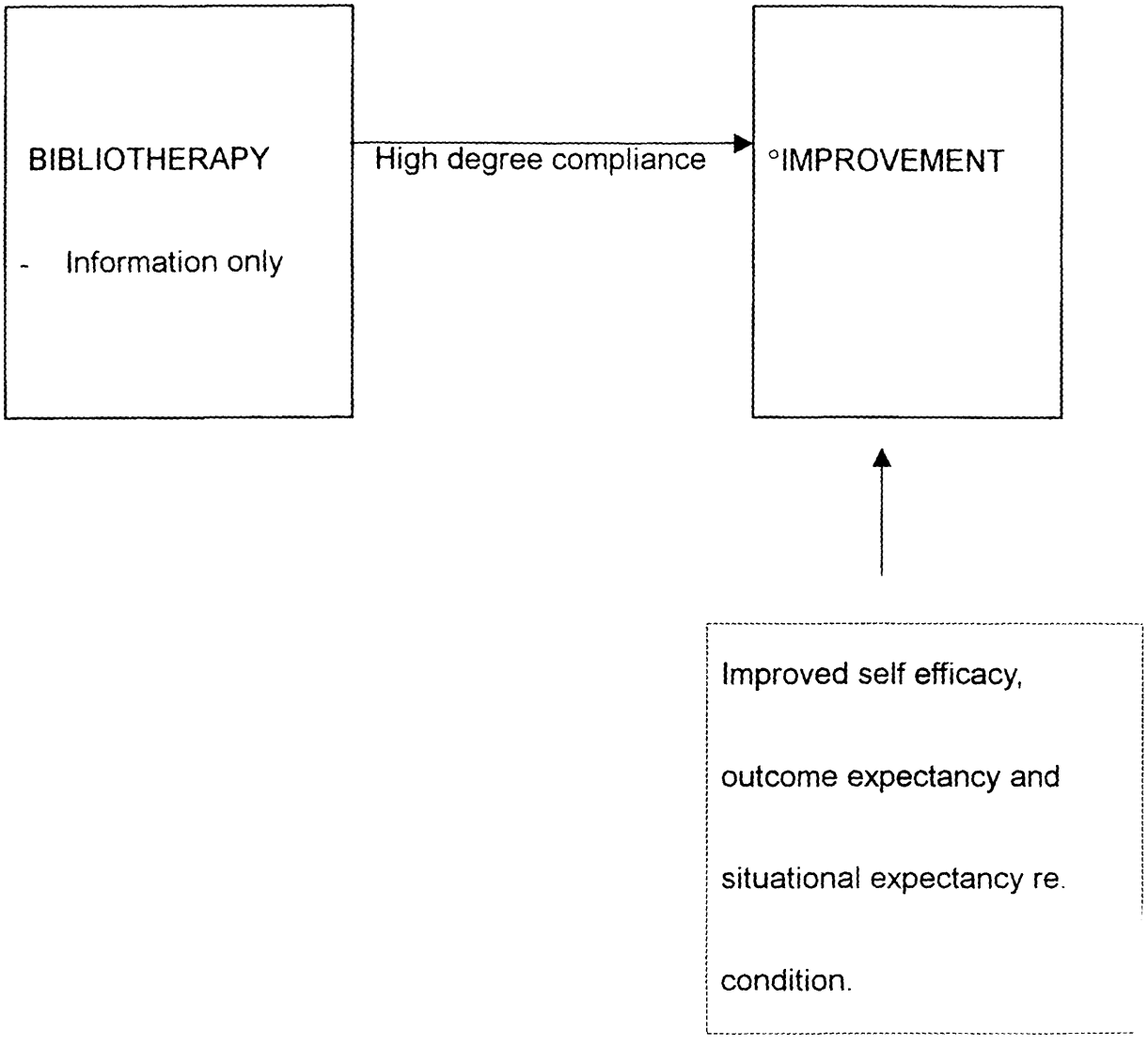
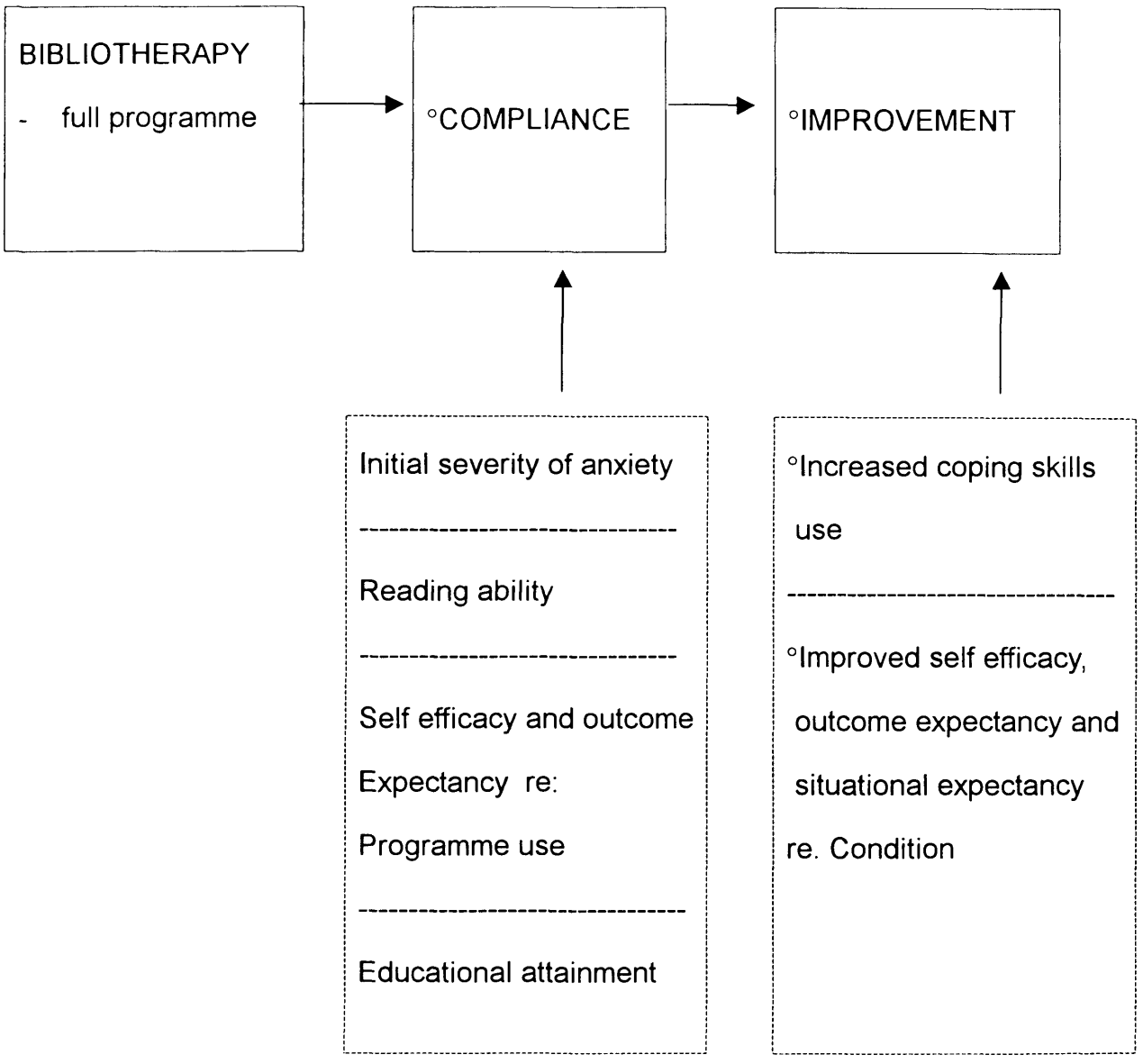


FIGURE 2 FACTORS POTENTIALLY INFLUENCING OUTCOME DURING BIBLIOTHERAPY FOR G.A.D. WITH FULL PROGRAMME



1.4.2 Aims Summarized

The aims of the study were to:

1. Evaluate the effectiveness in treating GAD of a cognitive behavioural bibliotherapy programme administered under very low therapist contact conditions.

2. Evaluate the effectiveness of an educational information only bibliotherapy programme administered under very low therapist contact conditions.

3. Explore factors which might be linked with improved outcome, ie patients' situational expectancy, outcome expectancy and self-efficacy beliefs regarding their experience of anxiety; their acquisition of coping skills; and their compliance with the programme.

4. Explore factors which might be predictive of poorer compliance with the programme and hence poorer outcome, ie patients' situational expectancy, outcome expectancy and self-efficacy beliefs regarding their use of the programme; their initial anxiety levels; their reading ability and educational attainment.

1.4.3 Hypotheses

Six research hypotheses were postulated arising from the above aims and the research literature reviewed earlier.

1. The cognitive behavioural bibliotherapy programme will lead to clinical improvements in people experiencing GAD.

   Null Hypothesis : the cognitive behavioural bibliotherapy programme will not lead to clinical improvements.

2. An information only bibliotherapy programme will lead to clinical improvements in people experiencing GAD, the degree of change being less than found with the cognitive behavioural programme.

   Null Hypothesis : the information only bibliotherapy programme will not lead to clinical improvements.

3. Improved clinical outcome with both bibliotherapy programmes will be positively associated with improvements in situational expectancy, outcome expectancy and self-efficacy regarding anxiety state.

   Null Hypothesis: there will be no association between clinical outcome and changes in situational expectancy, outcome expectancy and self-efficacy regarding anxiety state.

4. Improved clinical outcome with the cognitive behavioural programme will be positively associated with improvements in coping skills.

Null Hypothesis: there will be no association between clinical outcome with the cognitive behavioural programme and changes in coping skills.

5. Improved clinical outcome with the cognitive behavioural programme will be positively associated with the degree of compliance with the programme.

Null Hypothesis: there will be no association between clinical outcome with the cognitive behavioural programme and the degree of compliance with the programme.

6. The degree of compliance with the cognitive behavioural programme will be:

(a) positively associated with reading ability

(b) positively associated with level of educational attainment

(c) positively associated with self-efficacy and outcome expectancy regarding programme use

(d) negatively associated with initial severity of anxiety.

Null Hypothesis: there will be no association between degree of compliance with the cognitive behavioural programme and reading ability, level of educational attainment, self-efficacy regarding programme use or initial severity of anxiety.

1.4.4 Study Overview

The study occurred in two stages. In the first stage, reported on in Section 2 below, two bibliotherapy programmes were developed: information only or information plus cognitive behavioural coping skills. These programmes were then evaluated under high therapist contact conditions. This was to permit relatively safe and hence ethical administration of a new form of therapy. Further, it provided the therapist (the author) with the opportunity to examine in detail the interaction between patients and the programme. The information thereby obtained could be used to revise the programmes as necessary prior to the next stage of the study.

In the second stage of the study, the research hypotheses defined above were tested. This stage is described in Section 3 below.

CHAPTER 2

DEVELOPMENT OF THE BIBLIOTHERAPY PROGRAMMES

2.1 INTRODUCTION

This section describes the study's first stage in which two bibliotherapy programmes were developed, evaluated on a pilot basis and revised in the light of this evaluation. The information only programme was in effect a sub division of the full programme which consisted of information on anxiety plus cognitive behavioural coping skills advice. Hence at this stage, reference will only be made to the full programme, unless otherwise specified.

2.2 METHOD

2.2.1 Design

The programme was ultimately intended for evaluation and use with little or no therapist contact – minimal therapist conditions. At this stage of the study it was evaluated with a relatively large amount of therapist contact. In effect the programme served as a psycho- therapy manual, the content of the psychotherapy being strictly determined by the programme. The role of the therapist at this stage included the reduction of any ethical concerns arising

from the administration of an unproven treatment to patients with GAD, ie the author's bibliotherapy programme. Additionally, the therapist could evaluate in detail the patients' experience of the programme as it was administered, thus facilitating any subsequent revision prior to its evaluation in stage 2 under minimal therapist conditions.

The design of this stage reflected the low numbers of referrals of patients with GAD being made at the time to the author's normal workplace, a Community Mental Health Team (CMHT) in North Warwickshire NHS Trust. A survey of referrals to the CMHT in the previous 17 months identified only 8 potential referrals of patients with GAD. This represented only 2% of all referrals to the CMHT. Such a low level matches the epidemiological evidence described earlier which indicated patients with GAD were relatively unlikely to be referred to specialist mental health centres, despite high prevalence levels (Barlow, 1988). Due to waiting list pressures within the CMHT, it was not possible at that stage to seek extra suitable referrals for the project.

Due to the prediction of a small number of suitable patients, no comparison group was used. Instead, patients were used as their own controls. Measures were taken at four points: initial assessment (point A), post waiting list/pre therapy (point B), post therapy (point C) and follow-up after 3 months (point D).

DSM-III-R requires the relevant anxiety symptoms to be present for at least 6 months before a diagnosis of GAD can be ascribed. Such a time scale ensures the relative stability of the condition. More generally, Catalan et al (1984) found that among patients with new episodes of a range of psychological problems, 10% improved to non clinical levels within 1 month, increasing to 70% after 6 months. Hence, the use of the DSM III-R GAD diagnostic category in this study increases the control for changes over time.

Again because of the small predicted sample size, only one therapist, the author, was used thus reducing variance due to differences between therapists. Additionally, it enabled the author to monitor more closely the patients' experience of the programme. He was also the author of the programme.

Use was made of an independent assessor, not blind to treatment, to assess patients at points B, C and D and to check the treatment sessions complied with the bibliotherapy programme.

2.2.2 Sample

Places in the project were offered to all patients aged 16-69 who were referred to the CMHT within a 12 month period who met the criteria for GAD according to DSM-III-R (APA, 1987) and who

were also defined as clinical cases by the Leeds Specific Anxiety Scale (Snaith et al, 1970).

Additional primary diagnoses of other anxiety disorders or depression were accepted given the high co-morbidity between such conditions (Rapee et al, 1988; Sanderson & Barlow, 1990; Wittchen & Essau, 1993) and the finding that successful treatments for GAD might well result in improvements in any co-morbid condition (Borkovec et al, 1995).

Excluded were patients with GAD in association with other additional primary diagnoses including: interpersonal problems including psychosexual dysfunctions; eating disorder; alcohol or substance misuse; or psychoses.

A summary of the criteria used is shown in Appendix 1.

2.2.3 Therapist and Independent Assessor

The therapist was a chartered clinical psychologist with 11 years post qualification experience in the NHS, offering cognitive behavioural psychotherapy to a range of patients including those with GAD. He was registered as a therapist with the British Association of Behavioural and Cognitive Psychotherapy.

The independent assessor was similarly qualified, with 13 years relevant post qualification experience plus a PhD in Clinical Psychology.

2.2.4 The Programme

The bibliotherapy programme was developed by the author from existing materials originally produced by the author for use in an ongoing series of anxiety management groups run within the local CMHTs.

The materials were multi-modal in content, ie contained components which focussed on each of Lazarus's (1981) three dimensions of anxiety, the physiological, behavioural and cognitive. Butler and Booth (1991) recommend that any treatment programme for GAD should be broad in focus, addressing the different elements of GAD including anxious cognitions, avoidance, social withdrawal and physical tension.

Also drawn on was the treatment literature reviewed above which concluded that cognitive behavioural treatments for GAD had been found to be effective, albeit no clear evidence yet existed as to the optimal content of the treatment. Common elements of effective treatments which were included in the programme were relaxation, distraction and cognitive restructuring. The relaxation component was based on the progressive relaxation method (Jacobson, 1938). The distraction techniques drew on Meichenbaum's (1977) Stress Inoculation Training. The cognitive restructuring techniques were an abbreviated version of Beck and Emery's (1985) cognitive therapy. Such a combination of

these three components has been found to be effective in the treatment of GAD (Barlow et al, 1984).

The programme also included a section on lifestyle, a common ingredient in many anxiety management programmes. This included advice on how to develop social support given this is linked strongly with good psychological health (Cohen & Wills, 1985). It also contained advice on commonly used stress management strategies such as time management and the use of leisure including exercise to relax. Butler et al (1987) reported that GAD patients experienced physical exercise as relaxing, concluding that it might be usefully included in future treatment programmes.

The content and format of the programme were designed to facilitate use and hence increase compliance, following the advice of reviewers of the bibliotherapy literature (Dow, 1982; Glasgow & Rosen, 1978; Turvey, 1985). Important elements included the use of simple language; section summaries; interactive exercises; advice on how to use the programme including frequent time tabling information; diagrams or cartoons to break up the text; repetition of key information; suggested action being presented in a detailed, concrete and specific form; advice on maintenance of skills use; and preparation for relapses or new problems.

The programme was made up of 9 sections. Each was arranged in a sequential manner, subsequent sections building to some degree on the contents of previous ones. There was also an attempt made to sequence them in the order of increasing complexity or difficulty of use. In this way, patients would be hopefully encouraged by earlier achievements to proceed when the effort required increased.

In summary, the 9 sections comprised:

Section 1 – 'Introduction to the Programme'; this included advice on how and when to use the programme.

Section 2 – 'What is Anxiety', described a model of anxiety, its causes and consequences. Drawn on were Lazarus's (1981) tripartite model and Beck & Emery's (1985) cognitive model.

Section 3 – 'Managing Physical Tension', included details of the link between physiological arousal and anxiety plus instructions via an audio tape on how to learn the progressive relaxation (Jacobson, 1938). The use of an audio tape follows from both general clinical practice and the finding of one review of the bibliotherapy literature that the inclusion of audio or video tapes improved compliance (Gould & Clum, 1993).

This was the first skills section presented as in the author's clinical experience, patients often find a practical, relatively concrete coping technique such as relaxation quickly increases

their confidence that they can control their symptoms. Additionally, being able to relax can lead to better employment of cognitive and behavioural coping skills (Zeiss et al, 1979). Hence, it was thought that this would be a useful prelude to learning the other skills.

Section 4 – 'Stress Reducing Lifestyle', included the use of self monitoring of tension and anxiety, a frequently included component of effective therapy for GAD (e.g. Durham & Turvey, 1987); plus advice on time management, leisure and social support.

Section 5 – 'How to Worry Less', included a description of the cognitive model plus advice on the use of distraction and cognitive restructuring.

Section 6 – 'Containing Panic Attacks', included advice on how to apply the skills learned to date for the control of panic attacks. These were focussed on given they are frequently associated with GAD as a symptom, albeit at a level which falls short of meeting criteria for a diagnosis of P.D. (Sanderson & Barlow, 1990)

Section 7 – 'Avoidance', included advice on the construction of a systematic desensitisation hierarchy, a generally accepted effective treatment for anxious avoidance. Butler et al (1987) found avoidance to be a common coping strategy used by GAD

patients and included systematic desensitisation in their effective treatments (Butler et al, 1987, 1991).

Section 8 – 'Sleep Problems', included advice on how to apply the skills learned to date to improve sleep. Disturbed sleep is one of the diagnostic criteria for GAD within DSM III-R (APA, 1987).

Section 9 – 'Tranquillisers', included advice on the uses and potential problems associated with tranquillisers, plus advice on how to safely reduce useage. This also contained a subsection providing a summary of the programme, advice on skills maintenance and a discussion of preparation for future problems including relapse.

The cognitive behavioural programme consisted of all 9 sections outlined above. It was intended that the information only programme would only consist of Section 2.

2.2.5 Measures

Copies of all the measures and the structured interview used are included as Appendices 2 and 3 respectively.

Suitable patients were selected using the Anxiety Disorder Interview Schedule - R (ADIS-R). This is a structured interview developed by Di Nardo et al (1987), designed to assess for current episodes of anxiety, including GAD. It permits differential diagnosis among the anxiety disorders, according to DSM-III-R

criteria (APA, 1987). The author trained in its use via a training videotape (Brown et al, 1994).

The ADIS-R was used in preference to a more general screening interview such as the Structured Clinical Interview for DSM-III-R (Spitzer et al, 1987) because it provided a more detailed examination of the anxiety disorders. This was seen as important given the high degree of overlap between the different anxiety disorders (Barlow et al, 1986; Turner et al, 1986) and the co-morbidity of GAD with other anxiety disorders (Rapee et al, 1988; Sanderson & Barlow, 1990).

The ADIS-R was used as part of a wider structured interview. This broader interview was used to assess for difficulties other than anxiety which might require treatment in their own right. It was structured to increase the probability that different patients received similar amounts and types of contact with the assessor.

To assess clinical change, patients completed the Spielberger State-Trait Anxiety Inventory (STAI; Spielberger et al, 1970); the Leeds Specific Anxiety Scale (LAS; Snaith et al, 1976); the Carrol Depression Scale (CDS; Carrol et al, 1981); and measures developed by the author: a severity of problems scale (SPS) and an impact of problems scale (IPS).

The STAI, the LAS and the CDS are standardised measures, widely used in the anxiety outcome literature. The LAS was used

in addition to the more widely used STAI as it is quick to complete and provides a clinical caseness rating, a case being defined by a cut off score of ≥ 7. A measure of depression (CDS) was useful given a degree of depression is often associated with anxiety, sometimes as a result of the chronic experience of anxiety.

The problem ratings scales used visual analogue scales for each of up to 3 current problems relevant to the patients' anxiety. Patients were asked to rate the impact of the problem on their life and its severity on two scales anchored 0 = 'No Impact At All' or 'No Problem' and 8 = 'Very Great Impact' or 'Very Severe'. Each patient's impact and severity scores was an average of those across all 3 problem areas.

The independent assessor rated each patient's anxiety symptoms using the Hamilton Anxiety Glossary (HAG; Power et al, 1985), a structured clinical interview developed from the Hamilton Anxiety Scale (HAS; Hamilton, 1959). The HAG was developed to improve the inter-rater reliability of the HAS (Power at al, 1985). As with the STAI, it is a frequently used measure of change in anxiety treatment outcome studies.

The therapist and each patient completed a therapy session questionnaire (TSQ) after each appointment. This was developed by the author from the Helpful Aspects of Therapy form (Elliott et al, 1994; Llewelyn, 1988). The questionnaire was designed to identify whether the appointment was helpful on a 9

point scale anchored at 1 = very helpful, down to 9 = very unhelpful. It also sought through open ended questions reasons as to why the appointment was helpful or unhelpful.

This information was complemented by the 'Treatment Programme Evaluation Questionnaire'. Designed by the author, it sought patients' views on the bibliotherapy programme and therapy appointments. It contained a mixture of forced response and open ended questions, the latter usually seeking elaboration of the former. Areas looked at included how helpful overall patients found the treatment, how helpful was each section of the bibliotherapy programme, how easy to understand was each section, how much they read of the programme, how helpful were the contacts with the therapist and what were they doing differently as a result of treatment.

The reading difficulty of the programme was measured using the Flesch (1948) reading formula.

2.2.6 Procedure

To select suitable patients, an initial screening of written referrals to the CMHTs was routinely conducted by the CMHT's assessment panel. This consisted of a social worker, community psychiatric nurse and a clinical psychologist other than the author.

Potential GAD sufferers were then interviewed by the author using the ADIS-R as part of a structured general assessment interview. If this identified that the patient met the project's inclusion criteria (as detailed in Section 2.2.2), they were invited to join it. Their names were then placed on the project's waiting list for treatment by the author. Patients were seen in the order originally referred, their length of wait being determined by the author's existing general clinical caseload.

Therapy for each patient consisted of sixteen 50 minute weekly sessions of individual therapy with the author as therapist. At each session, the programme materials were used as the sole focus of therapy. Each section of the programme was presented to each patient in a fixed order and at a fixed rate. The patients were encouraged to read the programme at home and carry out the exercises advised. The therapy sessions were designed to allow patients to ask questions about the programme, discuss any problems they were experiencing in using it and for the therapist to offer support and encouragement in its use.

If a patient raised a problem or question not covered by the programme, this was acknowledged but not addressed. However, if at any point such a problem arose which in the therapist's view threatened the patient's clinical outcome, the plan was to remove the patient from the project. If the patient's problem touched on an area covered in a later section of the

programme, this was mentioned and further discussion was left until this section was reached.

To encourage therapist compliance with the programme, all sessions of each patient's therapy were audio taped, with the patient's agreement. For each patient, tapes from two sessions were then chosen using a randomising procedure. These were then listened to seperately by the therapist and the independent assessor, both noting any deviations from the programme. Such checks were seen as a necessary condition for making valid inferences as to the potential efficacy of the bibliotherapy programme, as recommended by Kazdin (1980).

As outlined in Table 1 below, at points A, B, C and D patients completed the STAI, CDS and LAS. At points B, C and D they also completed the problem scales and the independent assessor completed the HAG. After each session, each patient and the therapist completed a session questionnaire. At point D, patients were sent the 'Treatment programme Evaluation Questionnaire' to complete. This was sent by Head of Psychology Department and was to be completed anonymously to encourage honest responding.

Table 1 TIME OF COMPLETION OF EACH MEASURE

Initial Assessment (A)	Pre-Therapy (B)	Post – Therapy (C)	3 Month Follow-up (D)
STAI	STAI	STAI	STAI
LAS	LAS	LAS	LAS
CDS	CDS	CDS	CDS
	Problem Scales	Problem Scales	Problem Scales
	HAG	HAG	HAG
			Treatment Programme
			Evaluation Questionnaire

2.3 RESULTS

2.3.1 Sample

Only 5 patients were recruited in the 12 month period used. All patients invited to join the project did so. 3 were male and 2 female, of average age 28.8 years.

The average duration of patients' problems at point A was 5 years 10 months, range 7 months to 16 years 0 months. All had a primary diagnosis of GAD. One also experienced Panic Disorder; another OCD; another secondary depression; and a fourth experienced minor phobias. None of these additional conditions were deemed to require treatment in their own right.

2.3.2 Treatment Programme Compliance

Compliance checks by the therapist and the independent assessor found no significant deviations between the contents of the therapy sessions and the bibliotherapy component.

2.3.3 Clinical Outcome

Given the very small sample size, non parametric (2 tailed) tests were conducted on all the clinical measures. Initially, Wilcoxon Signed Rank Tests were conducted for the CDS, LAS and STAI measures, comparing initial assessment and pre-therapy scores. This was to test for changes during the waiting period. No significant changes were found.

Subsequent, Friedman 1 way analyses of variances with repeated measures across time periods B to D inclusive revealed significant improvements on the CDS (Chi-square = 8.4; df = 2; $p < 0.05$); the HAG (Chi-square = 6.4; df = 2; $p < 0.05$); the LAS (Chi-square = 8.3; df = 2; $p = < 0.05$); the STAI-state (Chi-square = 7.6; df = 2; $p < 0.05$); the STAI-trait (Chi-square = 7.6; df = 2; $p < 0.05$); and the SPS (Chi-square = 7.6; df = 2; $p < 0.05$).

In terms of anxiety, all 5 patients were clinical cases on the LAS at initial assessment and pre-therapy stages. At post therapy, only 1 was, reducing to 0 by 3 month follow-up. Their depression scores on the CDS indicated 5 were clinical cases at the initial assessment and pre-therapy stages. This reduced to 0 cases at post therapy and 3 month follow-up.

2.3.4 Process Measures

Two questionnaires were used to gather information about the patients' and the therapist's experience of the treatment programme, including the bibliotherapy component. These were the Treatment Session Questionnaire (TSQ) and the Treatment Programme Evaluation Questionnaire (TPEQ). The purpose of this information was to help assess whether the contents of the bibliotherapy component was relevant to and useable by patients with GAD.

The information gathered via the TSQ and TPEQ was a mixture of quantitative and qualitative. No attempt was made to formally analyse the latter in any way, eg Grounded Theory Analysis (Glasser & Strauss, 1967) as this was not seen as necessary to meet the aims set out above. Unfortunately the TSQ and TPEQ from 1 patient were lost. Hence, all the results reported below arise from the remaining 4 patients.

Taking the written answers to the patients' and therapist's TSQ first, these are summarized in Appendix 4. The main relevant themes from the patients' feedback were: the value of time with the therapist to talk over difficulties experienced in using the bibliotherapy component; the motivating and normalising effects of hearing how the therapist also used the coping techniques; the reassurance of discovering others experienced such problems; the value of the therapist's feedback regarding progress; the importance of talking about problems facing them to someone who listened and was neutral; the difficulty experienced sticking to the relaxation exercises, changing their lifestyle, communicating more with others and looking at their thought patterns; the value of doing all these things; the value of practising opening up with the therapist as a prelude to doing it with others; the importance and desire to find out more about themselves - their feelings, their history and the causes of their difficulties; a desire to seek out further therapy to these ends; and

their fears and concerns about maintaining their gains after discharge.

The themes in the therapist's TSQ closely correspond to those of the patients. This said, there were some additional, more negative themes arising from the therapist's comments. One such was the difficulty keeping therapy content to the bibliotherapy component's structure and content when patients were presenting with current life problems which did not readily fit into these. There was a corresponding need to be creative in translating the programme's contents to address these problems, e.g. discussing to some degree relationship difficulties within the context of the social support component of the life style section. Similarly, the therapist reported how difficult it was on occasion not to follow some patients' desire to explore in greater detail their feelings and relationships. More positively, the 16 appointment limit reinforced the need to remain focussed on the programme. Comments were also made by the therapist about how the length of the leisure section took time away from potentially more important later sections; difficulties experienced by patients with exercises in the lifestyle and worry sections; and the potential value of an assertion section when discussing relationship problems.

Table 2 shows the average session ratings scores by patient and therapist. As can be seen, all 4 patients found the sessions to be helpful overall (1 = very helpful, 5 = neutral, 9 = very unhelpful), the group average being 3.18, σ = 0.73, range 2.2 – 4.2. These results accorded well with the therapist's in each patient's case, the group average being 3.00, σ = 0.21, range 2.9 – 3.2.

This said, Spearman rank correlations (two tailed) of patient and therapist ratings for each session were only significant in the case of one patient (ρ = 0.554; n = 17, p <0.01), the remainder being positive but non significant.

TABLE 2 Helpfulness of Therapy Sessions – Average Ratings by Patient and Therapist

Patient 1	Therapist	Patient 2	Therapist	Patient 3	Therapist	Patient 4	Therapist
2.2	3.2	4.2	2.7	2.9	2.9	3.4	3.2

TABLE 3 Helpfulness of Therapy Overall – Summary of Patients'

Responses (n = 4)

Very Helpful	Helpful	Unhelpful	Very Unhelpful
4	1	0	0

TABLE 4 In What Way Was Therapy Helpful? – Summary of Patients' Responses (n=4)

	Yes Definitely	Yes	No	Definitely Not
Understood more about my difficulties	4	0	0	0
Reassured me about my difficulties	2	2	0	0
Helped me cope with my difficulties	4	0	0	0

Turning now to the results of the TPEQ, these are summarised in Tables 3 and 4. As can be seen from Table 3, all 4 patients found treatment overall to be helpful or very helpful. They all found the treatment helped to reassure them about their difficulties, gain

greater understanding of these and cope better with them (Table 4). Interestingly given the therapist's concerns about the potential limitations of the content of the treatment programme, all 4 patients reported that the appointments were suitable in length, frequency and overall number and had no suggestions to add to the contents of the therapy.

TABLE 5 Helpfulness of Each Bibliotherapy Section – Summary of Patients' Responses (n = 4)

	Very Helpful	Quite Helpful	Not Particularly Helpful	Not Applicable
Introduction	2	1	1	0
What is anxiety?	3	1	0	0
Managing Physical Tension	4	0	0	0
Lifestyle	2	2	0	0
Worry	2	2	0	0
Panic	4	0	0	0
Avoidance	0	0	0	4
Sleep	0	2	0	2
Tranquilizers	0	0	0	4

TABLE 6 Ease of Understanding of Each Bibliotherapy Section - Summary of Patient's Responses (n = 4)

	Very Easy	Quite Easy	Quite Difficult	Very Difficult	Not Applicable
Introduction	2	2	0	0	0
What is Anxiety?	0	4	0	0	0
Managing Physical Tension	1	2	1	0	0
Lifestyle	0	4	0	0	0
Worry	0	2	2	0	0
Panic	0	4	0	0	0
Avoidance	0	0	0	0	4
Sleep	0	2	0	0	2
Tranquilizers	0	0	0	0	4

Their views of the bibliotherapy component were again broadly positive (Table 5). All 4 found helpful the sections on: what is anxiety, managing physical tension, lifestyle, worry and panic attacks. Three of the sections were seen as not applicable by at least 50% (n = 2) of patients: those on avoidance, sleep and tranquillisers. Of the sections deemed by patients to be relevant, four were seen as at least quite easy to understand by all patients

(Table 6). However, those on worry and managing physical tension were seen as quite difficult by 2 and 1 patients respectively.

The programme overall was rated as of 'standard ease' to read, using the Flesch (1948) formula. This means 75% of USA adults could read it without difficulty, the IQ required being 90+. In terms of individual sections, these were rated for 'quite easy' up to 'fairly difficulty' to read. The sections on worry and managing physical tension were rated as 'fairly difficult' and 'standard' respectively.

2.4 DISCUSSION

Whilst acknowledging a very small sample size and the absence of a control condition, taken together the therapy sessions and the bibliotherapy programme were associated with valuable clinical changes for all 5 patients during the period of therapy, gains which maintained at the 3 month follow up. In contrast, there were no changes during the waiting period for therapy. The improvements occurred in a number of important areas: anxiety, depression and patients' target problems.

The relatively uncontrolled nature of the pilot stage prevents the drawing of any firm conclusions of a causal nature. This said, 4 of the 5 patients had been experiencing GAD for between 2 and 5 years prior to entering therapy. Further, there were no changes

during the waiting period. Hence, the large degree of change in all 4 within the 4 month period of therapy may indicate a link between therapy and improvement.

Nor do the results permit firm conclusions to be drawn about the relative merits of the bibliotherapy programme and the therapy sessions. They indicate that the bibliotherapy programme was experienced as generally helpful and at least quite easily understood. Further, its contents, as applied by a therapist, were deemed relevant to the treatment of GAD by the patients and the therapist. Patients reported it helped them understand more about their condition, feel reassured and cope better with it.

It was also apparent that patients valued the meetings with the therapist for a number of reasons, including many that would not be present under minimal therapist contact conditions. These reasons included the motivating, reassuring and praising role of the therapist; having someone to talk to both about the programme and their life problems; and the role of the therapist in helping to translate the programme's contents to their particular problems.

The strongest conclusion that might be drawn from the above results is that the bibliotherapy programme warrants further evaluation as a treatment for GAD, under better controlled conditions.

The above results also helped identify potential areas in which the programme could be improved, especially for use under minimal contact conditions. These included making the sections on physical tension and worry more easily understood. It was decided to reduce the length of the physical tension section, separating the potentially confusing combination of information on the interaction between anxiety and symptoms from the advice on how to learn to relax. A new section was thereby created, entitled 'Stress and Illness'. (See Appendix 5).

In the leisure section, the therapist had reflected in his TSQ's on the relatively large amount of time given to leisure, at the expense of time on later, arguably more important sections. Perhaps in support of this, the therapist also commented on certain patients non completion of the exercises in this section. It was decided to reduce the length of this section, mainly by significantly reducing the number of exercises, particularly in the areas of pacing, leisure and social support.

In the worry section, patients had experienced difficulties understanding the author's attempts to simplify Beck's anxiogenic triad (Beck, 1979) into 2 cognitive errors. It was decided to replace this with an account of Beck's 10 common cognitive errors (Beck & Emery, 1985). In the author's experience, patients during therapy

often find these errors relatively easy to identify with, the number permitting a degree of personalising, thus improving the degree of fit to each person. Patients in the pilot trial had also experienced difficulties generating their own more helpful, less irrational thoughts. To reduce this problem, and hopefully thereby reduce the need for the therapist, this section was further revised to include a large number of common irrational or unhelpful thoughts, each illustrating one of the 10 common errors. Further, a list was provided of alternative more rational, hopefully more helpful thoughts. These could be either used in their own right in the form of coping self-statements (see Meichenbaum, 1974, 1977) or used to help patients generate their own alternatives.

In an attempt to further aid use and understanding, the entire programme was revised where possible to simplify the reading level.

Given the relatively low degree of relevance of the sections on avoidance, sleep and tranquillisers, it was decided to combine these into one section. In part this was an attempt to shorten the entire programme to reduce problems with compliance. The reduction in the number of sections also aimed to increase the emphasis on the core coping skills areas, albeit at the expense of particular symptom areas which might be of less general relevance. The core coping skill areas were taken as relaxation, lifestyle change, cognitive

change and assertion. The premise was the core coping skills could be applied to a range of different symptoms, including behavioural avoidance, sleep disturbance and panic attacks.

A new section on assertion was created. This arose from the therapist's experience of difficulties within the programme helping patients address relationship problems which were salient to their experience of anxiety. For example, the woman patient who was fearful of saying 'no' to her boss's seemingly excessive work load requirements, and a male patient who felt angry with his wife for not showing more interest in his work problems but who was fearful of saying anything in case it damaged their relationship. This addition fitted well with Borkovec and Newman's (1998) subsequent proposal that cognitive behavioural approaches to GAD be extended to include an interpersonal component. This followed from their belief that the worry central to GAD was often linked to interpersonal concerns.

CHAPTER 3

EVALUATION OF THE BIBLIOTHERAPY PROGRAMMES

3.1 INTRODUCTION

This chapter describes the study's second and main stage, the evaluation under minimal therapist contact conditions of the two bibliotherapy programmes developed in stage 1 of the study, as described in Section 2 above.

3.2 METHOD

3.2.1. Design

The design of this stage of the project was approved by the ethics committee of the Warwickshire Health Authority.

Chapter 2 above described the initial development of the full bibliotherapy programme. Subsequently amended in the light of the pilot study's results, the final programme had two primary components: an information component describing the causes and consequences of anxiety and a coping component based on cognitive behavioural therapy.

This stage of the study was designed to test the 6 research hypotheses defined above (section 1.5.3). To do so, two bibliotherapy programmes were created from that developed in the

pilot study: an information only programme (IOP) and one comprising information plus coping skills advice, hereafter referred to as the full programme (FP).

The IOP served as a treatment of interest in its own right, as follows from research hypothesis 2 which postulated that information alone on anxiety would produce clinical gains. The IOP also served as a treatment control for the FP, as required by research hypothesis 2 which postulated that the FP would produce greater clinical gains than the IOP.

To control for changes due to time, both treatment conditions were in turn compared with a no treatment, wait list control (WLC) condition. Patients were allocated randomly to each of the three conditions. To maintain the integrity of the 3 conditions, all patients were requested to avoid receiving additional psychological help during the duration of the project. This included the use of other self-help materials. No control of medical treatment was attempted, including use of psychotropic medication.

To increase the control for changes due to the passage of time, measures were taken at 2 points: initial assessment (pre) and 3 months after initial assessment (post).

A 3 month post period was chosen as this was seen as the minimum amount of time for patients to work through the FP. Ideally another, later measurement point would have been chosen. This was decided against on ethical and practical grounds. Ethically it was felt unreasonable to withhold the full programme for longer than 3 months from patients in the WLC and IOP conditions. Further, patients concurrently on a CMHT waiting list might have had their treatment delayed if the post period was longer than 3 months. Pragmatically, the assessors did not have sufficient time to conduct a third assessment interview with every patient thus extending the follow-up period. Further, it was thought likely that the WLC and IOP patients would be more likely to seek alternative treatments the longer the post period lasted.

The sample size was set at 60, random allocation creating 3 equal conditions of 20 clients each. Previous studies in the area have obtained significant results with comparable sample sizes (Gould et al, 1993; Kiely & McPherson, 1986).

Potential experimenter bias would have been reduced by using an assessor at the post stage blind to the clients' research condition. This was not possible due to the absence of additional suitably qualified staff. Instead, the author or a suitably trained psychology assistant conducted both the pre and post assessments.

Potential experimenter bias was reduced by the use of structured interviews and client self-administered measures. Also attempts were made at the post stage to reduce the assessors' awareness of the patients' research condition by recording this information separately to their clinical records.

The IOP and FP were administered under minimal therapist conditions. The assessor spent up to 10 minutes explaining to each patient the programme using a scripted description. Such conditions were seen as comparable to the ultimate intended use of the programmes if found to be effective. The procedure also attempted to control for the amount and content of contact with the assessor by the use of structured interviews and patient-administered questionnaires.

3.2.2. Sample

Included were the first 60 suitable patients who agreed to take part in the research project. Suitable patients were defined as males or females aged 17 – 69 inclusive, with a primary diagnosis of GAD. Additional primary diagnoses of other specific anxiety conditions or depression were deemed acceptable given the high degree of co-morbidity between such conditions (Rapee et al, 1988; Sanderson & Barlow, 1990; Wittchen & Essau, 1993). To recruit a sample of purely GAD sufferers would hence severely limit the generalisability

of the study's results. Further, as described earlier, Rapee (1991) has suggested that GAD be viewed as the basic anxiety disorder, such that treatment of GAD might be expected to positively impact on any other more specific anxiety disorder present, as found by Borkovec et al (1995).

To be excluded were patients with other additional primary diagnoses including: interpersonal problems including psychosexual dysfunctions; eating disorder; alcohol or substance misuse; or psychoses. Also excluded were patients who had ever or were receiving any form of psychological treatment for anxiety. This included bibliotherapy or simple advice on anxiety management from any source, including the referral agent.

3.2.3 Assessors

The assessors were a psychology graduate employed as a psychology assistant and the author.

3.2.4 The Bibliotherapy Programmes

The FP was broadly similar to that developed and evaluated in the pilot stage of the project (Chapter 2). Amended in the light of the results of this evaluation, it was made up of 8 sections. As before, each was arranged in a sequential manner, subsequent sections building to some degree on the contents of the previous ones. There

was again an attempt made to sequence sections in the order of increasing complexity or difficulty of use. The aim was to encourage patients by earlier achievements to proceed when the effort required increased.

Section 2.2.4 gives a detailed description of the original bibliotherapy programme. The amendments made and their rationale are discussed in more detail in Section 2.4.

In summary:

Section 1 – 'Introduction to the Programme'; this section was unchanged.

Section 2 – 'What is Anxiety?'; this section included a broader range of case vignettes given that patients in the pilot stage found these very useful. The aim was to increase patients' sense of identification with the programme, thereby potentially increasing their compliance with its use.

Section 3 – 'Stress and Illness'; this section was new and described the relationship between anxiety or stress and physical and emotional distress. The information included in it was previously included in the original 'Managing Physical Tension' section. Its separation into a new section meant there was a clear separation

between the information sections (Sections 2 and 3) and the skills sections (Sections 4 to 8 inclusive).

Section 4 – 'Managing Physical Tension'; this section was a simplified version of the original with the omission of the information now included in the 'How Anxiety Causes Illness' section.

Section 5 – 'Lifestyle and Stress'; this section was very similar to the original. It was shortened given that the pilot revealed it took a relatively large amount of time to work through. Reduced were the number of exercises suggested to patients given these were poorly taken up in the original, even with therapist support.

Section 6 – 'Changing the Way you Think and Feel' was a significantly re-written version of the original 'How to Worry Less'. It was simplified in a number of ways following the feedback in the pilot stage as described in Section 2.4.

Section 7 – 'Assertiveness'. This was a new section resulting from the author's experience as the therapist in the pilot stage, as reflected in the replies to the TSQ (see Sections 2.3 and 2.4 and Appendix 5 for a fuller account).

Section 8 – 'Bringing It All Together'; this new section was an abbreviated combination of the original separate sections on Controlling Panic Attacks, Avoidance, Sleep Problems, Tranquilliser Use and Maintenance. In this way the overall number of sections was reduced despite the inclusion of two new sections. This might help improve compliance when administered under minimal therapist conditions.

Further, the new programme structure emphasised the core anxiety management skills, each with its own section, i.e. relaxation skills (Section 4), lifestyle change (Section 5), cognitive change (Section 6) and assertiveness skills (Section 7). These core skills were then applied in Section 8 to some common symptoms for anxiety sufferers, e.g. sleep disturbance, avoidance and panic attacks.

The FP was comprised of all 8 sections as described above. The IOP was comprised of Sections 2 and 3, suitably re-numbered, with all references to the other sections removed. Copies of the FP is included as Appendix 5.

Both the FP and IOP were evaluated as being 'easy' to read overall, as were each of the sections using the Flesch (1948) formula. This means 86% of USA adults would be able to read it without difficulty (Ley et al, 1972), the IQ level required being greater than 84.

3.2.5 Measures

Copies of the structured interview used is included as Appendix 3 and the measures and questionnaires used as Appendix 6.

Patients were selected using a biographical questionnaire, a brief structured general clinical interview and the ADIS-R structured interview (Di Nardo et al, 1987).

The biographical questionnaire is one sent to all patients referred to the Psychology Service in the local CMHTs. It asks patients to describe their presenting problems, the history to these, their treatment history, and their personal history including educational and familial. The information provided permitted an initial screening by the author of patients' suitability, deemed particularly important given some of the initial interviews were conducted by a psychology assistant.

The subsequent, brief structured general clinical interview asked a number of broad questions about the patients' presenting problems, including identification by the patients of their main problems and their duration. If the main problem appeared to be anxiety related, the ADIS-R was then conducted.

The ADIS-R was described above (Section 2.2.5) as it was also used in the project's pilot stage. Both assessors were trained in its use via a training videotape (Brown et al, 1994) and peer supervision discussion of its use.

To assess clinical change and evaluate Hypotheses 1 and 2 (Section 1.5.3) patients completed a number of self-completion questionnaires. The standardised psychometric measures were the Beck Anxiety Inventory (BAI; Beck et al, 1988), the Hospital Anxiety and Depression Schedule (HAD; Zigmond & Snaith, 1983) and the Penn State Worry Questionnaire (PSWQ; Meyer, 1990). The BAI and HAD are amongst the most commonly used measures in the anxiety treatment literature, facilitating comparison between studies. Scores on the BAI can be sub divided into different levels of anxiety: minimal (0-7), mild (8-15), moderate (16-25) or severe (> 26). Those on the HAD can be similarly divided on each sub scale: not a case (0-7), possibly a case (8-10) or definitely a case (> 11). The PSWQ was chosen given the core role worry plays in the experience of GAD. On all 3 measures, higher scores indicate higher levels of symptoms.

The final measure used to monitor clinical change was developed by the author, being called the 'Health Questionnaire' (HQ). This self-report questionnaire assessed patients' use of psychotropic

medication in the previous 2 months (less, no change, more); number of visits to their G.P. for any reason in the previous 2 months; and number of days off work (or equivalent) due to illness in the previous 2 months. It also contained a 5 point, equally spaced scale to rate how anxious they had felt over the previous 1 month anchored at each end: 1 = not at all up to 5 = extremely anxious. There were four other 5 point equally spaced scales measuring the patients' quality of life in four main areas: work, leisure, family relationships and intimate relationships. Each point on the scale was labelled: 1 = extremely bad, 2 = bad, 3 = moderate, 4 = good and 5 = extremely good. Patients' quality of life scores were taken as an average across all 4 scales. These 4 scales were derived from a measure developed by Burton (Personal Communication, 1995) and used to measure change during counselling.

A range of other self completion measures were used to assess the relationship between clinical outcome and a variety of other variables (cf Hypotheses 3 – 6 inclusive, Section 1.4.3).

There existed no anxiety symptoms domain specific measure of self-efficacy. Given the importance of domain specific as compared to general self-efficacy measures (Bandura, 1991), the author developed a measure specific to the symptoms of GAD – entitled 'Expectations About Your Health' (EAH).

This was done by first generating with patients not involved in the research project, during one of their routine anxiety management groups, a list of statements describing their beliefs about anxiety and its symptoms. Examples included 'my symptoms are a sign I'm going mad or cracking up'; 'there is nothing anyone can do to reduce anxiety symptoms'; or 'my symptoms are a sign I can't cope – I'm weak'.

A list of 30 such statements were then shown independently to each of 10 clinical psychologists currently working in the same Psychology Department as the author. They were asked to attempt to place each statement in one of 3 defined categories: situational expectancy, outcome expectancy or self-efficacy. The final EAH only contained those statements upon which there was 100% agreement in category allocation between the 10 clinical psychologists.

The EAH contained 3 sections: situational expectancy, outcome expectancy and self-efficacy. There were 4, 4 and 6 statements respectively in each section. Patients were asked to rate how strongly they believed each statement using a 7 point visual analogue scale anchored 1 = totally disagree up to 7 = totally agree. The polarity of scales was randomly reversed to reduce response set

effects. Scoring took this into account, higher scores being seen as indicating higher levels of the respective dimension.

All 3 of Bandura's (1977, 1986, 1997) social cognitive theory components were measured. This is because all 3 have been proposed by Bandura as influencing the experience of stress and anxiety (see Section 1.3.1 above).

Patients' coping skills use were measured using the Health and Daily Living (HDL) questionnaire developed by Moos and colleagues (Billings and Moos, 1981). This is a well standardised, widely used measure of coping with 3 factors: active cognitive coping, active behavioural coping and avoidance coping. Adaptive coping would be reflected in higher levels of active cognitive and active behavioural coping and lower levels of avoidance coping.

Added to the original 28 questions were 3 derived by the author. These used the same response foil as the other questions, patients being asked to rate how often (No, Yes-once or twice, Yes-sometimes, Yes-fairly often) they had coped by using relaxation exercises, pacing themselves better or limiting the amount they had to do by saying 'No'. These 3 items were seen as related to key skill areas covered in the FP but not measured by the original HDL.

These additional items were defined by the author as active-behavioural coping strategies.

Patients compliance with and attitudes to the programmes were assessed via an author developed questionnaire, entitled 'use of the Programme' (UOP). There were different versions of this for the FP and IOP conditions.

The questionnaire was in 2 (IOP) or 3 (FP) sections. The first asked general questions about the entire programme, answered on 7 point visual analogue scales suitably anchored. Questions covered how much of the programme was read, how often, how many suggestions were tried, how often were they tried and how many of the quizzes were tried.

Section 2 assessed in more detail: how often each section had been read on a 5 point scale, (0= never, up to 4 = four or more times); how easy to understand was each section and how useful was each section, these being rated on 7 point visual analogue scales suitably anchored.

The third section (FP condition only) assessed the use of 10 different coping techniques recommended by the programme and how useful they were found to be. Use was rated in terms of whether patients

had at least tried the techniques: Yes, No or Not Applicable. Usefulness was rated on a 7 point visual analogue scale, anchored 0 = Not at all useful up to 7 = Very useful. Coping techniques were chosen from each section, e.g relaxation skills, talking more to someone when worried or stressed, changing your thoughts when worried or stressed and using assertion techniques when angry or stressed.

Three measures of compliance were derived from the questionnaire: general use, reading and coping use. The first was taken as the average to questions in Section 1 about the programme overall: how much read, how often, how many suggestions tried, how often suggestions tried, how many quizzes tried. The range of possible scores was 0 – 30. The second compliance measure was taken as the average of answers to Section 2 relating to how often each section was read. The range of possible scores was 0 – 32. The third measure was an average of scores in section 3 to questions relating to whether each coping technique had been used. A 'Yes' was scored 1, a 'No' zero and 'Not Applicable' was not scored and the average adjusted accordingly. The range of scores was 0 – 10.

Three different measures of compliance were seen as potentially useful given the difficulty assessing compliance by self-report as opposed to detailed behavioural observation. Each measure

assessed compliance in a different way: general use, reading use of each section or coping skill use from each section

The UOP questionnaires also assessed whether the programme had helped patients 'to understand your difficulties and symptoms', 'feel less anxious or worried about your difficulties or symptoms' and 'believe you could cope better with your difficulties or symptoms when they occur'. These were rated on 7 point visual analogue scales, suitably anchored. Derived was a score entitled 'attitude to condition'. This was used as a direct measure of the premise underlying Hypothesis 3 relating to improved clinical outcome being linked with improvements in situational expectancy, outcome expectancy and self-efficacy regarding anxiety state. This premise, as described in 1.4.2 above, held that anxiety levels might be reduced due to changes in the way the anxiety is perceived by the sufferer (Gould & Clum, 1993; Kiely & McPherson, 1986). The EAH measured such perceptions within the framework of social cognitive theory (Bandura, 1977, 1986, 1997). The questions in the UOP just described were an attempt to test this premise from a relatively atheoretical perspective.

The reading ability of patients was measured using National Adult Reading Test (NART; Nelson, 1982). This is a well standardised test originally developed for use in neuropsychological assessments and

now used as a quick and accurate measure of reading ability. Patients are required to read a list of 50 words printed in order of increasing difficulty, the assessor rating the accuracy of their pronunciation against the provided correct pronunciations.

Patients level of education was assessed during the initial assessment interview. They were asked how many years they had spent in full and part time education and what qualifications they had achieved.

Level of qualification was then categorised in order of academic level of achievement. In the absence of a recognised way of doing this, advice was sought from a senior lecturer in the local college of higher education. The result was 6 categories ranging from 1 = no formal qualifications up to 6 = post graduate degree or equivalent. Further details are given in Appendix 8

Patients were also asked for their current or most recent job title, or that of their partner if they worked in the home. Job titles were placed in a 7 category system using the Classification of Occupations and Coding Index (Office Population Censuses and Surveys, 1990). This ranged from 1 = Professional Occupation across to 7 = Unskilled.

As with self-efficacy in relation to anxiety symptoms, there was a need for a measure specific to patient's expectancies or beliefs about their use of the bibliotherapy programmes. As no such measure existed, the author developed one for the project.

As discussed in Section 1.3.3, Schwarzer (1992) concludes on the basis of the then available evidence that the intention to take up a behaviour was a joint function of outcome expectancy and self-efficacy beliefs about the behaviour. Further, that the latter was the crucial variable when the behaviour in question was relatively familiar.

Consequently, in terms of the intention to use the bibliotherapy programmes, the main focus of the measure was on self-efficacy beliefs. This was based on the assumption that the reading of written materials was a relatively familiar behaviour for all patients.

The author generated a list of 15 statements relating to specific behaviours involved in the programmes' use. The ultimate intention was to ask patients in the relevant conditions how confident they were that they could carry out the behaviours described. Examples included: 'you can continue to read it (the programme) even if it doesn't seem to be making sense at the time' ; 'you can set aside

time to read it when all you really want to do is sit and relax or go out'.

These statements were then read by the 10 clinical psychologists used to rate the anxiety self-efficacy statements. They were required to agree or disagree as to whether each statement related to self-efficacy beliefs. Only those 11 statements upon which there was 100% agreement were included. These were subsequently rated by patients on an 11 point visual analogue scale, anchored at 0 = Not at all confident across to 10 = Extremely confident. The final score was a simple addition of the scores on all 11 questions.

All 11 questions were included in the measure given to patients in the FP condition. The measure for the IOP patients was 1 question shorter – that relating to carrying out the coping exercises suggested. The IOP did not contain any such exercises.

In addition to the detailed self-efficacy questions, 4 more general questions were included in a separate section of the EAP measure. 2 of these were an attempt to measure outcome expectancy, i.e. 'how confident are you that reading and using the programme you've been given will a) help you to reduce your level of anxiety or stress and b) help you to cope better with the anxiety or stress you suffer?

The third additional question simply attempted to directly assess patients' intention to use the programme, i.e. 'do you intend to try and read the programme and follow its advice?' Derived from no particular theory, if subsequently linked with programme use, it would be a quick and simple means of predicting compliance.

Finally, and for the same reason, a direct question was asked of the patients' overall level of confidence that they had 'the ability to use the programme, being able to read and understand it and follow its advice?'

As before, the additional questions relating to outcome expectancy and self-efficacy were categorised by the 10 clinical psychologists, all 3 of those proposed achieving 100% agreement.

All 4 additional questions were answered on the same visual analogue scale used for the specific self-efficacy questions.

3.2.6 Procedure

The procedure adopted is summarized in Figure 3 below.

Potentially suitable patients were referred via 2 routes – direct from their GP or from one of the local CMHTs. All potential referral agents had received a leaflet describing the project, including the referral

criteria and procedure. They also received copies of a similar leaflet to give to patients. Surgeries were also given posters advertising the project to put up in waiting rooms. This advised interested patients to discuss with their GPs referral to the project. Copies of these materials are included as Appendix 7.

On receipt of a referral, GP referred patients were sent in the post the biographical questionnaire to complete and return prior to their appointment about 2 weeks later. CMHT referral patients also received a questionnaire if they hadn't already received one during their initial CMHT assessment. Confidentiality of all biographical questionnaires was ensured by the use of unique identifying codes.

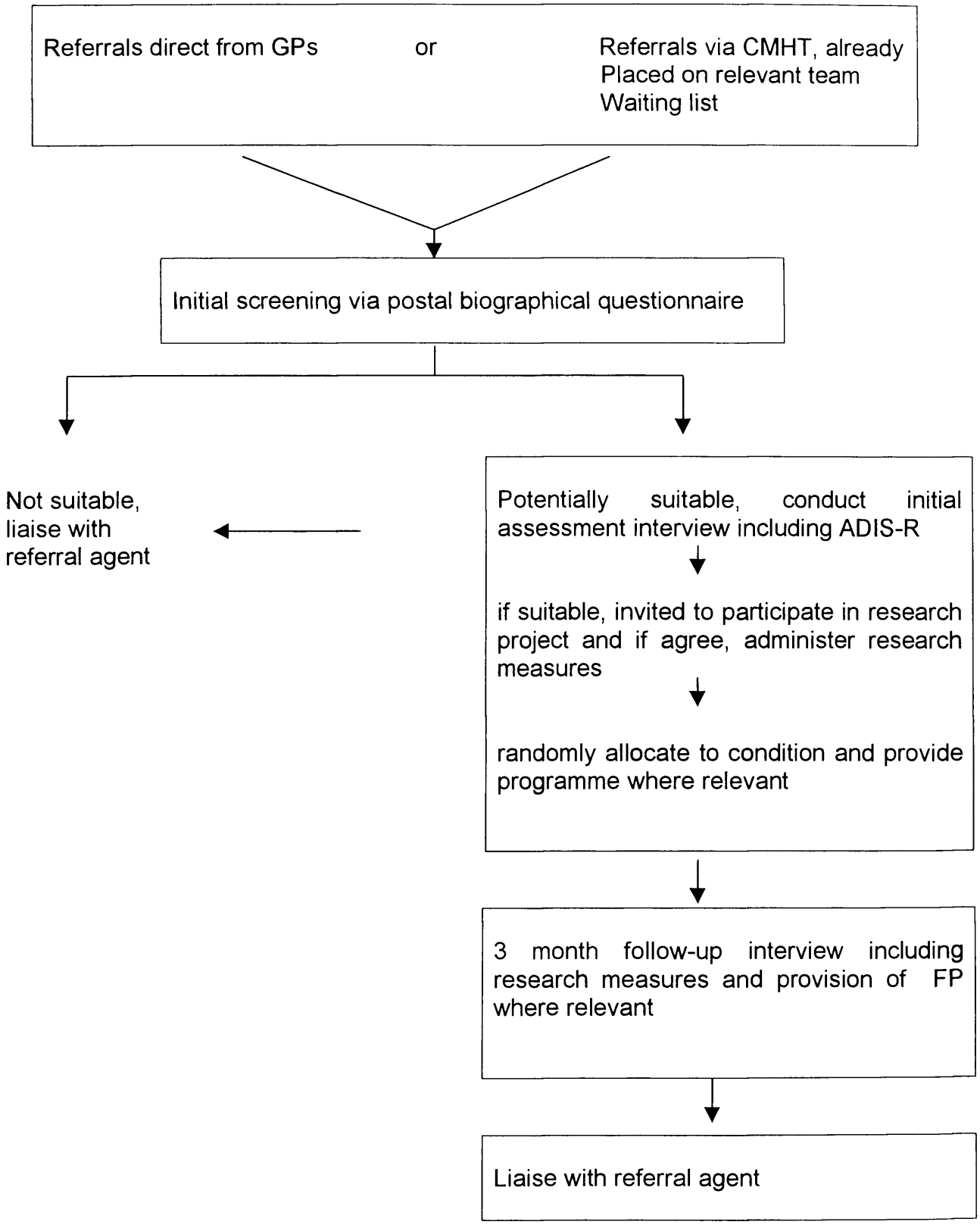
The biographical questionnaires were used as an initial screening device for inappropriate referrals. Potentially appropriate referrals then met with one of the assessors for an interview that lasted up to 2 hours.

The initial assessment interview lasted up to 2 hours. Initially, the research project was briefly described to each patient and their agreement sought to undergo the initial assessment. The structured interview was in 2 sections: a general, brief clinical interview lasting about 20 minutes followed by the ADIS-R which took up to 60

minutes. Patients responses to each question were written down to permit subsequent checking as to the final diagnosis.

If patients met the selection criteria (see Section 3.2.2 above), the research project was described in more detail, emphasis being placed on the possibility they may receive no help for 3 months; the requirement they avoid if possible seeking alternative sources of psychological help including the use of self-help materials; the amount of time entailed from them in completing the pre and post assessment measures; and finally, they were assured their treatment as usual would not be affected by either participation or non participation. In the case of CMHT referred patients, all had already undergone a CMHT initial assessment and were on a relevant CMHT waiting list of at least 3 months. Hence, participation in the project occurred whilst they waited for care. Patients referred directly by their GPs fell into 2 categories: those that did or did not also meet the CMHT's referral criteria. To facilitate this decision, the psychology assistant discussed all her assessments with the author who was also a member of the CMHT assessment panel. In the case of doubt or concern, patients were to be reassessed by the author and automatically excluded from the project, to control for contact with the assessors. They were to be offered the full programme if excluded.

FIGURE 3 PROCEDURE SUMMARISED



If a project patient also met the CMHT's criteria, they were to be offered this service in addition, and if accepted, allocated to the relevant waiting list. If a project patient did not meet the CMHT's criteria, they were only offered a place in the project.

Patients agreeing to participate in the research project then read a further leaflet summarising it and then signed two copies of a consent form, one for their records, one for the project.

Basic biographical information was then obtained: date of birth, current or most recent job title (or that of partner if the patient worked in the home), number of years in full and part time education and qualifications achieved.

The assessment measures were then completed by each patient, the assessor briefly introducing each measure in turn. The NART was the only assessor administered measure, requiring the assessor to record each patient's pronunciation of each of a list of 50 words. Completion of the measures took approximately 20 minutes.

Whilst the patient completed the different measures, the assessor allocated them to a research condition. This was done by reference to a prepared list of 60 spaces, each allocated to one of the conditions using a random number table. Patients were placed in

the next available space on the list. Correct allocation was ensured by the second assessor checking after the interview that the next available space had been filled.

Which condition each patient was allocated to was only recorded on this list. The patients' records did not indicate which condition they were in to help reduce assessor awareness of condition at the post stage.

On completion of the self-administered measures, each patient was informed which condition they were in and the randomisation procedure explained to them. Once again their commitment to continue was sought.

The interview then ended for the WLC patients. For those in the FP or IOP conditions, the relevant bibliotherapy programme was described to each patient. This description followed a scripted format and took up to 10 minutes.

Each patient then completed the relevant programme use self-efficacy questionnaire. Whilst doing so they were given the programme to refer to as necessary. The need for this followed from the content of the questionnaire, referring as it did for example to how easy they may find specific sections to read or use. Schwarzer

(1992) reported that the degree of knowledge of the required actions influenced the respective roles of situational expectancy, outcome expectancy and self-efficacy in predicting subsequent behaviour. On completion of the questionnaire, the interview was ended.

After the initial interview, all referral agents were written to. For patients included in the project, the letter simply confirmed this and made no mention of the condition to which they had been allocated. For patients excluded, the letter was more detailed, explaining why and advising as relevant transfer to alternative psychological care.

All patients were contacted subsequently by post to arrange the second assessment interview. These occurred 3 calendar months after the initial interview. All patients were permitted to contact the author or the CMHT if necessary during this 3 month period.

The second 3 month interview took approximately 50 minutes. All patients received the same questionnaires to complete as at the pre stage with the following exceptions: the NART and the programme use self-efficacy questionnaire were not repeated as these were not change measures. One additional measure, the programme use feedback questionnaire, was completed by patients in the FP and IOP conditions.

Patients in the IOP and WLC conditions were then offered the full bibliotherapy programme. At this point, all patients were informed they had completed participation in the project and no further contact would be had with the assessors. This was then communicated to the referral agents via letter and/or verbally. Where relevant, possible alternative, additional sources of psychological help were discussed.

Finally, the accuracy was checked of the diagnostic categories ascribed to each patient. Barlow (1988) found that amongst the anxiety disorders, GAD was the most difficult to reliably diagnose, leading Borkovec and Wiseman (1996) to recommend additional independent assessment of all patients. This was done by an independent clinical psychologist experienced in adult mental health, blind to treatment condition and patients' scores on the different measures. The clinical psychologist read the initial assessments of each patient and ascribed a diagnosis, primary and secondary, to each. This diagnosis, if in agreement with the original assessor's, was that ascribed to the patient. Cases were referred for a third opinion where diagnosis was unclear or there was disagreement between the original assessor and the independent clinical psychologist. The third opinion sought was from another clinical psychologist experienced in adult mental health. If agreement could not be achieved, the patient was to be excluded from the project.

3.3 RESULTS

Analyses conducted throughout were two tailed unless otherwise specified, taking a criterion significance level of $p < 0.05$.

Tests for normality of data were conducted prior to all analyses reported below. The tests were the Kolmogorov-Smirnov and Shapiro-Wilk, plus visual observation of box plots and histograms. Where data was seen as non normally distributed, the relevant non parametric analysis was conducted.

3.3.1 Sample

60 patients were recruited to the study over an 18 month period. All patients invited to join the study did so.

On intake to the study, all patients were thought to have a primary diagnosis of GAD. However, the subsequent retrospective checks by the independent assessor identified that 12 patients did not meet this criterion. They were consequently excluded from all analyses. 2 more clients failed to attend their follow-up appointments, one from each treatment condition. These were also excluded from all analyses. Visual inspection of the demographic variables and different outcome measures at the pre stage did not indicate the 2 clients differed noticeably from the remaining patients.

This left 46 patients with a primary diagnosis of GAD for whom data was collected at both pre and post stages. There were 25 females and 21 males, of average age 41.1 years (range 20.0 – 65.0). The average duration of the GAD at the pre stage was 7.6 years (range 0.6 – 35.0).

Of the 46 patients, 10 had an additional primary diagnosis of: depression (n = 4), panic disorder (n = 2), agoraphobia with or without panic attacks (n = 2), simple phobia (n = 1) and somatisation disorder (n = 1). For each of them, the patient identified the GAD as the problem causing them most distress and which they consequently most wished help with.

To decide whether subsequent analyses needed to take into account the presence of additional primary diagnoses, initial 3 way repeated measures analyses of variances (time x condition x primary diagnoses) were conducted on the outcome variables. No interactions involving primary diagnosis (GAD only vs GAD plus other primary diagnosis) was found.

It was concluded that the presence of an additional primary diagnosis did not influence the outcome in the 3 conditions. Hence, the data for patients with or without additional primary diagnoses were pooled for all subsequent analyses. Group sizes were FP = 16, IOP = 16 and WLC = 14.

This said, independent Mann-Whitney tests on each of the outcome variables at the pre stage showed that patients with an additional primary diagnosis were significantly more anxious on the BAI ($z = 2.29$; $p < 0.05$) and more depressed on the HAD ($z = 2.84$; $p < 0.01$).

3.3.2 Tests of the Hypotheses

The results summarized below are taken in the order of the original hypotheses.

Hypothesis 1: The cognitive behavioural bibliotherapy programme will lead to clinical improvements in people experiencing GAD.

Hypothesis 2: An information only bibliotherapy programme will lead to clinical improvements in people experiencing GAD, the degree of change being less than found with the cognitive behavioural programme.

Clinical outcome was assessed using the Beck Anxiety Inventory (BAI), the Hospital Anxiety and Depression Scale (HAD), the author designed Health Questionnaire (HQ) and the Penn State Worry Questionnaire (PSWQ).

The means and standard deviations for each of the outcome measures are summarized in Table 7 below:

TABLE 7 MEAN SCORES BY CONDITION AND TIME

(standard deviation)

Experimental Condition		Measure *								
		BAI	HAD Anxiety	HAD Depression	PSWQ	Quality Of Life	Sick Leave	Stress	Medi-cation	GP Visits
FP (n = 16)	Pre	27.0 (15.3)	15.1 (3.6)	8.9 (3.0)	62.9 (13.3)	11.1 (3.1)	10.0 (11.0)	4.0 (0.9)	0.4 (0.5)	2.9 (2.4)
	Post	13.8 (10.2)	9.8 (4.7)	5.2 (4.0)	55.0 (13.6)	14.4 (3.3)	4.0 (10.0)	2.6 (1.0)	0.3 (0.5)	0.9 (1.2)
IOP (n = 16)	Pre	20.7 (9.8)	13.9 (3.5)	8.3 (3.3)	62.1 (11.4)	10.7 (2.9)	8.6 (15.5)	3.7 (0.7)	0.3 (0.5)	1.6 (1.1)
	Post	15.4 (7.1)	11.5 (3.8)	7.4 (3.4)	62.1 (12.6)	12.7 (2.4)	8.6 (20.2)	2.9 (0.7)	0.3 (0.5)	0.7 (1.1)
WLC (n = 14)	Pre	25.9 (9.7)	13.9 (2.5)	7.4 (3.6)	64.3 (8.6)	11.4 (2.7)	11.5 (18.7)	3.8 (0.8)	0.5 (0.5)	1.5 (1.2)
	Post	22.3 (11.2)	13.8 (3.2)	7.9 (3.7)	64.7 (11.4)	12.9 (3.0)	11.6 (21.1)	3.6 (1.1)	0.4 (0.5)	1.1 (0.8)

*Higher score indicates higher level of symptoms, worry, quality of life, sick leave, stress, medication or GP visits.

Analyses for hypotheses 1 and 2 were 2 tailed. This was decided on given the bibliotherapy for anxiety literature is far from conclusive as to the impact on efficacy of different lengths of programme (see Section 1.2.2).

The initial analysis tested for the effectiveness of the randomization procedure by which clients were allocated to one of each of the conditions – FP, IOP or WLC.

Taking pre scores on each of the outcome measures, one way ANOVA tests (BAI, HAD, PSWQ, HQ – quality of life subscale) or Kruskal-Wallace tests (HQ – stress level, days sick, change in medication or GP visits subscales) revealed no significant main effects for conditions taking a significance level of $p < 0.05$. Hence it would appear the randomization procedure was effective.

This permitted the use in subsequent analyses of pre to post change scores.

The analyses for hypotheses 1 and 2 were combined to reduce the probability of artificially increasing the level of significant changes due to multiple comparisons hence reducing the family wise error rate.

One way ANOVA or Kruskal-Wallace tests were conducted, taking pre-to-post change scores on the respective outcome measures. These revealed significant main effects by condition on the BAI ($F(2,43) = 4.15$; $p < 0.05$); HAD – anxiety ($F(2,43) = 5.74$; $p < 0.01$); HAD – depression ($F(2,43) = 5.72$; $p < 0.01$);

PSWQ ($F(2,43) = 3.68$; $p < 0.05$); HQ – quality of life ($F(2,43) = 3.96$; $p < 0.05$); and HQ – stress (Chi-square = 7.36; df = 2; $p < 0.05$).

Subsequent unplanned post hoc multiple comparisons using the Tukey HSD or Mann-Whitney test revealed the FP condition to show significantly greater or pre to post changes than the WLC condition on the BAI ($p< 0.05$); HAD – anxiety ($p < 0.01$) ; HAD – depression ($p < 0.01$); HQ – quality of life ($p < 0.05$); and HQ - stress level ($z = -2.53$; $p < 0.05$). The latter result has not been automatically adjusted for the 3 multiple comparisons conducted. Using the Bonferonni method to do so and taking a criterion significance level of $p < 0.05$, the adjusted criterion level would be $p < 0.02$ and the HQ – stress level result remains significant.

There were no significant differences between the FP and IOP conditions or the IOP and WLC conditions. There were however trends in the expected directions, as can be seen by a comparison of the mean level of change within each condition on each outcome measure (Table 8). In the case of the differences between the FP and IOP conditions, these approached significance on the BAI ($p = 0.073$), HAD-depression subscale ($p = 0.064$) and PSWQ ($p = 0.065$).

TABLE 8 MEAN CHANGE SCORES (Pre to Post) WITHIN CONDITIONS (standard deviations)

EXPERIMENTAL CONDITION	Measure*								
	BAI	HAD Anxiety	HAD Depression	PSWQ	Quality of life	Sick Leave	Stress	Medication	GP Visits
FP	13.25 (12.21)	3.69 (5.69)	5.38 (4.61)	7.88 (8.33)	3.31 (4.08)	5.81 (7.65)	1.31 (1.08)	4.94 (0.50)	1.31 (2.68)
IOP	5.31 (9.31)	0.88 (3.41)	2.44 (2.66)	0.01 (8.63)	2.00 (2.94)	0.3 (11.48)	0.81 (0.75)	5.56 (0.25)	.94 (1.00)
WLC	3.57 (7.68)	0.43 (2.98)	0.14 (2.50)	0.43 (11.86)	0.29 (3.43)	1.08 (9.70)	0.21 (1.12)	4.43 (0.55)	0.36 (1.28)

* higher scores indicate greater improvement pre to post

The superiority of the FP condition relative to the IOP and WLC conditions is reflected in the within group changes pre to post. Paired t or Wilcoxon Signed Rank tests are reported in Table 9.

TABLE 9 SIGNIFICANCE OF PRE TO POST CHANGES WITHIN CONDITIONS (2 tailed)

MEASURE	CONDITION		
	FP	IOP	WLC
BAI	P < 0.001	P < 0.05	Ns
HAD – anxiety	P < 0.01	P < 0.05	Ns
HAD – depression	P < 0.01	ns	Ns
PSWQ	P < 0.01	ns	Ns
HQ – quality of life	P < 0.01	p < 0.05	Ns
Stress	P <0.01	p < 0.01	Ns
Sick leave	P < 0.05	p < 0.01	Ns
GP visits	P < 0.05	ns	Ns

The results show that in the FP condition there were significant changes on 8 measures: the BAI ($t = 4.34$; $df = 15$; $p < 0.001$); HAD-anxiety subscale ($t = 3.78$; $df = 15$; $p < 0.01$); HAD-depression subscale ($t = 3.20$; $df = 15$; $p < 0.01$); PSWQ ($t = 3.78$; $df = 15$; $p < 0.01$); HQ-quality of life ($t = 3.25$; $df = 15$; $p < 0.01$); HQ-stress ($z = 3.10$; $p < 0.01$); HQ-sick leave ($z = 2.50$; $p < 0.05$); and HQ-GP visits ($z = 2.17$; $p < 0.05$).

In the IOP condition, there were fewer and generally weaker significant pre to post changes on 5 measures: BAI ($t = 2.33$; $df = 15$; $p < 0.05$); HAD- anxiety sub-scale ($t = 2.86$; $df = 15$; $p < 0.05$); HQ-quality of life ($t = 2.72$; $df = 15$; $p < 0.05$); HQ-stress ($z = 2.92$; $p < 0.01$); and HQ-GP visits ($z = 2.80$; $p < 0.01$).

In the WLC condition, there were no significant pre to post changes.

To complement the above analyses which are based on changes in absolute scores on the respective measures, the clinical relevance of such changes was assessed by using clinical severity levels or 'caseness' rates on the BAI and HAD measures respectively.

The Kendall tau-b statistic was calculated with a 4 x 4 contingency table for the BAI and a 4 x 3 for the HAD.

Analysing the pre scores first revealed no significant differences between groups in caseness, indicating the randomization procedure had been effective.

Analyzing the post scores revealed significant differences in the expected direction between conditions in severity levels on the BAI (Kendal tau-b = 0.351; $p < 0.01$) and caseness levels on

HAD-anxiety subscale (Kendal tau-b = 0.350; $p < 0.01$). The actual severity or caseness levels are shown in Tables 10 and 11 below. There were no between group differences found in post depression caseness levels on the HAD-depression subscale.

Given the relatively small observed frequencies in some of the cells in Tables 10 and 11, the four BAI categories of severity were collapsed into two (minimal/mild and moderate/severe). Similarly, those for the three HAD-anxiety and HAD-depression caseness categories were collapsed into two (not a case and possibly/definitely a case).

A subsequent three way log linear analysis (condition x caseness x time) on each measure was consistent with the results quoted above. On the BAI and HAD-anxiety there were significant interactions between condition and severity/caseness at the post stage. For the BAI, $X^2 = 8.09$, df = 2, $p < 0.05$ and for the HAD-anxiety $X^2 = 8.865$, df = 2, $p < 0.05$.

TABLE10 BAI SEVERITY LEVELS BY CONDITION AT PRE AND POST INTERVENTION STAGES

CONDITION	SEVERITY							
	MINIMAL		MILD		MODERATE		SEVERE	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST
FP	2	4	2	7	4	3	8	2
IOP	2	3	2	7	6	3	6	3
WLC	1	1	0	2	7	7	6	4

TABLE 11 HAD-ANXIETY CASENESS LEVELS BY CONDITION AT PRE AND POST INTERVENTION STAGES

CONDITION	CASENESS					
	NOT CASE		POSSIBLY CASE		DEFINITELY CASE	
	PRE	POST	PRE	POST	PRE	POST
FP	1	6	1	3	14	7
IOP	1	3	2	3	13	10
WLC	0	0	1	2	13	12

As can be seen from Table 11, at the pre stage the percentage of definite cases on the HAD-anxiety subscale by condition were FP = 88%, IOP = 81%, WLC = 93%. This reduced to 44%, 63% and 86% respectively at the post stage. Taking the more conservative definition of caseness available which uses a cut-off score of > 8, the caseness levels at the pre stage were 93.8, 93.8 and 100%

respectively, reducing at the post stage to 62.5, 81.3 and 100% respectively.

The respective depression caseness levels in each condition were 25.0; 31.3 and 28.6% at pre and 18.8, 18.8 and 21.4% at post.

For hypotheses 3 – 6 inclusive, regression analyses were not conducted as the sample sizes were deemed too small given the number of variables being considered, as follows from Harris's (1985) recommendation that the sample size should exceed the number of predictor variables by at least 50. Instead, correlations were conducted to explore the hypothesized relationships between the different variables. To reduce the number of correlations conducted and hence the potential increased family wise error rate, the outcome variables chosen were the HAD-anxiety and depression subscales, and the GHQ-quality of life measure. These were chosen given significant changes were found on them under Hypotheses 1 and 2 above and they represented a broad range of potential change areas. Only one anxiety measure was chosen given the high intercorrelation between the BAI and HAD-anxiety subscales ($r = 0.69$; $n = 46$; $p < 0.001$).

Correlations conducted were 1 tailed unless otherwise specified given the strong expectations of either relationships in a predicted direction or no relationship at all.

Hypothesis 3 Improved clinical outcome with both bibliotherapy programmes will be positively associated with improvements in situational expectancy, outcome expectancy and self-efficacy regarding anxiety state.

Initial tests for the effectiveness of the randomization procedure on the relevant measures was conducted using a one way ANOVA (health self-efficacy) or Kruskal-Wallace tests (health situational or outcome expectancies) taking pre scores on each measure. These tests revealed no significant main effects by condition, indicating the randomization procedure was effective.

To test the null hypothesis, correlations (Pearson or Spearman) were conducted between the pre to post change scores on the above variables and each of the main outcome variables on which significant change had occurred, within each of the FP and IOP conditions.

Given the multiple correlations carried out, the family wise error rate was reduced by using the Bonferroni adjustment resulting in a new criterion level of significance of $p < 0.02$.

For the FP, improvements on the anxiety subscale of the HAD were positively correlated with improvements in health self-efficacy ($r = 0.57$; $n = 16$; $p < 0.01$), health situational expectancy ($p = 0.67$; $n = 14$; $p < 0.01$) and health outcome expectancy $p = 0.69$; $n = 16$; $p < 0.01$. The percentage of variance on the HAD-anxiety subscale accounted for by each of these variables was hence 32.7%, 44.6% and 47.2% respectively.

The correlations between improvements in HQ – quality of life subscale and all three health efficacy/expectation measures were significant and in the expected direction until the Bonferroni adjustment was made whereupon they all became non significant. The percentage of variance on the HQ – quality of life subscale accounted for by the health self-efficacy, health situational expectancy and health outcome expectancy were 23.8%, 29.2% and 11.6% respectively.

For the IOP condition, there was only one near significant correlation found, that between self-efficacy and HAD – anxiety ($r = 0.52$; $n = 16$; $p = 0.021$), the self efficacy variable accounting for 26.5% of the variance on the HAD – anxiety subscale. The

situational and outcome expectancy variables accounted for 14.7% and 9.3% respectively of the variance on this outcome measure.

Hypothesis 4: Improved clinical outcome with the cognitive behavioural programme will be positively associated with improvements in coping skills.

Changes in coping skills were measured on 3 dimensions – active behavioural, active cognitive and active avoidance.

To test the null hypothesis, correlations (Pearson) were conducted between the pre-to-post change scores on the above variables and each of the main outcome variables, for data from the FP condition. As before the Bonferroni adjustment was made resulting in a criterion significance level of $p < 0.02$.

Improvements on the anxiety subscale of the HAD were positively associated with a reduction in active avoidance coping ($r = 0.64$; $n = 16$; $p < 0.01$), with the latter variable accounting for 40.1% of the variance in the former variable.

Improvements on the depression subscale of the HAD were positively associated with a reduction in active avoidance coping

($r = 0.65$; $n = 16$; $p < 0.01$) and an increase in active behavioural coping ($r = 0.55$; $n = 16$; $p < 0.01$). Hence, the percentage of variance accounted for in the change on the HAD – depression subscale by changes on the active avoidance and active behavioural coping measures were 42.6% and 30.1% respectively.

Improvement on the HQ – quality of life subscale was positively associated with an increase in active behavioural coping ($r = 0.82$; $n = 16$; $p < 0.001$), with the latter variable accounting for 66.9% of the variance in the former variable.

Within the IOP condition, the correlations between outcome and coping measures were generally low and only one reached significance. Reduced avoidance coping was correlated with improvements on the HAD – anxiety subscale ($r = 0.64$, $n = 16$; $p <0.01$).

Hypothesis 5: Improved clinical outcome with the cognitive behavioural programme will be positively associated with the degree of compliance with the programme.

There were three potential measures of compliance with the programme – use of the coping advice within the programme, the

amount the programme was read and general use of the programme.

Given there were no pre scores on these measures, it was not possible to make use of pre-to-post change scores. Correlations (Spearman or Pearson) were conducted using the post scores on these measures and the change scores on each of the main outcome variables, within the Full Condition.

As before, the Bonferroni adjustment was made for multiple correlations resulting in a new criterion level of significance of $p < 0.02$.

Use of the coping advice was significantly positively associated with improvements on the HAD – anxiety subscale ($\rho = 0.67$; $n = 16$; $p < 0.01$) and non signficantly positively associated with improvements on the HQ – quality of life subscale ($\rho = 0.42$; $n = 16$; $p < 0.05$). Use of coping advice accounted for 45.0% and 17.8% of the variance respectively on these two outcome variables.

Hypothesis 6: The degree of compliance with the cognitive behavioural programme will be:

(a) positively associated with reading ability; (b) positively associated with level of

educational attainment; (c) positively associated with self-efficacy and outcome expectancy regarding programme use; (d) negatively associated with initial severity of anxiety.

To test the null hypothesis, correlations (Pearson) were made between the use of coping advice compliance measure and the various variables hypothesized as being associated with compliance. This compliance measure was chosen given the above results showing a link between it and outcome and given the need to reduce the family wise error rate due to multiple correlations. The analysis using the initial level of anxiety was 2 tailed given the relatively weak evidence base for the original prediction, combined with the possibility that any relationship found could logically be in either direction.

Where necessary, Bonferroni adjustments were made for the multiple correlations conducted. This resulted in criterion significance levels of .05, .05, .02 and .05 for each of the above hypotheses respectively.

There was no significant relationship found between the use of coping advice compliance measure and any of the potentially related variables.

In terms of the amount of variance on the compliance measure accounted for by each of the above variables this was: 1.1% by the NART; 3.1% by level of qualifications; 16.2% by the outcome expectation regarding programme use; 1.9% by the general self-efficacy expectation regarding programme use; and 9.4% by the initial level of anxiety on the HAD.

3.3.2 Supplementary Analyses

Subsequent to the main results reported in 3.3.2 above, supplementary analyses were conducted and are reported below. These were conducted to aid the interpretation of the main results.

Generally explored was the potential existence of a ceiling or restricted range effect on any of the variables included in the analyses conducted for Hypotheses 3 – 6 inclusive. A ceiling or restricted range effect might be expected to lower the probability of obtaining an association where this was predicted.

The examination took the form of an exploration of the actual mean, range, standard deviation and shape of distribution on each variable with reference to the potential range of scores on each.

Potential ceiling effects identified are detailed in Table 11 below.

TABLE 12 EXPLORATION OF POTENTIAL CEILING EFFECTS

MEASURE	$\bar{X}$	σ	ACTUAL SPREAD	POTENTIAL SPREAD
Compliance – coping	0.78	0.18	0.25-1.00	0.00-1.00
- general	4.35	0.78	2.60-5.40	0.00-6.00
- reading	2.78	0.79	1.50-3.47	0.00-4.00
Programme use – self efficacy	8.13	1.81	5.00-10.00	0.00-10.00

Potential ceiling effects were noted on 2 of the programme compliance measures (general use and coping use) and the programme general self-efficacy measure. The distribution on each were positively skewed with relatively low standard deviations (Table 12).

Under Hypothesis 3 as a complement to the use of the self efficacy, outcome and situational expectancy measures, correlations were also made between changes on the main outcome measures and the attitude to condition measure. The latter measure was an atheoretical attempt to measure whether patients' attitude to their condition after intervention was related to outcome. These correlations for the FP showed significant relationships between the patients' attitude to their condition and outcome on the HAD – anxiety ($\rho = 0.56$; $n = 16$; $p < 0.02$), and

HQ – quality of life (ρ = 0.74; n = 16; p <0.001). The correlation with the HAD – depression (ρ = 0.43; n = 16; p < 0.053) neared significance. The amount of variance accounted for by the patients' attitude to their condition on the HQ – quality of life, HAD – anxiety and HAD – depression measures were 54.2%, 31.7% and 18.8% respectively.

For the IOP condition, there was one significant correlation, that between the patient attitude to condition and HAD – anxiety measures (ρ = 0.55; n = 16; p < 0.02), with 29.8% variance being thereby accounted for.

Also in relation to Hypothesis 3, correlations were conducted between the 3 coping and the 3 health belief dimensions. This was to check for the independence of coping and health belief variables. Two tailed Pearson or Spearman correlations with a criterion level of significance of p < 0.02 found significant relationships in the FP condition between avoidance coping and situational expectancy (ρ = 0.71; n = 16; p < 0.02) and outcome expectancy (ρ = 0.63; n = 12; p < 0.02). In the IOP and WLC conditions, no significant correlations were found, all co-efficients being very small.

Under Hypothesis 4, additional analyses were conducted to explore the relationship between changes in coping and outcome.

To see if there were between group differences in change on each coping dimension, initially one way ANOVA or Kruskal Wallace tests using pre scores were conducted to test for pre-existing differences between the conditions. None were found.

Subsequent one way ANOVA or Kruskal Wallace Tests used change scores on each coping dimension. That for behavioural coping found a significant between group difference ($F(2, 43) = 4.804$; $p < 0.05$). Subsequent unplanned post hoc comparisons found significant differences in the expected direction between the FP and WLC conditions ($p < 0.01$) and the IOP and WLC conditions ($p< 0.05$).

The means by condition on each coping dimension are given in Table 13 below. Improvements in behavioural or cognitive coping are reflected in higher positive scores with those on avoidance coping being reflected in higher negative scores.

TABLE 13 MEAN PRE TO POST CHANGE SCORES BY CONDITION ON EACH COPING DIMENSION

(standard deviation)

	BEHAVIOURAL COPING	COGNITIVE COPING	AVOIDANCE COPING
FP	5.25 (9.47)	-0.69 (6.55)	-3.19 (3.23)
IOP	4.56 (5.68)	0.56 (3.76)	-2.12 (2.83)
WLC	-2.14 (5.22)	-0.43 (4.47)	-1.93 (3.32)

Finally, examination was made of the patients' reported use of each section and the degree of usefulness associated with each one. This was with a view to exploring the possibility that a lack of change in cognitive coping was related to a lack of use of the cognitive section of the FP. One way ANOVA or Kruskal Wallace tests failed to find any differences between sections in either the amount each was used or their perceived usefulness.

3.4 DISCUSSION

3.4.1 Efficacy of the Bibliotherapy Programme

The above results offer strong support for the efficacy of the FP administered under minimal contact conditions relative to no

treatment or GP treatment as usual. There were significant differences between the FP and WLC conditions on a range of outcome measures covering anxiety and depression symptoms, quality of life and level of stress. There were corresponding pre to post gains in the FP condition in the number of GP visits and days spent ill, gains not experienced in the WLC condition.

Given the FP has been shown to lead to clinical improvements in patients with GAD, null hypothesis 1 can be rejected.

This finding lends support to the limited existing literature which has found bibliotherapy to be of use in treating patients with a range of anxiety disorders (Kiely & McPherson, 1986; White, 1995). In contrast, other studies have found only very limited gains (Donnan et al, 1990; Milne & Covitz, 1988) or none at all (Holdsworth et al, 1998). The longer term maintenance of those gains found needs evaluating, no study reviewed having a follow-up period longer than the 3 months used in the current study. It is also recognised that the current results may have been subject to a degree of experimenter bias. The author was one of two psychologists who administered the random allocation of patients to conditions, and hence could have unduly influenced this process. Further, the author was one of the two assessors at the post stage, neither of whom were blind to treatment condition. The design attempted to control for such potential sources of bias

via the use of an allocation procedure which was checked by the second psychologist and the use of self-completion questionnaires on all measures.

There are only trends indicating the potential superiority of the FP relative to the IOP, and the IOP relative to no treatment. These trends are illustrated by observation between conditions of the changes pre to post in respective means; the near significance of these differences on 3 outcome measures between FP and IOP conditions; the presence of strongly significant pre to post changes on 8 of the 9 measures in the FP conditions, compared with weaker and fewer changes in the IOP condition on 5 of the 9 measures, with no significant changes in the WLC condition; and finally, the presence of significant between group differences in the expected direction in anxiety caseness levels at the post stage.

Whilst strong, such trends do not permit rejection of null hypothesis 2. It is possible that a study with a larger sample size, and hence more statistical power, would permit this. The current study's power was weakened by the loss of 20% of its sample due to the initial misdiagnosis of GAD, a general difficulty when attempting to diagnose GAD (Barlow, 1986).

The absence of significant differences between the FP and IOP conditions, combined with the above trends indicating the potential efficacy of the IOP condition, may indicate that the effectiveness of the FP is due to the additive effect of information about anxiety and coping skills advice. Kiely and McPherson (1986) found that advice only can lead to clinical gains for patients suffering anxiety and stress. Further research could usefully conduct a further component analysis, comparing the relative efficacy of information only, coping skills advice only and the two combined. Durham (1999) also suggests that further research is needed into how different coping components interact, e.g. relaxation skills and cognitive change strategies.

Another potential reason for the absence of more marked differences between the FP and IOP conditions is the effect of the initial assessment meeting with a psychologist for up to 2 hours. The study's procedure aimed to minimise discussion at this meeting, use being made of self-completion measures and a structured interview format. However, even with these, in general clinical practice the author finds patients often comment on how useful it can be to simply describe their difficulties, in writing or verbally. In so doing, they report being able to see their difficulties more clearly, including potential causal factors. This can lead to the beginnings of a positive change process. In

addition, there may be other, less specific and uncontrolled for positive consequences of contact with a health professional.

Such an effect might have contributed to the improvement noted in patients in all 3 conditions. Further studies may wish to consider ways of reducing assessment time. This said, the power of any treatment intervention arguably needs to be strong enough to account for such factors.

The absence of a stronger difference between IOP and WLC conditions, as contrasted with Kiely and McPherson's (1986) results, may be at least in part a result of what appears to the author as a general increase in the amount of information about stress and anxiety available to the general public between 1986 and the present. Such an increase, if it has occurred, may diminish the potential value of an information only programme.

Whilst the FP has been found to be effective in statistical terms, clinical caseness rates indicate that there remain high levels of distress in the majority of patients after receipt of the programme. In the FP condition, the rate reduced pre to post from 93.8% down to 62.5%. This level compares closely to the average level of 60% found in the cognitive behavioural therapy for GAD literature (Fisher & Durham, 1999) and the levels of 62% (White, 1995) and 57% (Kupshik & Fisher, 1999) found in the

bibliotherapy for anxiety literature. The latter level is probably improved by the exclusion from the data of up to 22% of their sample who dropped out of the study.

Such across study comparisons are aided by similar levels of caseness at the pre stage between the current and other studies (eg Barlow et al, 1992; Borkovec & Costello, 1993; Butler at al, 1991; Durham et al, 1999; White, 1995). Also, where studies used the same measures of anxiety as the current study, initial and post intervention levels of anxiety appear similar across studies (Butler et al, 1991; Durham et al, 1994; White, 1995).

Despite the apparent comparability in effectiveness of individual therapy and bibliotherapy for GAD or anxiety more generally, the current study offers some support to earlier findings that therapist contact can enhance treatment outcome with bibliotherapy for anxiety (Kupshik & Finch, 1999; White, 1995). In the pilot stage reported in Section 2, caseness levels fell following individual therapy plus bibliotherapy from 100% to 20% at post therapy and 0% at 3 month follow-up. These are considerably larger changes than achieved in the FP condition of the subsequent main study. The two bibliotherapy programmes used were broadly similar, the main difference between the two stages of the project being the presence of 16 hours of therapist contact discussing the programme in the pilot compared with only up to 10 minutes in

the main study's FP condition. Such tentative comparisons are hampered by the use of different methods of defining caseness at each stage of the current study, the pilot stage's very small sample size and its relatively poorly controlled design. Future research might usefully compare bibliotherapy with and without therapist contact, with an individual psychotherapy condition, perhaps in combination with a no treatment control to replicate the current findings.

The current study also found that the effectiveness of the FP was unaffected by the presence of co-morbid anxiety disorders or depression. This fits with Borkovec et al's (1995) finding that successful individual cognitive behavioural therapy for GAD also resulted in improvements in co-morbid anxiety disorders and/or dysthymia. Unfortunately the current study did not assess the impact of the interventions on co-morbid anxiety conditions. It did find significant improvements in depression level following use of the FP. These findings also fit with the view of GAD as a core component of other anxiety disorders (Rapee, 1991) or even neurotic disorders in general (Tyrer et al, 1993).

Another positive finding from the current study was the very low drop-out rates of 5.9% from each of the intervention groups. This level is similar to that found by White (1995), perhaps because both studies assessed patients within the context of an NHS

secondary care Psychology Service. Such a context may enhance compliance as reflected in drop-out rates given it requires a degree of motivation to attend such a unit, there is a degree of pre-selection by GPs and for some patients in the current study and all in the White (1995) study, the interventions were a potential pre-cursor to individual therapy, an option which might motivate patients to comply. In contrast, other studies in the field found much higher drop-out levels, perhaps because of the use of GPs who simply handed the programme over to suitable patients (Donnan et al, 1991; Holdsworth, 1996) or self-selecting patients who had no contact with a health professional, receiving their materials via the post (Finch et al, 2000).

3.4.2 Processes potentially related to outcome

3.4.2.1 Health beliefs

The study found evidence that in the FP and IOP conditions outcome was associated with changes in health self-efficacy, health situational expectancy and health outcome expectancy. Within the FP condition these relationships were strongest, with significant correlations between changes in HAD-anxiety and changes on all 3 health belief dimensions with near significant results between all 3 and changes in HQ-quality of life. Ranging from 12.6% up to 47.2%, relatively large degrees of variance on the outcome measures were associated with each of the health belief dimensions.

In the IOP condition, the relationships were weaker with only one near significant correlation between changes in HAD-anxiety and health self-efficacy. The degrees of variance on the HAD-anxiety accounted for by the 3 dimensions were correspondingly smaller but still relatively large at between 12.6% and 23.8%.

These findings lend support to the hypothesis arising from Bandura's (1977, 1986, 1997) social cognitive theory, and the supporting evidence reviewed earlier, that there is an association between the degree of emotional disturbance experienced by people and their beliefs about their condition. More specifically, in the current study patients' improved clinical state in the FP and IOP conditions are associated with their beliefs that: the outcome of their anxiety is not necessarily disastrous (situational expectancy), something can be done to better manage their anxiety (outcome expectancy), and they can do this something (self efficacy).

On this basis, Null Hypothesis 3 can be rejected.

The linkage between peoples' beliefs about their condition and outcome is reinforced by the study's findings of association between outcome and patients' beliefs as more directly measured by the attitudes to condition measure. As with the measures based on the social cognitive theory, the associations were

strongest within the FP condition, with significant correlations between changes on the attitude measure and both the HAD-anxiety and GHQ-quality of life measures, that with the HAD-depression being nearly significant. The amount of variance associated with these correlations were relatively high and ranged from 18.8 to 54.5%.

In the IOP condition, there was only one significant correlation, that with HAD-anxiety with 29.7% of its variance being accounted for.

These correlations show that outcome was associated, particularly in the FP condition, with patients' increased beliefs that they knew more about their condition, felt less anxious about it and more confident they could cope better.

What cannot be assumed on the basis of this correlational data is that the changed beliefs brought about the improved outcome. For example, as Eastman and Marzillier (1984) argue, it is difficult in such circumstances to determine whether beliefs change as a result of improved coping which is itself perhaps the key determinant of subsequent change.

As reviewed earlier, there is evidence that self-efficacy beliefs and coping abilities can be independent of each other. They can

also be closely associated, as follows from social cognitive theory which proposes that one of the 4 routes to improved self-efficacy is an improved sense of mastery or coping capacity.

In the current study, it is possible that the belief changes occurring within the IOP condition at least were independent of coping change given the programme contained no coping skills advice. This fits with Kiely and McPherson's (1986) original suggestion that given clinical change was not associated with coping behaviour change, it might have been due to improved beliefs about their anxiety. This was a link proven in the Borden et al (1991) study with panic attack sufferers.

Whilst the current study did find a relationship in the IOP condition between reduced avoidance coping and improved anxiety level on the HAD-anxiety, there was no correlation found between changes on the health belief dimension and coping dimension indicating the two variables are independent of each other.

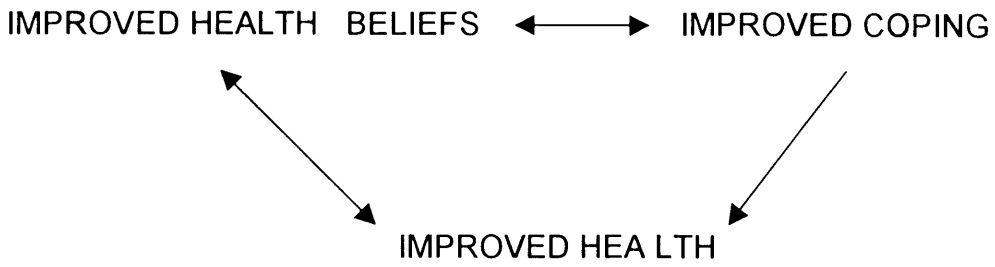
That clinical change following the FP was more strongly associated with changes in beliefs might be due to the additive effect proposed in Section 3.4.1. It was proposed that clinical improvement in the FP condition was the result of both general information about anxiety and coping skills advice. The provision of information via the IOP may have changed beliefs via the

verbal persuasion and vicarious experience routes defined by social cognitive theory. This change may have been more limited than suggested possible by Kiely and McPherson's (1986) study due to the proposed increase in general knowledge about stress and anxiety. Such an increase would lessen the impact of the IOP and reduce the association between clinical change and belief change.

With the impact on beliefs of the IOP weakened, the differential effect of the provision of coping skills advice might be heightened. Such advice, if it led to improved coping skills would increase self-efficacy beliefs by increasing patients' sense of mastery. Further, any consequent improvement in clinical condition due to either improved beliefs or improved coping would in a self-perpetuating manner lead to further clinical gains, via Bandura's (1976, 1987, 1996) fourth proposed route to improved self-efficacy, improvement in autonomic or emotional arousal.

This interactive explanation of the clinical change process has three main elements: belief change, coping change, and clinical change. (Figure 4). Improved beliefs might result in improved health and/or improve the uptake of coping behaviours. In parallel, improved coping might improve health or reciprocally improve health beliefs. Finally, improved health might reciprocally improve health beliefs.

Figure 4: PROPOSED MODEL OF INTERRELATIONSHIP BETWEEN COPING, BELIEFS AND CLINICAL OUTCOME



This model, as derived from social cognitive theory, describes causal relationships which the results of the current study cannot directly support using correlational data. A larger scale study, perhaps using multiple regression techniques, would help clarify the interrelationships. The current study has found that there is the predicted interrelationship between changes in health beliefs and clinical outcome.

3.4.2.2 Coping

It has also provided support for the hypothesised relationship between changes in coping and clinical outcome in the FP condition. There were significant correlations between improvements in behavioural coping and improvements on the HAD-anxiety and HQ-quality of life subscales; and reductions in

avoidance coping and improvements on the HAD-anxiety and depression subscales. There were correspondingly large amounts of variance on the different outcome measures associated with the coping changes, ranging from 30.1% up to 66.9% These correlations permit rejection of Null Hypothesis 4.

That the FP is contributing to this improvement in coping via its provision of coping advice is suggested by the finding of significantly greater improvements in behavioural coping in the FP condition compared with the WLC condition, paralleling the clinical superiority of the FP. In parallel, the IOP condition was associated with weaker changes in coping, with only one significant correlation, that between changes in HAD-anxiety and avoidance coping. Comparisons of the means on the 3 coping dimensions confirm the trend of superiority for the FP condition relative to the IOP and WLC conditions.

These findings complement those reviewed earlier of Kiely and McPherson (1986) and Holdsworth et al (1996). Kiely and McPherson found no relationship between coping skills change and outcome, but their bibliotherapy programme contained no coping skills advice. It is unclear why in the current study the IOP condition was associated with some limited improvement in coping. In the Holdsworth et al study, the bibliotherapy condition was not associated with greater improvements in coping than the

treatment as usual condition, but neither was it related to improved clinical outcome. They did not report analyses to indicate whether outcome was associated with coping changes within either condition.

The absence in the current study of an association between changed cognitive coping and outcome may be linked with a number of factors. It is possible that the relatively short time scale of the project prevented patients fully utilising the later, cognitive section of the programme. In partial contradiction of this possibility, the relevant section was not read less often than any other, nor was it rated as any less useful.

A second possible reason for the lack of association noted is a time scale which may have been too short for the relevant cognitive changes to occur. Thirdly, it is possible the process of cognitive change was too complex for patients to achieve without therapist guidance, Butler and Booth (1991) suggesting that therapist contact may facilitate the transmission of more complex forms of therapy. The earlier sections of the programme were behavioural in content, including a relaxation tape which was relatively straight forward to self-administer. Another reason for the lack of association found relates to the coping measure used. It may not have been sensitive to the changes which might result from cognitive therapy. The cognitive dimension to the measure

used included items such as 'prayed for guidance and/or strength', 'drew on past experience, I was in similar situations before' or 'took one day at a time, one step at a time'. These were not areas or beliefs addressed by the programme. In partial support of this possibility, there was a significant main between group effect found on the PSWQ, indicating differential between group rates of improvement in level of worry. However, it did not reflect significant superiority for the FP condition, just a trend in that direction.

As mentioned earlier, further research could usefully conduct a more detailed component analysis, permitting consideration of the differential impact of the cognitive section. The use of a longer follow-up period and using a measure of cognitive change such as the Dysfunctional Attitude Scale (Weisman & Beck, 1978) would also potentially help clarify the validity of the above suggestions.

3.4.2.3 Compliance

The third variable that was predicted to have a relationship with outcome was compliance with the programme. Of the 3 compliance measures developed for the study, the only one which was found to be related to outcome was the measure of coping advice compliance. This was significantly associated with improvements on the HAD-anxiety and near significantly with

those on the HQ-quality of life, being associated with 45.0% and 17.8% of variance on each respectively. Such evidence provides support for the rejection of Null Hypothesis 5.

Such a qualified result perhaps fits with the very limited available literature for bibliotherapy of anxiety reviewed earlier which found a significant relationship (Rosen et al, 1976), a trend (Kuplik & Fisher, 1999) and no relationship (Kiely & McPherson, 1986).

In retrospect, it is perhaps not surprising in the current study that of the 3 compliance measures used, it was the coping skills measure that was related to outcome. This assessed whether or not use was made of each coping technique covered in the FP. In contrast, the general use measure simply asked in very general terms about programme use, e.g. overall how much was read or overall how often was it read. The reading use measure asked how often each section was read. Given coping change was related to outcome, it is perhaps more likely that outcome will be related to a compliance measure which directly assesses the use of the coping advice.

Relatedly, it is possible the potential ceiling effects identified for the general use and coping use measures would have restricted the degree of association between these measures and outcome. Even though there appears no such effect for the reading use

measure, the average score of 2.78 indicates each section of the programme was read 2.78 times. The programme itself recommended each section was read 2 to 3 times, indicating a high degree of compliance was achieved. The potential ceiling effect on the coping use measure might be reduced if a different response foil had been adopted, enquiring about how often each technique had been tried, thus increasing its sensitivity and hence range of scores.

It is possible that the general or reading use measures would have been more predictive of outcome if drop-outs had been more of a problem in the current study. People who drop-out are perhaps less likely to make use of the programme and thereby would create a larger degree of variance in compliance scores to allow a better assessment of the potential role of compliance.

That compliance was generally high, including the low level of drop-outs, may be related to the design issues discussed earlier. The study potentially recruited a more motivated patient group. Further, subsequent contact with a psychologist who introduced the programme to them, albeit only taking up to 10 minutes to do so, may have increased compliance. Kupshik and Fisher (1999) found compliance with their bibliotherapy programme was enhanced with greater levels of therapist contact. In contrast, compliance including drop-outs may be more of a problem under

purely self-administered conditions. Hence subsequent research might examine compliance under purely self-administered compared with the minimal contact conditions used in the current study, potentially in a primary care setting to reduce any potential motivational effects caused by referral to a psychology service.

More generally with respect to future research into the processes which may relate to outcome, larger sample sizes and the use of multiple regression techniques would permit a more powerful exploration of the relevant variables. The current study serves to confirm that variables worthy of further consideration in this regard include health beliefs, coping and programme compliance.

3.4.3 Potential Predictors of Programme Compliance

There were no significant relationships found between the use of coping advice compliance measure and reading ability, level of educational attainment, programme use beliefs (self-efficacy, outcome and situational expectancies), or initial anxiety level. Hence Null Hypotheses 6(a), (b), (c) and (d) cannot be rejected.

Overall, the absence of such relationships may be due to some of the processes already discussed. For example, the small sample size within the FP condition would reduce the statistical power of the analyses. A potential ceiling effect on the compliance measure may have reduced the ability to assess the relationship

with the other variables. More specifically, the lack of a relationship with reading ability and level of educational attainment may be at least in part because the programme was easy to read. The two bibliotherapy for anxiety studies reviewed earlier which found trends suggesting the existence of such links did not assess the ease of reading of their material (Finch et al, 2000; Kupshik & Fisher, 1999). Further, Finch et al made use of a seemingly complex array of bibliotherapy and up to 18 audio and video tapes.

Turning to the role of programme use beliefs, the degree of variance on the compliance measure associated with outcome expectancy regarding programme usefulness was 16.2%. This indicates there is some relationship between the two variables, with patients who believe the programme will be useful being more likely to use it. In developing the study's hypotheses, it was suggested that outcome expectancy beliefs would be a more accurate predictor of programme use in terms of coping skills use. This was based on findings reviewed earlier that show outcome expectancy beliefs are more important than self-efficacy beliefs when the behaviour use being predicted is relatively unfamiliar to patients. This view finds limited support in the study's results.

The potential role of outcome beliefs has practical implications for programme administration. Firstly, it would indicate that it would

be useful to ask potential recipients of such a programme whether they expect it to be useful to them in managing their anxiety. If they have markedly negative views, perhaps an alternative form of intervention might be considered. Alternatively, the programme administrator could discuss the patients' doubts with them, perhaps aiming to increase their outcome expectancy beliefs and hence potentially subsequent compliance and outcome.

The potential role of initial anxiety as a predictor of programme use was originally viewed as speculative as it was based on very limited and indirect supporting evidence. Arguably, a case could be made in either direction given higher levels of anxiety could both inhibit reading ability due to poorer concentration or motivate patients to persist, despite poorer concentration. Perhaps the absence of the predicted relationship indicates both processes were at work.

In general, the potential value of such variables in predicting programme use may be stronger when programme compliance is generally lower, e.g. if totally self-administered. Despite the current absence of the predicted relationships, they may be usefully considered further by research employing larger sample sizes, a better measure of compliance and under different forms of programme administration.

3.5 CONCLUDING COMMENTS

It seems reasonable to conclude on the basis of the current results, and the reviewed literature, that a cognitive behavioural bibliotherapy programme can bring about clinically significant gains for a large minority of patients, suffering either a range of anxiety disorders or more specifically, GAD. In the case of GAD, the presence of other co-morbid anxiety disorders or depression does not appear to affect outcome.

Such conclusions need to be made cautiously given they are effectively based on only 2 studies – the current one and that by White (1995). Moreover, there are 3 other studies indicating limited or no gains following such a programme.

More research is needed both to replicate the current findings and to further develop our understanding of which are the effective components in such a programme. The indications are that information alone contributes to outcome, perhaps via improved health beliefs. The addition of coping advice considerably enhances effectiveness.

Whilst reduced worrying did occur following both interventions, particularly the FP, this effect was not as strong as might be wished for given the central role of worry in GAD. To enhance the programme's effectiveness may require a different approach

to the cognitive change component, a longer period of use and/or at least some contact with a therapist.

Another reason for exercising caution when considering the clinical use of bibliotherapy for GAD is the high residual level of clinical caseness found. Contact with a therapist, either alongside the programme or subsequently may well enhance outcome.

Despite these limitations or concerns, a bibliotherapy programme as developed by the current study or by White (1995) might be a very useful intervention with at least some patients experiencing GAD. Even if only a large minority benefit in terms of clinical significant change, this would be of considerable value in absolute terms given the high prevalence levels of GAD. Further, bibliotherapy programmes may be readily administered in Primary Care where the vast majority of such anxiety disorders are currently treated. The Department of Health's (1999) National Service Framework for Mental Health includes as a major objective the improved availability in Primary Care of psychological therapy for common mental health problems such as anxiety.

It is possible that administration in Primary Care under totally self-administered conditions would increase the problem of

compliance including drop-outs, thus reducing treatment effectiveness, wasting scarce resources and most importantly, wasting patients' time and energy. The latter effects might exacerbate patients' conditions and even discourage them from seeking other, potentially more effective care.

The indications are that some contact with a health professional to at least introduce the programme may enhance compliance. Further research examining the impact on compliance of different modes of administration would be useful. Compliance may also be enhanced if attention is given to the patients' programme outcome expectancy beliefs, i.e. do they believe such a programme will help them? Again further larger scale research may throw additional light on the importance of this and other variables, including reading ability or educational attainment. These may become more important determinants of compliance and hence outcome if compliance levels are lower.

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APPENDIX 1

CRITERIA FOR SAMPLE - STAGE 1

STRESS AND ANXIETY INFORMATION PROGRAMME

SELECTION CRITERIA

INDICATIONS :

A primary diagnosis of Generalised Anxiety Disorder requires achievement of A through F:

A. **Unrealistic or excessive anxiety and worry** (apprehensive expectation) about two or more life circumstances, e.g. worry about possible misfortune to one's child (who is in no danger) and worry about finances (for no good reason), **for a period of six months or longer,** during which the person has been bothered more days than not by these concerns.

B. **If another Axis I disorder is present, the focus of the anxiety and worry in A is unrelated to it,** e.g. the anxiety or worry is not about having a panic attack (as in Panic Disorder) being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive Compulsive Disorder) or gaining weight (as in Anorexia Nervosa).

C. The disturbance does not occur only during the course of a Mood Disorder or a psychotic disorder.

D. **At least 6 of the following 18 symptoms** are often present when anxious (do not include symptoms present only during panic attacks). :

Motor tension

1) trembling, twitching, or feeling shaky
2) muscle tension, aches, or soreness
3) restlessness
4) easy fatigability.

Autonomic hyperactivity

5) shortness of breath or smothering sensations
6) palpitations or accelerated heart rate (tachycardia)
7) sweating, or cold clammy hands
8) dry mouth
9) dizziness or lightheadedness
10) nausea, diarrhoea, or other abdominal distress
11) flushes (hot flushes) or chills
12) frequent urination
13) trouble swallowing or "lump in throat"

Vigilance and scanning

14) feeling keyed up or on edge
15) exaggerated startle response
16) difficulty concentrating or "mind going blank" because of anxiety
17) trouble falling or staying asleep
18) irritability

E. It cannot be established that an organic factor initiated and maintained the disturbance e.g. hyper-thyroidism, Caffeine Intoxication.

F. For the purposes of the research project, age of patients restricted to 17 to 69 inclusive.

CONTRAINDICATIONS

A. Primary diagnosis of some other mental health condition, e.g. depression, psychosis, phobia disorder.

B. Previous receipt of care from mental health services, including primary care counsellor.

C. History of suicide attempts or hospitalisation for mental health reasons.

D. **Needs care of CMHT - please refer as normal where they will automatically be considered for inclusion in the project.**

APPENDIX 2

MEASURES USED - STAGE 1

MODIFIED COMPOSITE HAMILTON ANXIETY RATING SCALE

0=not present.

1=mild:occurs irregularly and for short periods.

2=moderate:occurs more constantly and of longer duration requiring considerable effort on part of patient to cope with it.

3=severe:continuous and dominates patient´s life.

4=very severe:incapacitating.

	0	1	2	3	4
Anxious Mood Worries, anticipation of the worst, fearful anticipation, irritability.					
Tension Feelings of tension, fatigability, startle response, moved to tears, trembling, feelings of restlessness, inability to relax.					
Fears Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.					
Insomnia Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.					
Intellectual (cognitive) Difficulty in concentration, poor memory.					
Depressed Mood Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.					
Somatic (muscular) Pains and ache, twitchings, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.					

	0	1	2	3	4
Somatic (sensory) Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.					
Cardiovascular Symptoms Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missed beat.					
Respiratory Symptoms Pressure or constriction in chest, choking feelings, sighing, dyspnoea.					
Gastrointestinal Symptoms Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, loosness of bowels, loss of weight, constipation.					
Genitourinary Symptoms Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.					
Autonomic Symptoms Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.					
Behaviour at Interview Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exopthalmos.					

0=absent. 1=mild/trivial. 2,3=moderate. 4=severe/incapacitating.

	0	1	2	3	4
Agitiation Restlessness associated with anxiety.					
Psychic Anxiety Tension and irritability, worrying about minor matters, apprehensive attitude, fears.					
Somatic Anxiety Gastrointestinal, wind, indigestion, cardiovascular, palpitations, headaches, respiratory, genitourinary, etc.					
Hypochondriasis Self-absorption, pre-occupation with health, conviciton of disease, hypochondriacal delusions.					

CODE:

DATE:

TARGET PROBLEMS

RATING SCALES:

(a) How great an impact has the problem had on your life?

0 1 2 3 4 5 6 7 8

No impact at all — Very great impact

(b) How severe is the problem?

0 1 2 3 4 5 6 7 8

No Problem — Very Severe

PROBLEM:

1.

Impact _____ Severity _____

2.

Impact _____ Severity _____

3.

Impact _____ Severity _____

CARROLL QUESTIONNAIRE

DIRECTIONS: Complete ALL the following statements by CIRCLING YES or NO, based on how you have felt during the PAST FEW DAYS.

1.	I feel just as energetic as always	YES	NO
2.	I am losing weight	YES	NO
3.	I have dropped many of my interests and activities	YES	NO
4.	Since my illness I have completely lost interest in sex	YES	NO
5.	I am especially concerned about how my body is functioning	YES	NO
6.	It must be obvious that I am disturbed and agitated	YES	NO
7.	I am still able to carry on doing the work I am supposed to do	YES	NO
8.	I can concentrate easily when reading the papers	YES	NO
9.	Getting to sleep takes me more than half an hour	YES	NO
10.	I am restless and fidgety	YES	NO
11.	I wake up much earlier than I need to in the morning	YES	NO
12.	Dying is the best solution for me	YES	NO
13.	I have a lot of trouble with dizzy and faint feelings	YES	NO
14.	I am being punished for something bad in my past	YES	NO
15.	My sexual interest is the same as before I got sick	YES	NO
16.	I am miserable or often feel like crying	YES	NO
17.	I often wish I were dead	YES	NO
18.	I am having trouble with indigestion	YES	NO
19.	I wake up often in the middle of the night	YES	NO
20.	I feel worthless and ashamed about myself	YES	NO
21.	I am so slowed down that I need help with bathing and dressing	YES	NO
22.	I take longer than usual to fall asleep at night	YES	NO
23.	Much of the time I am very afraid but don't know the reason	YES	NO
24.	Things which I regret about my life are bothering me	YES	NO
25.	I get pleasure and satisfaction from what I do	YES	NO
26.	All I need is a good rest to be perfectly well again	YES	NO

27.	My sleep is restless and disturbed	YES	NO
28.	My mind is as fast and alert as always	YES	NO
29.	I feel that life is still worth living	YES	NO
30.	My voice is dull and lifeless	YES	NO
31.	I feel irritable or jittery	YES	NO
32.	I feel in good spirits	YES	NO
33.	My heart sometimes beats faster than usual	YES	NO
34.	I think my case is hopeless	YES	NO
35.	I wake up before my usual time in the morning	YES	NO
36.	I still enjoy my meals as much as usual	YES	NO
37.	I have to keep pacing around most of the time	YES	NO
38.	I am terrified and near panic	YES	NO
39.	My body is bad and rotten inside	YES	NO
40.	I got sick because of the bad weather we have been having	YES	NO
41.	My hands shake so much that people can easily notice	YES	NO
42.	I still like to go out and meet people	YES	NO
43.	I think I appear calm on the outside	YES	NO
44.	I think I am as good a person as anybody else	YES	NO
45.	My trouble is the result of some serious internal disease	YES	NO
46.	I have been thinking about trying to kill myself	YES	NO
47.	I get hardly anything done lately	YES	NO
48.	There is only misery in the future for me	YES	NO
49.	I worry a lot about my bodily symptoms	YES	NO
50.	I have to force myself to eat even a little	YES	NO
51.	I am exhausted much of the time	YES	NO
52.	I can tell that I have lost a lot of weight	YES	NO

Adapted from Carroll, 1980

OFFICE USE
Code: Date:

SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
In collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

Name _____ Date _____ S ____

Age _____ Sex: M ____ F ____. T ____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	(1)	(2)	(3)	(4)
2. I feel secure	(1)	(2)	(3)	(4)
3. I am tense	(1)	(2)	(3)	(4)
4. I feel strained	(1)	(2)	(3)	(4)
5. I feel at ease	(1)	(2)	(3)	(4)
6. I feel upset	(1)	(2)	(3)	(4)
7. I am presently worrying over possible misfortunes	(1)	(2)	(3)	(4)
8. I feel satisfied	(1)	(2)	(3)	(4)
9. I feel frightened	(1)	(2)	(3)	(4)
10. I feel comfortable	(1)	(2)	(3)	(4)
11. I feel self-confident	(1)	(2)	(3)	(4)
12. I feel nervous	(1)	(2)	(3)	(4)
13. I am jittery	(1)	(2)	(3)	(4)
14. I feel indecisive	(1)	(2)	(3)	(4)
15. I am relaxed	(1)	(2)	(3)	(4)
16. I feel content	(1)	(2)	(3)	(4)
17. I am worried	(1)	(2)	(3)	(4)
18. I feel confused	(1)	(2)	(3)	(4)
19. I feel steady	(1)	(2)	(3)	(4)
20. I feel pleasant	(1)	(2)	(3)	(4)

Consulting Psychologists Press
577 College Avenue, Palo Alto, California 94306

SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-2

Name _____ Date _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	ALMOST NEVER	SOMETIMES	OFTEN	ALMOST ALWAYS
21. I feel pleasant	(1)	(2)	(3)	(4)
22. I feel nervous and restless	(1)	(2)	(3)	(4)
23. I feel satisfied with myself	(1)	(2)	(3)	(4)
24. I wish I could be as happy as others seem to be	(1)	(2)	(3)	(4)
25. I feel like a failure	(1)	(2)	(3)	(4)
26. I feel rested	(1)	(2)	(3)	(4)
27. I am "calm, cool, and collected"	(1)	(2)	(3)	(4)
28. I feel that difficulties are piling up so that I cannot overcome them	(1)	(2)	(3)	(4)
29. I worry too much over something that really doesn't matter	(1)	(2)	(3)	(4)
30. I am happy	(1)	(2)	(3)	(4)
31. I have disturbing thoughts	(1)	(2)	(3)	(4)
32. I lack self-confidence	(1)	(2)	(3)	(4)
33. I feel secure	(1)	(2)	(3)	(4)
34. I make decisions easily	(1)	(2)	(3)	(4)
35. I feel inadequate	(1)	(2)	(3)	(4)
36. I am content	(1)	(2)	(3)	(4)
37. Some unimportant thought runs through my mind and bothers me	(1)	(2)	(3)	(4)
38. I take disappointments so keenly that I can't put them out of my mind	(1)	(2)	(3)	(4)
39. I am a steady person	(1)	(2)	(3)	(4)
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	(1)	(2)	(3)	(4)

GENERAL HEALTH QUESTIONNAIRE

GHQ-28

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks.* Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

A1 – **been feeling perfectly well and in good health?**	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2 – **been feeling in need of a good tonic?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A3 – **been feeling run down and out of sorts?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A4 – **felt that you are ill?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A5 – **been getting any pains in your head?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A6 – **been getting a feeling of tightness or pressure in your head?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A7 – **been having hot or cold spells?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B1 – **lost much sleep over worry?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B2 – **had difficulty in staying asleep once you are off?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B3 – **felt constantly under strain?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B4 – **been getting edgy and bad-tempered?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B5 – **been getting scared or panicky for no good reason?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B6 – **found everything getting on top of you?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B7 – **been feeling nervous and strung-up all the time?**	Not at all	No more than usual	Rather more than usual	Much more than usual

PLEASE TURN OVER

HAVE YOU RECENTLY

C1 – **been managing to keep yourself busy and occupied?**	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2 – **been taking longer over the things you do?**	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3 – **felt on the whole you were doing things well?**	Better than usual	About the same	Less well than usual	Much less well
C4 – **been satisfied with the way you've carried out your task?**	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5 – **felt that you are playing a useful part in things?**	More so than usual	Same as usual	Less useful than usual	Much less useful
C6 – **felt capable of making decisions about things?**	More so than usual	Same as usual	Less so than usual	Much less capable
C7 – **been able to enjoy your normal day-to-day activities?**	More so than usual	Same as usual	Less so than usual	Much less than usual
D1 – **been thinking of yourself as a worthless person?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D2 – **felt that life is entirely hopeless?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D3 – **felt that life isn't worth living?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D4 – **thought of the possibility that you might make away with yourself?**	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5 – **found at times you couldn't do anything because your nerves were too bad?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D6 – **found yourself wishing you were dead and away from it all?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D7 – **found that the idea of taking your own life kept coming into your mind?**	Definitely not	I don't think so	Has crossed my mind	Definitely has

A ☐ B ☐ C ☐ D ☐ TOTAL ☐

Published by The NFER-Nelson Publishing Company Ltd.
Darville House, 2 Oxford Road East, Windsor, SL4 1DF, Berks.

First published 1978.

ISBN 07005 0210 6
Printed in Great Britain.

Code 4075.02.4

(FORM B)

THE LEEDS QUESTIONNAIRE

Please indicate how you have been feeling during the last day or two. Underline the answer which best describes how you have felt.

1. I get very frightened or panic feelings for apparently no reason at all.

   a) Yes definitely b) Yes sometimes c) No not much d) No not at all

2. I feel anxious when I go out of the house on my own.

   a) Yes definitely b) Yes sometimes c) No not much d) No not at all

3. I get palpitations, or a sensation of 'butterflies' in my stomach or chest.

   a) Yes definitely b) Yes sometimes c) No not much d) No not at all

4. I feel scared or frightened.

   a) Yes definitely b) Yes sometimes c) No not much d) No not at all

5. I feel tense or 'wound up'.

   a) Yes definitely b) Yes sometimes c) No not much d) No not at all

6. I get dizzy attacks or feel unsteady.

   a) Yes definitely b) Yes sometimes c) No not much d) No not at all

Please check that you have answered all the items. Thank you.

PSYCHOLOGIST USE
Code:
Date:
SA:

SESSION QUESTIONNAIRE (FORM P)

DIRECTIONS:

Below are a few questions about the therapy session you have just had. They are designed to help your therapist know which parts of your therapy are helping you and which are not. Such information is very important given all patients need different types of help. Also, no therapy session is perfect so there is always room for improvement. The information you give is important in designing the rest of your treatment programme.

Please answer as accurately as you can.

QUESTIONS:

1. Overall, how helpful was this session?
   (Ring the relevant number on the scale below).

1	2	3	4	5	6	7	8	9
Very Helpful		Helpful		Neutral		Unhelpful		Very Unhelpful

2. Why did you find the session unhelpful or helpful?

3(a) Of the events which occurred in the session, which one did you feel was the most helpful for you? It might have been something you said or did, or something your therapist said or did.

(b) Why did you find this event helpful?

4. How helpful did you find it? (Ring the relevant number on the scale below).

1	2	3	4	5
Very helpful		Helpful		Neutral

5(a) Did anything else of particular importance happen during this session? Include anything else which may have been helpful, or anything which may have been unhelpful.

(b) Why did you find this event(s) important?

6. Has anything particularly important happened in your life since your last session?

Thank you for your time in answering this questionnaire

PSYCHOLOGIST USE	
Date of session:	--/--/--
Session Number:	_____
Code:	_____

SESSION QUESTIONNAIRE (FORM T)

DIRECTIONS:

Below are a few questions about the therapy session you have just completed. Please answer as accurately as you can.

QUESTIONS:

1. Overall, how helpful do you think this session was to the patient? (Ring the relevant number on the scale below).

1	2	3	4	5	6	7	8	9
Very Helpful		Helpful		Neutral		Unhelpful		Very Unhelpful

2. Why do you think this session was unhelpful or helpful?

3(a) Of the events which occurred in the session, which one did you feel was the most helpful for the patient? It might have been something you said or did, or something the patient said or did.

(b) Why did you think this event was helpful?

4. How helpful do you think the patient found it? (Ring the relevant number on the scale below).

1	2	3	4	5
Very helpful		Helpful		Neutral

5(a) Did anything else of particular importance happen during this session? Include anything else which may have been helpful or unhelpful.

(b) Why was this event(s) important?

6. Has anything particularly important happened in the patient's life since your last session?

Thank you for your time in answering this questionnaire

PSYCHOLOGIST USE	
Date of session:	/ /
Session Number:	
Code:	

TREATMENT PROGRAMME - EVALUATION QUESTIONNAIRE

INSTRUCTIONS

This questionnaire is designed to obtain feedback from patients who have recently finished a course of treatment offered by the Psychology Department.

Our aim is to use the information you give us to update where necessary the treatment programmes we offer, with a view to offering the best possible service to patients. All treatment programmes can be improved upon in some way, however small. So please do not hesitate to be as honest and detailed as you can in your answers. All your answers will be treated in the strictest confidence.

To help you answer the questions it will help you to look at the programme file you were given by your therapist.

Thank you for your assistance in completing this questionnaire.

Mr Peter Watson
District Psychologist

SECTION A

1. Overall, how HELPFUL has the treatment programme been in helping you deal with the difficulties you were experiencing at the start of therapy?

Was it ...

Very Helpful	Quite Helpful	Not Very Helpful	Not at all Helpful
☐	☐	☐	☐

Please tick one box

2. In what ways did you find it

(a) Helpful?:

(b) Unhelpful?:

3. Has the treatment programme	Yes Definitely	Yes	No	Definitely Not
(a) Helped you to understand more about your difficulties?	☐	☐	☐	☐
(b) Helped to reassure you in any way?	☐	☐	☐	☐
(c) Helped you to cope with your difficulties more successfully?	☐	☐	☐	☐

Please explain briefly your answers to:

(a)

(b)

(c)

4(a) Thinking now about the programme file you were given by your therapist, how HELPFUL did you find each section? (You will find it useful to refer back to your own file).

			Very Helpful	Quite Helpful	Not Particularly Helpful	Not at all Helpful
Section 1	Introduction to the programme		☐	☐	☐	☐
2	What is Anxiety		☐	☐	☐	☐
3	Managing Physical Tension	Part A	☐	☐	☐	☐
		Part B	☐	☐	☐	☐
4	Stress Reducing Lifestyle		☐	☐	☐	☐
5	How to Worry Less	Part A	☐	☐	☐	☐
		Part B	☐	☐	☐	☐
6	Controlling Panic Attacks		☐	☐	☐	☐
7	Avoidance		☐	☐	☐	☐
8	Sleep Problems		☐	☐	☐	☐
9	Tranquilizers		☐	☐	☐	☐

(b) If you found any section(s) unhelpful, please explain why this was, mentioning which section(s) it was.

5(a) How easy was each section to UNDERSTAND?

			Very Difficult	Quite Difficult	Quite Easy	Very Easy
Section 1	Introduction to the Programme		☐	☐	☐	☐
2	What is Anxiety		☐	☐	☐	☐
3	Managing Physical Tension	Part A	☐	☐	☐	☐
		Part B	☐	☐	☐	☐
4	Stress Reducing Lifestyle		☐	☐	☐	☐
5	How to Worry Less	Part A	☐	☐	☐	☐
		Part B	☐	☐	☐	☐
6	Controlling Panic Attacks		☐	☐	☐	☐
7	Avoidance		☐	☐	☐	☐

8	Sleep Problems	☐	☐	☐	☐
9	Tranquilizers	☐	☐	☐	☐

(b) If you found any section(s) hard to understand please explain why this was, mentioning which section it was.

6. Were there any topics not covered by the programme which you feel would have been useful in helping you cope better with your difficulties?

7. (a) Was each contact you had with your therapist during treatment?

Too long	Too short	A suitable length
☐	☐	☐

If they were too long or too short, how long would you have liked?

_____ mins.

(b) Were your contacts with your therapist

Too often	Not often enough	Often enough
☐	☐	☐

If they were too often or not often enough, how often would you have liked them? _____ contacts every _____ week(s).

(c) Was your total number of contacts with your therapist

Too many	Too few	A suitable number
☐	☐	☐

If there were too many or too few, how many would you have liked?

8. Are there any ways in which you feel that the time spent with your therapist could have been improved?

9(a) As a result of your treatment programme, do you now do anything(s) new, however small, to cope better with your difficulties?

YES ☐ NO ☐

(b) If Yes, what do you do and how useful do you find it?
Use your programme file to remind you of the technique covered by the programme.

SECTION 2

1. Do you still have your programme file?

YES ☐

NO ☐

2. If No, what happened to it?

Gave it to someone else ☐

Threw it away ☐

Lost it ☐

Did something else ☐ Please say what:

3. How much of the programme did you read?

All	Most	Some	None
☐	☐	☐	☐

4(a) Do you intend to read the programme again in the future?

Yes ☐

No ☐

(b) Please explain briefly your answer to (a).

5(a) Has anyone else apart from yourself read the programme?

Yes ☐

No ☐

(b) If Yes, who and why?

10. Finally in this section, are there any other comments you would like to make about your treatment programme?

APPENDIX 3

STRUCTURED INTERVIEW (ADIS III-R)

BACKGROUND INFORMATION

All the information you give here will be totally confidential, as will your answers to all the questionnaires you complete later.

Name:..... Age: .....

Marital status: .....

Job/Role: ..... Partner's Job/Role .....
(give most recent if currently unemployed) (if applicable)

Education: ....

a) What qualifications do you hold (include numbers of GCSE's, etc)?

.....

.....

.....

.....

b) How many years did you spend in full-time education? .....

c) How many years did you spend in part-time education? .....

A D I S I N T E R V I E W I N T R O D U C T I O N

The interview should begin with a brief introduction and explanation of the purpose of the interview.
A brief description of the presenting complaint should be obtained. In this section, a preliminary determination of the presence of panic attacks, phobic anxiety, and chronic worry should be made (as well as any medical difficulties or life circumstances that may be associated with the presenting complaints).

I will be asking you a number of questions about different areas of your life. First, I would like to get a general idea of what sorts of problems you have been having recently. What have they been?

If you had to identify one factor, what would you say is the main reason that brought you here today? (record patient's response verbatim)

How long have you been experiencing these difficulties?

What, if any, treatment have you received for them (eg counselling, drugs, self-help books ..) ?

Have you experienced similar or different difficulties (emotional) in the past ? If so, please describe.

What, if any, treatments, were received or tried for them?

ADIS-R

INTERVIEW

A. INTRODUCTION TO INTERVIEW

I will be asking you a number of questions about different areas of your life. First, I would like to get a general idea of what sorts of problems you have had recently. What have they been?

Now, I want to ask you more questions about some specific kinds of problems which may or may not apply to you. We have already talked about some of them generally, but now I would like to get more details.

B. GAD

Questions in this section should be used to establish the presence of tension or anxiety with no apparent cause, or anxiety which is related to excessive worrying about family, job performance, finances, etc. and minor matters. This tension is NOT part of, or anticipatory to panics or phobic anxiety.

1(a) What kinds of things do you worry about?

(If patient identifies anxiety, tension or worry which is anticipatory to panics or exposure to phobic situations as the major source of anxiety, ask

(b) Are there things other than _____ which make you feel tense, anxious or worried? What are they?

2. Do you worry excessively about minor things? What are they?

3. During the past 6 months, have you been bothered by :

(a) Muscular Tension

jittery or jumpiness	_____	twitching	_____
trembling or shakiness	_____	restlessness	_____
muscle tension, aches, soreness	_____	fatigability	_____

(b) Autonomic Hyperactivity

sweating _____
palpitations _____
cold/clammy hands _____
dry mouth _____
flushing or pallor _____
dizziness or lightheadedness ____
upset stomach or diarrhoea ____
frequent urination ____
trouble getting breath or lump in throat ____

(c) Vigilance, scanning

difficulty concentrating or mind going blank because of anxiety _____
irritability or impatience _____
trouble falling or staying asleep _____

(d) Apprehensive Expectation

worrying or fearful much of the time about things that might happen ____

DIAGNOSIS OF GAD requires symptoms in 3 of the above 4 categories continuous for at least 6 months

YES/NO

Duration of current episode _____ months

If GAD present GO TO Q.4
If GAD not present GO TO SECTION C

On an average day over the last month, what amount/percentage of the day do you feel tense, anxious or worried?

_____%

5. Last time you experienced an increase in tension, anxiety or worry (aside from panics or phobic exposures) what was happening ?

How did it occur?

Where did it occur/situation?

What were you thinking?

6. How long has the tension, anxiety or worry been a problem?

From _____ to _____ Duration _____ months

7. How did it start?

8. How do you cope with it?

9. How much does it interfere with your life, work, social activities, family etc.?

0	1	2	3	4
None	Mild	Moderate	Severe	Very severe/ grossly disabling

C. PANIC DISORDER

1(a) Have you had times when you have felt a sudden rush of intense fear or anxiety or feeling of impending doom?

YES/NO

If YES - CARRY ON

If NO - GO TO SECTION D

(b) How long does it usually take for the rush of anxiety to pass?

_____ minutes

2(a) In what situations have you had these feelings?

If patient indicates that panic symptoms occur only in a specific situation, e.g. public speaking, heights, driving, etc. further enquiry is necessary to assess the presence of panics which occur while at home, unpredictably in a variety of situations, or at unexpected times.

(b) When you are faced with (phobic situation), does the anxiety come on as soon as you enter it, or is it sometimes delayed, or unexpected? Have you had these feelings come "from out of the blue", while you are at home alone, or in situations where you did not expect them to occur?

YES/NO

PANIC ATTACKS = sudden rushes of intense fear or anxiety, at least some of which have been unexpected.

PANIC ATTACKS ? - YES - GO TO Q.3

NO - GO TO SECTION D

3. During the most recent period of attacks, did you usually experience :

(a) Dyspnea, difficulty breathing ___

(b) Palpitations ___

(c) Chest pain or discomfort ___

(d) Choking or smothering sensations ___

(e) Dizziness, vertigo, or unsteady feelings ___

(f) Paresthesias - tingling or prickling sensations ___

(g) Hot or cold flushes ___

(h) Sweating ___

(i) Faintness ___

(j) Trembling or shaking ___

(k) Fear of dying ___

OR

Fear of going crazy or doing something uncontrolled ___

(l) Nausea or abdominal distress ___

PANIC DISORDER REQUIRES 4 OR MORE symptoms per typical attack

4. During the past 6 weeks, how many panics have you had? (In the absence of marked physical exertion or presence of phobic stimulus or a life threatening situation)

_____ per week for _____ weeks

5. Between panic attacks, do you worry about having more?

YES/NO

6(a) During the time that the attacks were most frequent, how often did they occur?

_____ per week for _____ weeks

(b) When was this period?

From _____ to _____

7(a) How long have panic attacks been a problem?

From _____

(b) How did they start?

3. How much have the panic attacks interfered with your life, job, travelling, activities, etc.?

0	1	2	3	4
None	Mild	Moderate	Severe	Very severe/ grossly disabling

DIAGNOSIS OF PANIC DISORDER -

Q1	YES?		YES/NO
Q2(b)	YES?		YES/NO
Q3	4 or more symptoms per typical attack		YES/NO
Q4	6 panics in 6 week period for definite diagnosis?	OR	YES/NO
OR	3 panics in 3 week period for probable diagnosis?		YES/NO
Q5	YES?		YES/NO
Q8	Some impairment in functioning?		YES/NO

PANIC DISORDER - DEFINITE _____

PROBABLE _____

NO _____

Duration of current episode _____ months

D. PHOBIAS

For each situation, make separate ratings for level of fear, and degree of avoidance using the following scale:

0	1	2	3	4
No fear/ never avoids	Mild fear/ rarely avoids	Moderate fear/ sometimes avoids	Severe fear/ often avoids	Very severe fear/always avoids

1. Do you currently feel fear or a need to avoid things, such as :

		FEAR	AVOID
1(a)	SIMPLE PHOBIAS (single, non social phobias not associated with fear of leaving the home)		
	Certain animals	____	____
	Blood and injury	____	____
	Other	____	____
(b)	SOCIAL PHOBIA (fear of situations involving other people not associated with leaving home)		
	Public speaking	____	____
	Eating in public	____	____
	Writing in front of others	____	____
	Using public toilets	____	____
	Meetings	____	____
	Dating	____	____
	Dealing with authority	____	____
	Other	____	____
(c)	AGORAPHOBIA (fear of leaving familiar setting of home. Usually associated with panic disorder)		
	Travelling (driving, travelling in car/bus/ plane/train/taxi)	____	____
	Shops	____	____
	Crowds	____	____
	Heights	____	____
	Driving	____	____
	Walking	____	____
	Lifts	____	____
	Being at home	____	____

4(a) Have you ever been bothered by fears not currently experienced?

YES/NO

If YES, What and When ?

DIAGNOSIS OF PHOBIA :

Persistent and recurring irrational fear of a specific object, activity or situation with avoidance? (See Q.1 above)		YES/NO
Impairment in functioning? (See Q.2 above)		YES/NO
If YES to both of above, PHOBIA present		YES/NO
Subtype (See Q.1 above)	Simple	YES/NO
	Social	YES/NO
	Agoraphobia	YES/NO
	Mixed	YES/NO

Duration of current episode _____ months

E. OBSESSIVE - COMPULSIVE

1(a) Are you bothered by thoughts or images that keep recurring to you that are unreasonable or nonsensical that you cannot stop from coming into your mind? This is not the same as worrying about things that might happen. I mean things like repetitive thoughts about hurting or poisoning someone, or shouting obscenities in public, or horrible images such as your family being involved in a car accident.

YES/NO

(b) If YES, please describe :

the Thoughts

the Images

the Urges

(c) Do you fight these thoughts/how do you get rid of them?
What happens when you try to resist them?

2(a) Have you had to repeat some act over and over again that does not seem to make sense and that you do not want to do, e.g. washing something over and over again, or counting things or checking something repeatedly?

YES/NO

(b) If YES, what?

(c) Do you try to resist doing them, at least initially, and how?

(d) How anxious do you feel/what do you think of if you can't or don't carry out these acts?

3. How much do these problems interfere with your life, work, home, socially...?

0	1	2	3	4
None	Mild	Moderate	Severe	Very severe/ grossly disabling

4. How long has your current episode lasted?

_____ months

DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER :

(a) Presence of recurrent, persistent ideas, thoughts or images that are egodystonic (See Q.1(a) above) that the person tries to suppress (See Q.1(c) above) YES/NO

(b) Presence of repetitive behaviours designed to produce or prevent a future event or situation. The person must feel compelled to perform the act but also must desire to resist, at least initially (See Q.2(a) and 2(c) above) YES/NO

(c) The obsessions or compulsions cause distress or interfere with functioning (See Q.2(d) and 3 above) YES/NO

If YES to (a) or (b) and YES to (c) - OBSESSIVE-COMPULSIVE YES/NO

Duration of current episode _____ months.

F. MAJOR DEPRESSIVE EPISODE

1. Did you ever have a period of time when you felt depressed, sad, hopeless or lost interest in almost all of your usual activities?

YES/NO

2(a) Has there ever been a time when you felt this way nearly every day for at least 2 weeks?

YES/NO From _____ To _____

(b) When was the first time this happened?

From _____ To _____

(c) Have you been feeling this way nearly everyday for the last 2 weeks?

YES/NO

From _____

3. Rate the severity of symptoms during the current episode, checking it was nearly everyday for at least 2 weeks.
Use the scale below:

0	1	2	3	4
None	Mild	Moderate	Severe	Very severe/ grossly disabling

(a) Changes (gain or loss) in appetite or weight ____
(b) Insomnia or hypersomnia ____
(c) Unable to sit still or so slowed down that you could hardly move or carry on conversation ____
(d) Loss of interest or pleasure in usual activities ____
(e) Loss of energy or fatigue ____
(f) Feelings of worthlessness or guilt ____
(g) Thinking is slowed down, finding it hard to make decisions ____
(h) Thinking about death or hurting yourself? ____

DIAGNOSIS OF MAJOR DEPRESSIVE EPISODE :

(a) Feeling depressed, blue, sad, hopeless or lost interest in usual activities almost everyday over past 2 weeks (See Q.2(c) above) YES/NO

(b) At least 4 symptoms from Q.3 at least moderate severity YES/NO

IF YES to (a) and (b) - MAJOR DEPRESSIVE EPISODE **YES/NO**

Duration of current episode _____ months.

CONSENT FORM

STRESS AND ANXIETY INFORMATION PROGRAMME

You are invited to take part in a research study examining whether stress and anxiety information booklets are of help to people.

If you have read the attached leaflet explaining the research study and are willing to take part, please sign this form below:

I have read and understood the attached leaflet and agree to take part in the research study.

SIGNED: _____ DATE: _____

NAME: _____

STRESS AND ANXIETY INFORMATION PROGRAMME

You are invited to take part in a research study. This is looking at how useful people find information on stress and anxiety provided whilst they wait to start their counselling or therapy.

It is hoped that receiving such information in advance will help people to better understand their difficulties and help them cope more effectively with them. To this end, we have produced a series of information booklets on the topic of stress and anxiety.

To see if the booklets are useful, we need to compare people who receive them with those who don't. Hence, if you agree to take part in the study, it is possible you will not receive the booklets. If you do receive them, you will be asked to read them and, if possible, follow any advice included in them.

All people taking part in the study will meet three times with a member of the research team. The first two meetings will be shortly after you agree to take part. The third time will be after another 3 months.

Each meeting will last between 30 -70 minutes. During it, you will fill out some brief and simple questionnaires. These will measure how you are currently feeling and coping with your difficulties. All your answers will be recorded anonymously and be kept totally confidential.

If you take part you can decide at any time to stop doing so. You do not have to give a reason if you decide to stop. Whether or not you agree to take part, you will still receive the team's help as soon as your name reaches the top of the waiting list.

APPENDIX 4

TREATMENT SESSION QUESTIONNAIRES - SUMMARY OF COMMENTS

Illustrative verbatim excerpts from TSQs regarding aspects of each therapy session which were helpful/unhelpful and/or important in some way:

Patient 1: Patient's Perspective

Session 1
Important: To feel free to express my feelings about the treatment.

Session 2
Helpful: Able to express my most immediate concerns (ie the 'secrecy' which I see as a problem and unhelpful).

Session 3
Helpful: We discussed 'conflicts' within my personality.
My attitude to the relaxation tape – why was I impatient and what were the pros and cons.
It is helping to give me an insight into my own personality.
It opened up a lot of other issues.
(Important)
I think it is a long existing (suppressed?) problem.

Session 4
Helpful: It is helping me to find 'strategies' for dealing with the problems at the back of my mind.
The question of 'balance' in life – of acting out those things which worry you.
I'm starting to think constructively about my past and childhood.

Session 5
Helpful: Went over aspects of section 4 which was useful – reference to the use of 'red-spots' as stimuli.

Session 6
Helpful: It is helping to deal with my worries in a constructive manner.
It seems so apt – something very pertinent to my own sense of anxiety.
Not helpful – it focussed my mind onto the 'anxiety' problem.

Session 7
Helpful: The discussion of my 'internal' dialogue.

Session 8
Helpful: It's always useful and helpful simply to talk.
Considered different sorts of distraction exercises.

Session 9
Helpful: Trying to get into touch with my feelings – (not just my thoughts) – the underlying sadness I seem to feel.

Why do I have a low opinion of myself? This does seem relevant to me.
To try and 'let out' my feelings more – that is how I interpret it anyway.

Session 10
Helpful: A general talk through of all my concerns – penetrating questions are painful (but they are necessary).

Session 11
Helpful: I'm starting to unlock my real emotions – it's not so much painful as sad. I've thought this before – perhaps it's just a deeper level.
My own self-evaluation - worthless (and that people will pick-up on that).
(Important)
I can't move on until I've really looked at this within myself.

Session 12
Helpful: I am still coming to terms with the fact that there is no 'miracle' that puts life right for me.
The realisation that therapy is going to come to an end and quite soon will be taking away a support system.

Session 13
Helpful: I was in a relaxed frame of mind which seems to help.
What stuck in my mind was my susceptibility to invite criticism. I unburden myself in this environment because I feel safe and unless I express my real fears I will not be able to work things through.
(Important)
I did talk to my sister about my concerns.

Session 14
Helpful: Felt very low today – have positive feelings about therapy and I want it to work but sometimes it's hard to accept that there is no 'easy'answer, no magic solution.

Session 15
Helpful: Beginning to consider how to continue when therapy ends building up 'support' systems with family and colleagues.

Session 16
Helpful: To help me to think about what will happen when therapy ends.
Feeling more optimistic. This was a general rounding off but I felt more 'on top' than last week. Looking for balance in life within extremes of happiness or depression.
I briefly recounted our recent financial problems and the fact that both my wife and I have coped with them much more successfully in emotional and practical terms than when it last happened.

Patient 1: Therapist's Perspective:

Session 2
Helpful: Reassured that he can change.
Also that not expecting too much change.
He believes he cannot change.

Session 3
Helpful: F/F response → Relaxation Response

Session 4
Helpful: Discussed tape – which revealed a number of issues to do with impatience, others' criticisms, distancing from feelings/over control, too patient.
Also, lot of pressure from him to get a move on.
Transference issues not addressed.

Session 5
Helpful: Discussion of Section 4, need to prioritise leisure etc.
He's searching for the answers, the solution.
Not using deep relaxation ? resistance.

Session 6
Helpful: Discussion of leisure/hobbies. Prioritisation.
Reinforced progress with relaxation tape.

Session 7
Discussion of distraction as 1 way controlling negative thoughts.
Fear very great re anger, helping him put it in safer framework.
Finding cognitive section bit confusing.
He acknowledge how he's challenging therapy, testing how useful it is, I let him challenge, therefore reality testing belief that challenge is inappropriate.

Session 8
Discussion of distraction, successful use of.
Also how he talks to himself and effect this has.

Session 10
Discussion of blocking feelings, preventing people helping him
Discussion of end of therapy.
Discussion of blocking feelings, role of intellect/talking as defence.

Session 11
Difficult looking at his fears re. performance and evidence for them.

Session 12
Discussion of fear of conflict.
Tars in session, contacting past hurts. Cathartic.

Session 15
Discussion of need for external acknowledgement, lack of internal self worth/health.
Assertion techniques would be relevant here.

Session 16
Tendency to dwell on worst.
He is ? angry with me re discharge, missed appointment last week.
Difficulties discussing anger assertion section needed.
Discussion of discharge, black-white view of outcome.
Discussion of need for greater social support.

Patient 2: Patient's Perspective

Session 2
I found Brian was actually talking about me. I could see myself in the problems we were discussing.
Helpful: Talking about my childhood triggered off some useful thoughts, to me at least.
I believe it could pinpoint why I act and behave the way I do.

Session 3
When Brian is describing different types of people and how they are, (how they act) I can see him describing me.
Helpful: To encourage me to talk back, if there something Brian says which I do not agree with.
Sometimes is easy to sit back and listen rather than to take part.

Session 4
I think doing the relaxation exercise made me aware how important it is to do them regular. Making the effort.
Helpful: If you start thinking you are doing badly, it often makes you feel like giving up.

Session 5
I find it much more easier to talk to Brian as the weeks go by.
Helpful: Going over the previous session.
I find it reassuring. I find it makes me concentrate when I'm doing the sessions at home.
Important: I do feel Brian understands my problem.

Session 6
By discussing together, the course, it helps keep me in check as to whether or not I am doing the treatment correctly.
Helpful: How I confuse work definition to leisure.
Important: I was left wondering how I could unload some of my many work commitments and find time to do any leisure activities to even the balance somehow.

Session 7
I find each week I am becoming more confident. I am able to discuss with Brian things that may concern or worry me.
I believe the sessions are improving my lifestyle in general.
Helpful: It was reassuring for me to hear Brian say I was making good process.
I think we all need someone to tell us if we are improving, it helps to try and improve even more.
Important: It gives me the only opportunity to actually talk about myself to someone who is listening and I do not feel embarrassed when at the start I thought I would.
In the future I may find it easy to confide in a friend or another person when I need to discuss a problem a worry I would otherwise keep within myself.

Session 8
Helpful: I found it helpful because it was easy to tell Brian. I had found it most difficult and he was not surprised by this. So I did not feel in any way I had failed the task of the previous week
Important: I think Brian showing me his list and explaining how he's changed the way he deals with clients over the years to get where he is now.
It showed me the advice and help he's giving me, he also uses daily himself.

Session 9
Helpful: It has made me aware that I do worry about various things, without realising I am actually worrying and thinking negatively for some parts of the day.

Session 10
Helpful: It was reassuring to hear it come from Brian's own mouth I was improving.
Sometimes when I am trying out the exercises, I may not be getting it quite right. So by Brian checking some of the ones I had done the previous week and saying they were fine.
Important: In general, it helps discussing the session.
Session 11
Helpful: After having a very traumatic week, with the loss of my only auntie to which I was very close, I felt relaxed and able to talk to Brian without feeling too upset.

I can see after discussing my work problems, I will have to change certain things where I am able to, to lower the stress level in which I work.
I must not take on my managers stress/workload. This is not helpful to her and puts added pressure on us both. Thinking about it afterwards I realise more and more she has far more support, eg husband, large family etc than I have.
Important: I will have to break old habits.

Session 12
I felt so tired today, I found at times I wandered away from the conversation and my thoughts were floating about. Most of what Brian was saying seemed common sense to me.
Helpful: It does make me aware when I really need someone, no one wants to help.
They are always to busy, or something.
Well I'm busy as well.

Session 14
Helpful: I found it hard trying to think of the thoughts that go on inside my head when I am going/trying to go into a public house.

Session 15
It gave me the opportunity after reflecting upon last weeks session to try and understand 'WHY' I find it a problem going into crowded public houses and restaurants.
It gave me the opportunity to discuss with Brian something I felt before I could not own up to. Because of my ex-husbands behaviour with other men I have been afraid to enter a public place in case someone knew me (or know my ex). I believe this is the cause of some of my anger towards me and my oldest son who reminds me of his father.
Helpful: I believe I have gained quite a lot from the sessions I have had with Brian and will put it into practice what I have learned in the future when I leave the therapy sessions for good. It is something I will look back upon when my problems seem worse and go back through the exercises to see how I might improve, and what I did that helped improve situations as different times.
Important: I do find it hard to ask for help.
Maybe I am afraid of being turned down.
I do not know 'WHY' I have not asked Brian for further help.
I know it is a problem for me to ask for help.
If I have come to the end of the sessions, I accept it. Brian has other people waiting to see him.

Session 16
Helpful: Although I found it difficult to discuss some of the problems of the last few weeks it did help to talk them through with Brian.
It made me aware how much he's listening to me during the sessions.

Important: It has made me realise I would benefit from counselling, other therapy to understand what is it about me what makes me behave the way I do.

Helpful: Brian really gave me a confidence boost today, going over the sessions we have had and the result of how they have gone.
I feel I have come a long way since the therapy first began. It gave me a good feeling being praised by Brian for all that I had achieved.
(Important)
I found it helpful that Brian see the need for me to be more assertive and will buy the book he has suggested I read.
I shall miss his support and will try and find someone I can talk to and confide in.

Patient 2: Therapist's Perspective

Session 1
Strong sense of challenge, "lets see what I can do". Not very optimistic re outcome of therapy.
Important: Discussed how much her son irritates her because he reminds her of husband.

Session 2
Discussed life patterns, tendency to rush and do for others at expense of self.

Session 3
Discussion of symptoms IBS/loss periods/migraine/ulcer/sleep.
Helpful: Permission to feel angry, acknowledgement of anger as problem.

Session 4
Discussion of taking on too much, need to learn to look for and take more, concerned re weight, shy she eats too much especially in evenings, discussion of comfort eating.
Important: Warmer feel to session, beginning to feel benefits.

Session 5
R+ attempts to assert own needs eg. not chairing PTA next year.
R+ attempts to build leisure and saying no to boss.

Session 6
Praised efforts with children and delegation.
Unhelpful: ? Criticism of her attempts to increase leisure via "non leisure" type activities eg learning word processing, reading for her course, doing 30 lengths in swimming pool.

Session 7
Helpful: Discussion re her approach to people and situations, taking on too much, praising her gains to date.

Session 10
Feed back her successful progress.
Praised attempts with problem solving and distraction.
Pointed out need to prioritise herself + children.

Session 11
Lot of grief over A's death, near tears much of time.
Was able to reinforce coping and her use of social support.

Session 12
Tendency to have overly high standards re self and others →anger, guilt.

Session 13
Went into some detail her differential treatment of children as result of her problem solving attempts.
Also struggled with the problem solving exercise which she'd had difficulty with therefore overall a difficult session for her.
? Simplify cognitive exercises.

Session 14
Going this recent avoidance situation and exploration of associated feelings and thoughts, felt threatened and criticised, too many "why/what" questions re. what she felt/thought.

Session 15
Helpful: Ventilation, permission to have feelings.

Session 16
Discussed options re future in therapy.
Praised her coping to date.
She was much more reflective.
Plans for future therapy agreed – recommended private therapy organisation.

Lot of praise of her coping (had stories to relate)
Looked at her lack of self and other praise and imbalance of criticism, self and other.
Ending, she was quite choked up.

Patient 3: Patient's Perspective

Session 1.
Helpful: The idea of my parents visit being an 'event' which had to go well. He seemed to understand that.

Session 2.
Helpful: The discussion about my own parents and how I 'bite my tongue' rather than speak my mind these days.
If I speak my mind I upset everyone, if I don't I upset myself!

Session 3.
Helpful: Generally helpful just to discuss what I had read.
Important: Looking forward to using the tape, feel I shall at last be doing something positive.

Session 4.
Helpful: Good to discuss the exercises and to do them and feel I am doing them 'right'.

Session 5.
Helpful: Got a lot of encouragement from Brian, saying I seemed to be picking up relaxation techniques well.

Session 9.
Helpful: Good to discuss the weeks events, and gain encouragement from the fact that I talked with my brother about the baby, discussed having children with Andrea, and talked at work frankly with a workmate experiencing similar symptoms to my own.

Session 10.
Helpful: The idea of worry errors e.g. worry that doesn't fit the facts, overestimating the possibility of things going wrong.
Because it sounded like me.

Session 12.
Helpful: Interesting to look at the way I think.

Session 13
Helpful: The toughest session yet. Made me think hard.

Session 14.
Helpful: General discussion about ending therapy what my feelings were etc.

The praise for doing well, I am a 'success' story.
It is nice to be reassured about my progress, however I have to learn to find this praise from within myself.

Session 15.
Helpful: Enabled me to get things off my chest.
When we went through the exercise illustrating over-predicting/exaggerating problems. Used the visit to my mum and dads as the example. Traumatic, virtually in tears.
This event brought out the fact that I care a lot about my father and that I am worried about not having as close a relationship as I would like.

Session 16.
Helpful: A lot less traumatic but useful to try and see how I should be more subtle. Not bottle things up but also not snap at people, or apply my own standards.
Again the ideas of authoritarianism, the acceptance of others, not applying my standards to everyone else, difficult!
Our final session. Surprised how much I underestimated my assessment of the original problem. The improvement has been quite dramatic.

Patient 3: Therapist's Perspective

Session 1
Helpful = confirmed he's "rel. normal".
Talked briefly about upcoming problems.
Important: Mentioned particular upcoming problems and I did not help as fully as he might/did want, constrained by programme.

Session 2
Helpful: Discussed ways in which nausea may have come about and how maintained, including use of avoidance response.
Reassured re. normality of STAI and Leeds Scores.

Session 3.
Helpful: Addressed emotional blocking leading to physical tension, acknowledgement of build up of negative feelings, fear of losing control of them.
The tape in terms of selling hope.
Important: Addressed feeling worse after sessions, 'confronting' issues he normally avoids.

Session 4.
Important: Cut short discussion of feelings re redundancy, ? he wanted permission to cry with me.
Frustrating, very factual approach within programme. Similar to his father.

Session 5.
Helpful: Reinforced his sense of achievement, needs this external reinforcement.

Session 6.
Helpful: Difficult session, pushing re. leisure/hobbies, also re. intimacy, tendency to hold back from intimacy, lot time being taken up on leisure. Not doing leisure exercises.
Important: Anger with W's inability to hear/understand him.

Session 7.
Helpful: Ventilate feelings re MIL, F, B and 3rd baby, discussed lack of assertiveness and tendency to repress feelings.
Important: Assertion section missing.

Session 8.
Helpful: Addressed last sessions frustrations re opening up but being cut short. Acknowledged these. Encouraged him to persist, at least with others, also acknowledged the inevitability of it in therapy.

Session 9.
Helpful: Reinforced his attempts at discussing things with wife and brother. Likes being praised.
Important: Pushed with time spent on programme, "warning" we have maximum 7 more sessions.

Session 10.
Helpful: Reframed progress to date as more successful than he saw it. Addressed general tendency to under play achievements vs exaggerate potential.

Session 11.
Helpful: Challenger – re thoughts re failure, perfectionism, hard work but productive.
(a) Went through ex 5(b) and indicated he wasn't challenging negative thoughts re situation, was simply stating negative facts → to repeat.

Session 14.
Helpful: Praised progress, put it stronger than his "quite well".
More time on worry would be useful.

Session 15.
Helpful: Went through feared situation cognition in detail.
Not addressing negative thoughts on own.
(Important)
? cognitive section exercises too hard.

Session 16.
Helpful: May help him show feelings in more controlled way.
(Important)
Assertion skills .....

Patient 4: Patient's Perspective

Session 1
In some ways it was helpful in establishing whether or not being a worrier is inherited – perhaps unhelpful because I was unsure and had a lot to think about (also made me worry!)
Helpful: Being given the sheet called 'start here' which lists what the programme is aiming for as a final result eg reduce physical tension.
It gave me a goal to aim for.
Important: When we discussed that in the near future I would have to talk about my worries it made me realise in fact how hard it will really be, but I am determined to get through it.

Session 2
Helpful: When Brian explained the efficiency and arousal level graph, it put the situation into a better perspective.
We talked about finding 'the right moment' and talking your problems through 'a bit at a time' with the people who cause worry.

Session 3
Helpful: Brian explained the 'sleeping pattern' and how it was affected when you go to bed with a lot on your mind.
Important: Brian mentioned that he also did the relaxation tape – and how it wasn't a cure but it 'helped'. This made me feel better as it meant I didn't feel like 'a special case'.
I have noticed that in the past week my phobia for spiders has worsened. I have had 2 nightmares (which for me is very rare).

Session 5
Helpful: Again Brian set me an aim – by helping me to practice what I felt/or wanted to say to my mother.

Session 6
Helpful; Seeing that my life is starting to chnge – at home etc. I'm starting to (slowly) to communicate a little more with parents.
It gave me confidence and made me feel more enthusiastic.
Important; Unhelpful – having to do my 'Deep Relaxation' tape on holiday.

Session 8
Helpful; We covered (it seemed like) almost everything, such as my problems, what I can do, my progress in the course, followed the actual course (Section 4 & 5).

I told Brian how I had noticed a woman at the post office rushing around and getting worked-up because there was a queue, I knew that I also used to be like her about 5 months ago.
Important: I felt slightly pressured however into taking up a leisure activity.

Session 9
Helpful: We talked about the main 'routes' of my anxiety.
Brian helped me in solving the 'communication' problem between me and my mother.

Session 10
Helpful: I felt that I could get a lot of things 'off my chest' that were running through my mind.
He just listened.
It was different as when your parents split up you tend to hear both sides of the coin, here it was neutral.

Session 11
Helpful: When I left consultation I felt extremely happy – I had a huge smile on my face. How I have started to get over sharing my feelings/thoughts to my mother.

Session 12
Helpful: I found it quite easy and comforting to openly speak about everything.

Session 13
Helpful: Today Brian talked to me about my progress. It gave me great confidence.
Important: Yes, I talked about how at times I had found it very hard to attend appointments because it seemed like hard work.

Session 14
Important: Went through my fears in relation to my exams. For example: "What will I do if I fail?"
I realised that there is no point in worrying until I receive my exam results.
Yes, I sat down and talked to various members in my family about problems at home. I felt much better as a result of this.

Session 15
Helpful: We talked about my present circumstances in relation to being discharged.
Important: This was a sign of an improvement made since I started therapy at the hospital. At first I didn't express my feelings so openly.

Session 16
Helpful: We talked about how to continue with controlling anxiety after the programme.

Helpful: This was my last session for 3 months (discharged today). We covered everything that I had learnt, was extremely useful.

Patient 4: Therapist's Perspective

Session 1
Helpful: Discussion of home situation upsetting.
Permission to be upset/depressed, interested.

Session 2
Helpful: Patient talking to mother, courage shown.

Session 3
Helpful: Discussed problems with father and brother agreed to perhaps see them in July.
Praised ability to cut-off from people at night time to sleep.

Session 4
Helpful: Discussion of number of things he wants to say to mother.
Of upsets in past with father's family, been hurt by, acknowledgement of progress in relaxation.
Important: Would be useful to have Section on assertion.

Session 5
Helpful: Praised her progress to date re tape and discussion with Ps.
Discussion of problems with tape.
Important: Assertion again would be useful.

Session 7
Helpful: Discussion of problems with mother & father, discussion of how she avoids being upset with father.
Permission not to use red spots/relaxation tape, not pushing.
Reinforcement of how well she's handling problems and recognising irrational thinking, also discussed things with mother.
Important: Parents have split up, mother staying with S.

Session 8
Helpful: Reinforced her progress re parents, showing father hurt, coping in very difficult circumstances.
Reinforced her progress with tape and problem solved why not helping.
Discussed termination, her concerns re. what happens if people don't progress.
Looked at red spots, leisure. Felt pressured on latter item, lack of time, need to move as to worry.

Session 9
Helpful: Discussion of problems at home, vent.

Important: Mother disclosed as having affair.
Father may be selling home
Mother may be selling shop.

Session 11
Helpful: Discussed 5B and successful attempt to challenge negative thoughts in ex.
Ventilation re home + reinforcement of attempts to talk to mum.

Session 12
Helpful: Discussion of discharge, need to obtain support from others.

Session 14
Helpful: Discussion of exams, fears re failure.

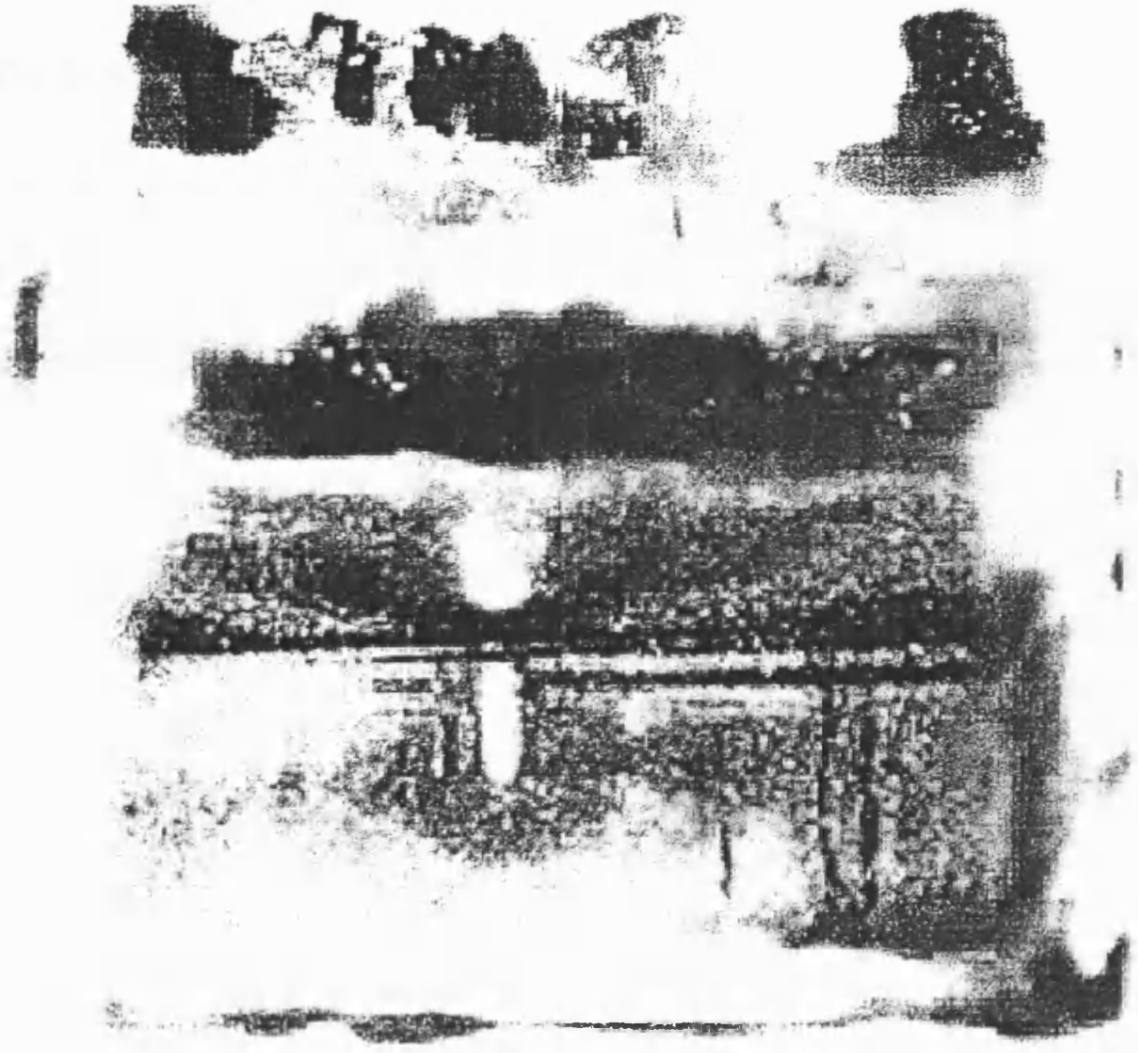
Session 15
Helpful: Discussion re further therapy, not offering her any except follow-ups.
Useful opp to practice but in my view may have poorly expressed by her.

Session 16
Helpful: Unloading.
Acknowledgement of how hard she's work and how much she's achieved.
Important: Thought she was pregnant.
Home may be repossessed.

APPENDIX 5

FULL PROGRAMME - STAGE 2

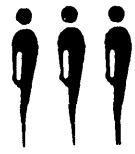
A Self help Programme for Anxiety and Stress



Designed at Kaleidscope 01203 354171

BY BRIAN KIELY
CLINICAL PSYCHOLOGY SERVICE

NORTH WARWICKSHIRE NHS TRUST



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SECTION 1

HOW TO USE THE PROGRAMME

This is the introduction to the programme. It outlines what is in the programme and how it will help you. Most importantly, it gives advice on how to get the most from it.

The Section is divided up as follows:

1.1 Who is the programme for?

1.2 Why this programme?

1.3 What is in the programme?

1.4 How will it help you?

1.5 What do you have to do?

1.6 Summary

1.7 Conclusion

ACKNOWLEDGEMENTS

Grateful thanks go to the many people who have used these booklets and helped me improve them in the light of their experience.

Thanks also to the staff of the North Warwickshire NHS Trust's Health Promotion Service who assisted in their development.

1.1 WHO IS THE PROGRAMME FOR?

This programme will help anyone suffering from stress - which means us all from time to time. In particular it will help:

- anyone suffering from tension, headaches, tiredness, poor sleep, anxiety, panic attacks, irritability, guilt or low mood. Stress is a major cause of such difficulties.

- anyone suffering physical conditions which may be made worse by too much stress, eg stomach ulcers, cancer or heart disease.

1.2 WHY THIS PROGRAMME?

Over the past 14 years, I have worked as a Clinical Psychologist with a wide range of people suffering from stress. This range has gone from NHS staff suffering difficulties at work across to people referred by their GP or Psychiatrist because of their severe difficulties coping with day to day life.

They were all helped by some basic information on how to manage stress. Hence this programme. It contains a number of methods proven by research to greatly reduce stress. It is designed as a self-help programme for a number of reasons including:

1. You do not have to sit on a long waiting list to see someone like me.

2. It is more convenient, being easier to fit your treatment into your normal lifestlye.

3. You can work at your own pace.

4. It reminds you what to do. You have the programme written down to constantly refer back to, now and over the years to come.

5. It will help you in the future. As new problems arise, you can refer back to the programme for new ideas on how to deal with them.

6. It works! Research has shown that self-help programmes work with a wide range of problems.

1.3 WHAT IS IN THE PROGRAMME?

The programme consists of 8 sections and two tapes. Each section covers a different aspect of stress. You will need to read all of them, and listen to the tape. Here's a brief description of each section:

* Section 2: "What is Stress?" Gives you the basic facts about stress.

* Section 3: "Stress and Illness" Explains how stress causes physical illness and emotional difficulties.

* Section 4: "Managing Physical and Mental Tension" Plus the tape, helps you to learn different ways of relaxing your mind and body.

* Section 5: "Lifestyle and Stress" Describes ways of reducing your stress by changing your lifestyle.

* Section 6: "Changing the way you think and feel" Helps you to worry less.

* Section 7: "Assertiveness" Describes how to reduce your stress by being more assertive.

* Section 8: "What now?" Helps you to put together all the skills learned so far and helps you to plan for the future.

1.4 HOW WILL IT HELP YOU?

It <u>will</u> help you to greatly lower your level of stress in a range of stress creating situations.

It <u>will not</u> mean that you never suffer from stress again. Sorry, but we all suffer from problems and worries. Hence, we will all suffer some stress some of the time. Nor will the programme discuss in detail specific causes of stress such as job insecurity or an unhappy marriage.

This is because there are too many causes of stress to discuss each one in detail in a programme such as this. Instead, I describe a number of specific stress management techniques which can help in a wide range of problem situations, including problems at work or at home.

In particular the programme <u>will help you to</u>:

a) Reduce any anxiety you suffer from, including panic attacks.

b) Reduce how much time you spend worrying.

c) Worry more usefully when you have to worry, thinking more positively.

d) Face difficult situations with more confidence, less anxiety.

e) Feel less tired, less low, less irritable. Stress can wear you out physically and emotionally. Reducing it leaves you feeling brighter, having more energy.

f) Reduce any symptoms of physical tension eg headaches, indigestion, tiredness, general aches and pains etc.

g) Improve your general state of physical health. This includes helping in the treatment of heart disease, stomach ulcers, bowel problems, etc.

h) Assert yourself more, saying "No" to unreasonable demands or being able to ask for more, without feeling guilty.

i) Sleep better.

j) Reduce any tablets you are taking for anxiety. Be careful though - never reduce your tablets quickly or without first talking to your GP.

1.5 WHAT DO YOU NEED TO DO?

To reduce your stress you will need to learn some new skills, eg relaxation, pacing yourself, thinking more positively and asserting yourself more.

Just as when learning any skill, whether it be reading, writing or driving, you will need to:

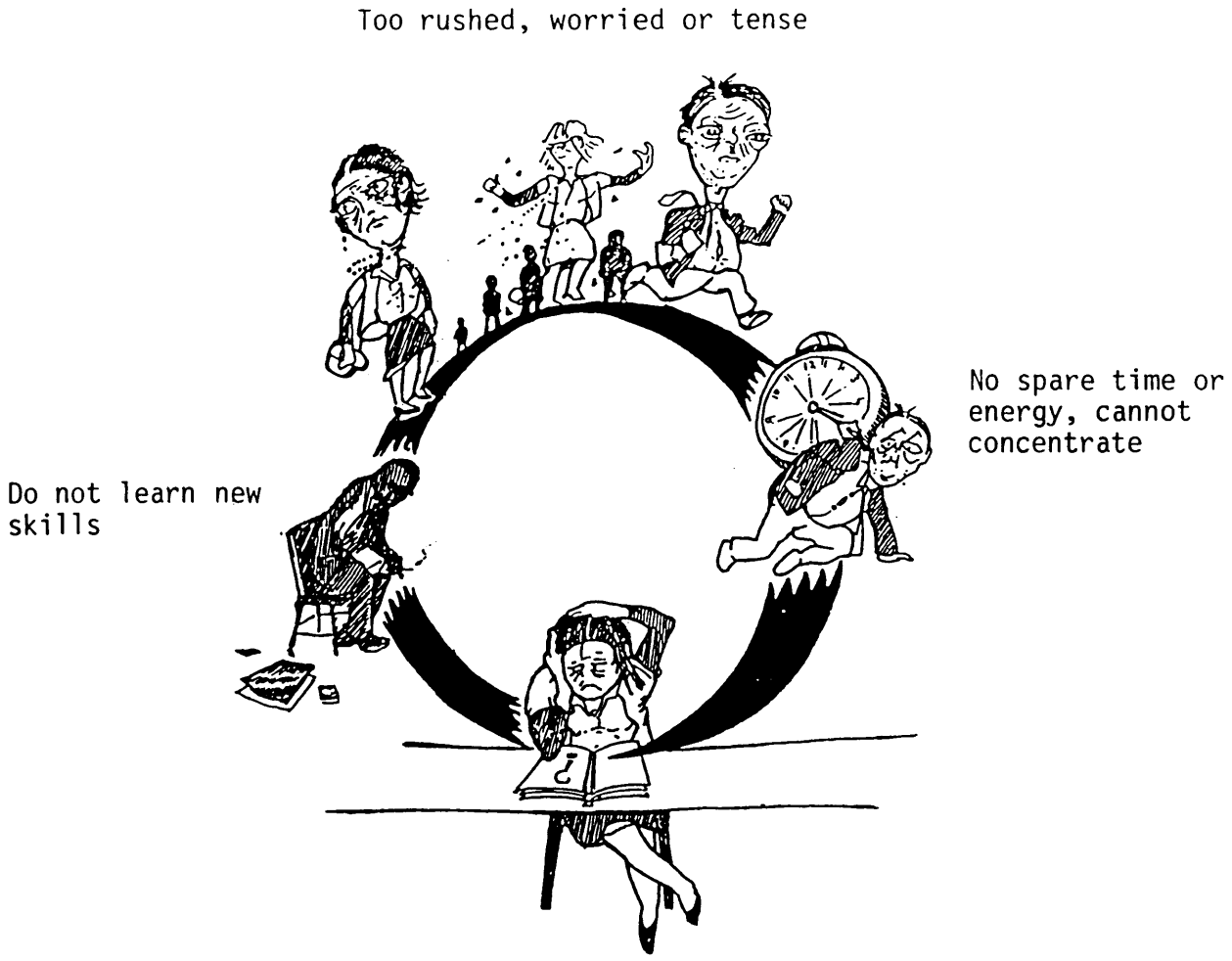
- **practise a lot**

- **be patient**

That's the bad news! The good news is that over the years, all the patients I have treated have learned the skills described in this programme - if they practised and were patient. The more you put into the programme, the more you will get from it.

PRACTISE = You will need to look at the programme at some point everyday.

At first, you might find you are too rushed, worried or tense to stop and practise. You maybe cannot find the time, energy or have difficulties concentrating - all very common symptoms of anxiety! This can feel like a vicious cycle:



You will need to find a little time, every day, perhaps increasing it over time. A few minutes per day at first, slowly building up to say 30 minutes at a time. As you learn the skills, it will become easier to find the time and to concentrate, to practise.

PATIENCE = **Do not expect too much, too soon.**

If you do, you will be disappointed, feeling a failure. This may mean you give up too soon. If you go too fast, you will not learn the skills properly.

To begin to learn the skills in this programme will take you at least 3 months.

Here are some tips to help you get the most from the programme:

a) Try and set aside a few minutes everyday to look at it.

b) Build up a routine, try and do it at about the same time each day.

c) Find somewhere quiet to do it, free from interruptions.

d) Do it when you are not too tired to concentrate on it.

e) Slowly build up the amount of time you can spend on it from a few minutes to upto half an hour. If you cannot find even 30 minutes for yourself everyday you are doing far too much.

f) Try not to expect miracles, do not expect too much too soon.

g) Try and read each section at least twice, let it sink in.

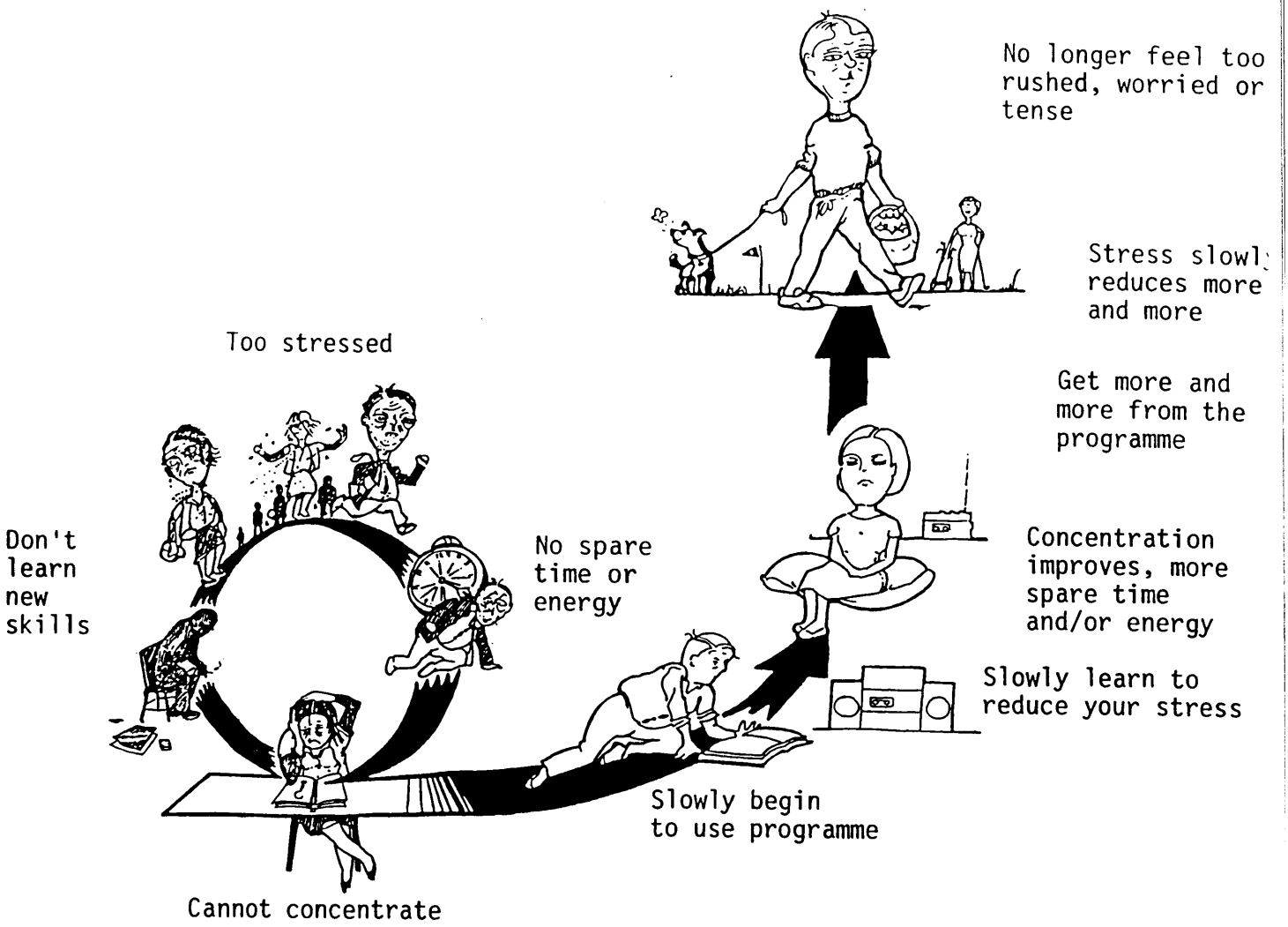
h) Spend at least two weeks on each section and a lot longer on Sections 4 to 8.

i) Try not to skip bits - even the bits that at first do not seem useful. They are there because they can help.

j) Expect set-backs. Sometimes you will feel you take two steps backwards for every one forward.

k) Talk to a friend or partner about the programme. Show them it. Let them know more about your stress and what you will need to do to reduce it. Maybe they can help you. Maybe the programme can help them too.

If you follow these tips you will slowly break the vicious cycle:



1.6 SUMMARY - INTRODUCTION

This programme will help you to significantly lower the amount of stress you suffer from.

This will help anyone but in particular, people suffering from anxiety, irritability, low mood, guilt and certain physical conditions.

It is designed as a self-help programme because research has shown they work. They are also convenient; you can work at your own pace; it helps you to remember what you have to do; and it is something to refer back to when new problems occur.

Research has shown that the techniques described in the programme can help you to:

Feel less anxious
Help you worry less and think more positively
Face difficult situations with more confidence
Feel less tired and low, less irritable
Reduce symptoms of physical tension
Improve your general state of physical health
Assert yourself more without feeling guilty
Sleep better
Reduce any tablets you take for anxiety

To gain the most from the programme, you will need to practise it often. You will also need to be patient, not expecting too much too soon.

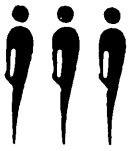
The more you put into the programme, the more you will get from it.

For some people, this programme is all they need to help them cope better with their stress. It is one of the aims of this research project to see just how much help the pack is. Hence, about 3 months after you first receive the pack, one of us will be back in contact with you. This will be to check how you are and also what, if any, extra help we can offer you. If you need couselling therapy, this will be arranged as soon as possible.

Meanwhile, whilst you are waiting to be contacted, if you feel you have got worse and can't cope any longer, please contact the clinician who originally assessed you. He or she can then discuss how we can help you.

1.7 CONCLUSION

You may need to re-read this section at least twice more, just to let it all sink in. Then when you feel you are ready to, move onto Section 2.



NORTH WARWICKSHIRE NHS TRUST

SECTION 2

WHAT IS STRESS?

Very few of us really know what stress is. As a result, when we suffer from it we often don't know what's happening to us. This can make us even more worried and even more stressed. The aim of this section is to give you the facts about stress. In this way, some of your fears may be removed.

The Section is divided up as follows:

2.1 SOME FACTS ABOUT STRESS

Here are some basic facts about stress.

Fact 1: **We all suffer from stress**

Unfortunately everyone suffers from stress from time to time. We all suffer from problems. When problems occur, we all suffer the occasional headache, bad night's sleep, feeling of panic or bout of indigestion.

Fact 2: **For some, stress can ruin their life**

The people I see who suffer from stress do not just have the occasional headache etc. For them, life can feel almost impossible, their stress is almost always there. Here are some examples of ex-patients I have treated to show you what I mean I have changed bits of their stories to disguise them.

a) **John** had recently been made redundant from his job as a fitter. Money had become very tight. Not only had he lost his job, he and **Debbie** were trying to buy their first house. They had also just got married and were expecting their first baby.

Lots of good changes - a new home, getting married, expecting a baby. But all these changes meant upheaval, planning, uncertainty, getting used to new things, more costs. So even good changes caused stress, worry and in the end, anxiety.

Add this to John's redundancy. The end result for John and Debbie were headaches, bad sleep, lots of arguments and constant tiredness. John was beginning to drink more, using up money they didn't have. Debbie was smoking and eating more, making her feel even worse.

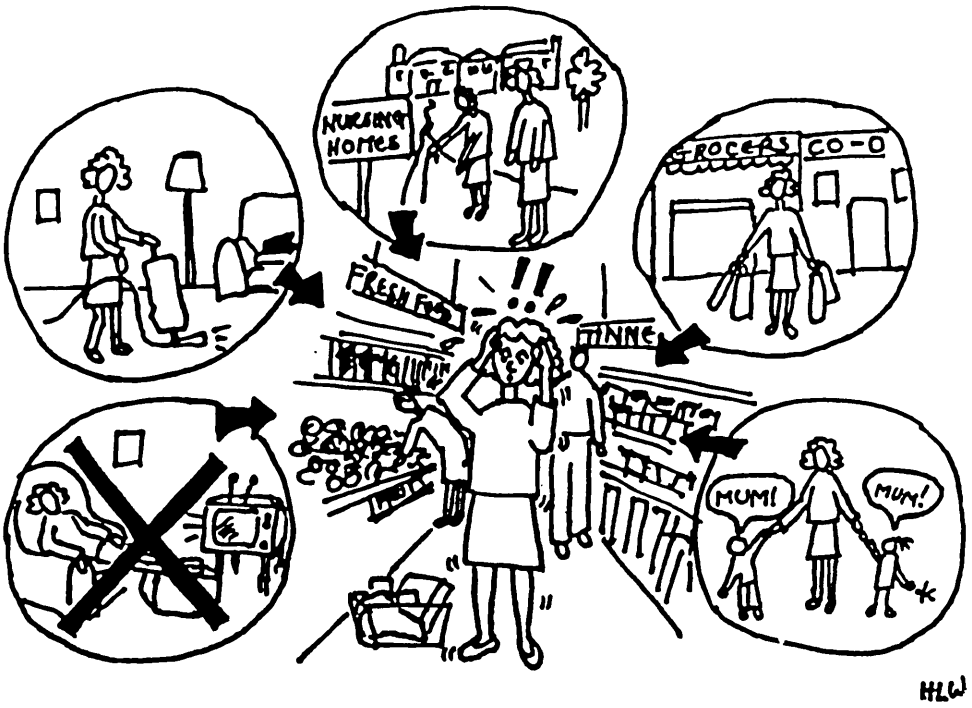
They were both worried about jobs, the mortgage, the baby etc. Add to this other worries about their relationship. The end result for John and Debbie was that they felt stress was ruining their life together.

b) **Susan** was a nurse, wife and mother, working hard to look after a ward full of patients, her two young children, a home and her husband. She enjoyed looking after people and whilst it was very tiring meeting everyone elses' needs, it was also very satisfying. The main problem was that she never had enough time to do it all. She certainly never had any spare time for "luxuries" as she saw them such as going to the pictures, reading or even watching her favourite TV soap. She had long ago given up trying to keep fit down at the local leisure centre.

At work too things had begun to get harder, what with the new audit procedures and the need to make already scarce resources stretch even further.

One day she had a huge shock. She had a panic attack in the local supermarket. She had dashed there between her job and picking up the children.

The panic happened as she stood in the queue thinking about all she had to do that night - the ironing, bathing the children etc etc. First to occur were the palpitations, the light headedness. Before she knew it, her legs were wobbling. It was all she could do to get out of the shop and home.



Since then, she avoided all shops, for fear of another attack. Instead her husband did all the shopping. She still did her other jobs but her confidence had crashed. She always seemed to feel on edge - nervous of another attack, of her husband getting fed-up with her. She also felt stupid, guilty and quite depressed on occassion.

Susan's rushed, too busy lifestyle plus her panic attacks were ruining her life.

c) **Peter** was a bank clerk. He enjoyed his job, the attention to detail, the arithmetic, the book-keeping. He felt in control. Friends described him as likeable but tense. He didn't worry too much but was careful, always checking what he did for mistakes.

When he checked things, her would sit or stand with his shoulders hunched, his jaw clenched, frowning. He was not aware of how tense he was although he usually had at least one headache a week. Five years ago he had a stomach ulcer which surprised him - he thought only busy, stressed people had those.

Peter was referred to me because his checking was getting worse. He was checking totals of numbers upto ten or more times. He was unable to leave the house without checking at least three times all the doors and windows. He was constantly worrying about something going wrong if he made a mistake. His headaches were getting worse.

His worrying, checking and headaches were preventing him enjoying his job and life in general.

d) **Janet** had always been a worrier. She though she was born that way, taking after her mother who had always suffered from her nerves. She was 45, her children had grown up and left home. Now she found she had a lot of time on her hands.

When I saw her, she was worrying about what would happen when she and her husband went on holiday to Yugoslavia, six months later. She hated aeroplanes and was terrified that her plane might crash or be hijacked. The only way she had flown before was to take a Valium and two stiff gins at the airport!

She was also worrying about whether her husband's stomach would play up again. Five years before, their holiday in Spain had been "ruined" because Eric was in bed for three days with an upset stomach.

Another thing she was worrying about was her son's wedding the following month. Would her dress be all right, would she get on with the in-laws, how would the reception be? Everytime she thought about the wedding, images of disasters flashed through her mind.

Janet's enjoyment of life was severly reduced. All the things others might look forward to and enjoy, she dreaded. She only felt happy when they were over and the worst had not happened.

e) **David** was a production line worker who hated his boring job but generally enjoyed life - going down the pub, out for meals with his family etc. He had always been a bit of a worrier but tended to put a brave face on it, keeping things to himself. When I first met him, he had just suffered his first heart attack; he had long suffered from angina. The attack had terrified him. He constantly worried that he might do too much physically and bring on another attack. He also worried about dying and leaving his family without enough money.

After advice from his Doctor, he was reducing his weight, how much he drank and completely stopped smoking. He was still worrying a lot though. He was also having difficulties going back to work.

f) **Clare** was someone everyone liked. Whenever they had a problem, they knew she would listen and help. She never seemed to get upset herself, she was always calm and cheerful. Even if people put on her or treated her badly, she just smiled, took it for granted, and got on with life. She hated arguments and always tried to keep situations calm. This meant she bottled her feelings up, not showing them incase she upset others. Indeed sometimes she didn't even realise when she was upset.

Then one day she suffered a panic attack, out of the blue, at work. Her confidence fell to rock bottom. People said she was a changed person - irritable, nervy, withdrawn, low.

Clare's panics had changed her life. It was as if she was a different person.

Clearly, all the people described above were finding life very difficult. The stress and anxiety caused by a variety of problems was spoiling their lives.

Through treatment, they all learned to manage their stress better. This lead to a reduction in their symptoms. They felt better physically and emotionally and life became more enjoyable.

Fact: 3 **Stress is a large and secret problem**

According to one recent study - nearly half the adults in the UK are suffereing from anxiety at any one time.

Stress is said to play a part in about two thirds of the illnesses people go to their G.P.'s with. Upto 40% of all work absenteeism is due to stress.

1 in 10 prescriptions written by G.P.'s are for tranquillisers.

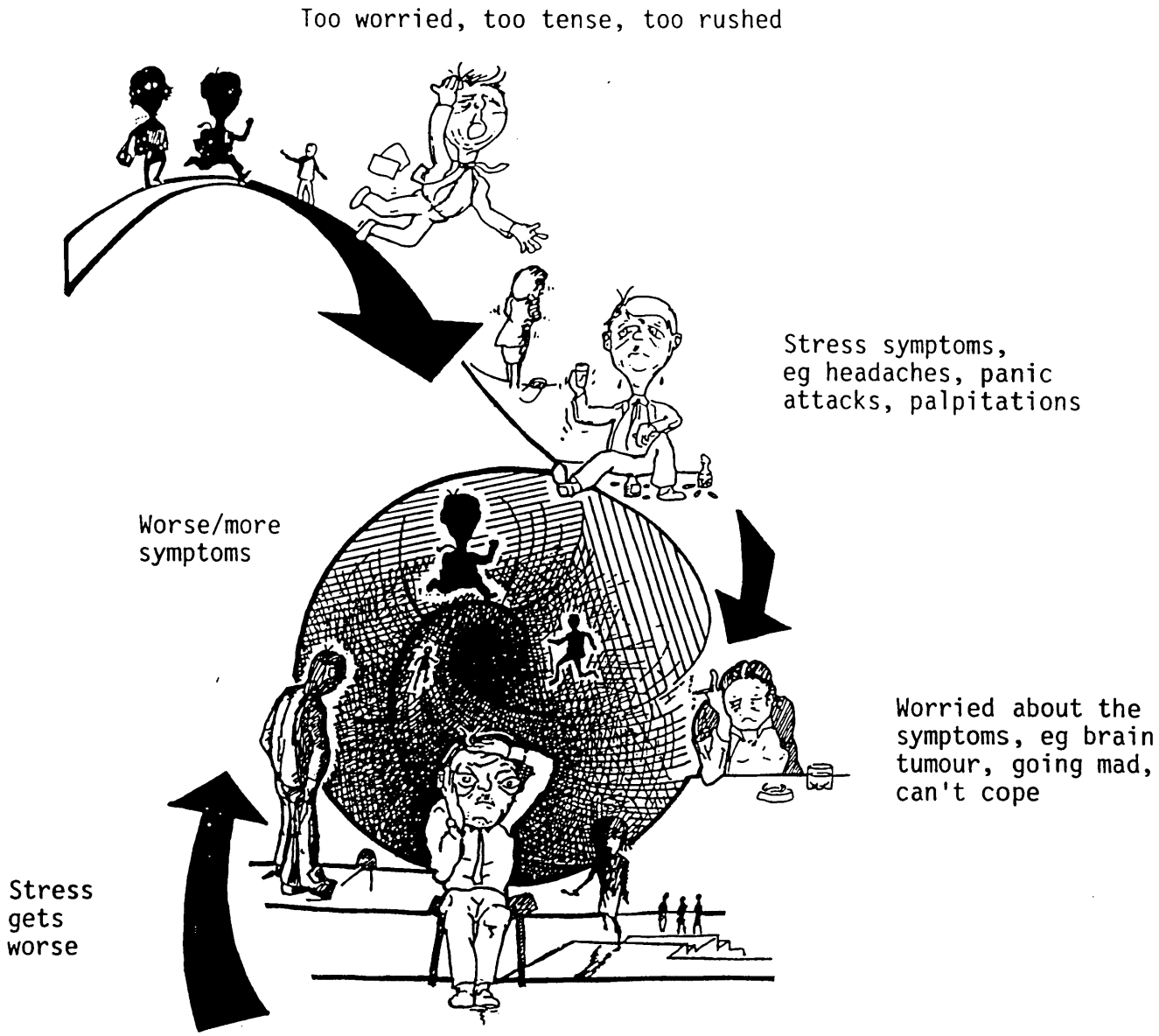
Many people who suffer from stress keep quiet about it. They may feel guilty, feel a failure or be scared of other's opinions.

Fact 4: **Stress causes more stress**

Anxiety causes many different symptoms. People often worry about their symptoms - what is causing them? What might they lead to?

Stress Symptoms	-	Common Fears About Them
Headaches	-	Brain Tumour?
Palpitations	-	Heart Disease/Attack?
Panic Attacks	-	Going mad, will be locked up, will make a fool of yourself?
Bad Sleep	-	Too tired to work, can't cope?
Stomach Upsets	-	Cancer?
Any stress symptoms	-	Can I cope, will I keep my job, will my partner get fed-up of me?

A vicious cycle can be set-up:



In your work, be it in or out of the home, stress can cause more stress in another way. Say you are stressed in the first place because of having too much work to do. You may begin to suffer stress symptoms such as poor concentration, irritability and general tiredness. Such symptoms will make your work harder to do, eg because you fall out with colleagues who could help because you snap at them or because you can't concentrate on your work so it takes longer to finish. If you begin to struggle in these ways, you may fall even further behind. This could cause you more stress. Another vicious cycle has been set up.

Fact 5 Stress affects our bodies, our minds and our behaviour

As you saw in Fact 2, each person I described suffered different symptoms of stress- headaches, bad sleep, irritability, tiredness, drinking or eating or smoking more, panic attacks, avoiding things, guilt, loss of confidence, depression, checking, stomach ulcer, and simply not enjoying things.

Below is a fuller list of the symptoms that stress causes. It is not a complete one but shows how wide the effects of stress are. The list is split into 3 parts - how it affects our mind, our behaviour and our bodies.

COMMON SYMPTOMS OF STRESS

Mind/Mood	Behaviour/What we do	Physical/Our Bodies
Poor concentration Irritable Running yourself and others down Thinking you are no use, you cannot cope, others are against you, you have a serious disease, you are dying, you are going mad, you are losing control Low mood Guilt Anxiety Suspicious	Nail Biting Fidgeting Pacing up and down Moving jerkily Jumping at noises Avoiding certain situations Smoking, eating or drinking more	Difficulties Swallowing Difficulties Talking Headaches Stomach Upset Diarrhoea or constipation Difficulties with sleep Stomach Ulcer Indigestion Sweating or hot flushes Tingling in hands or feet Dizziness Loss of interest in sex High Blood Pressure Palpitations Backache Lower immunity to illness
Add here your own symptoms if they are not above:		

N.B. Stress is not the only cause of many of the above symptoms. It is a common one though.

Section 3 explains how stress causes illness.

Fact 6: Stress Can Cause Anxiety

Stress can lead to many emotional problems eg anxiety, irritability, guilt and depression. A very common consequence of stress is anxiety, this is why the stress symptoms described in Fact 5 are exactly the same as the anxiety symptoms so many people suffer. Indeed, for many people, stress is anxiety. This is why the stress reduction techniques covered in this programme can lead to great reductions in anxiety.

Fact 7: Stress management can help certain physical conditions

It is still not clear to what degree stress causes serious physical conditions. It is clear that stress can cause us to eat, drink or smoke too much. It can also raise our blood pressure. Such changes can seriously damage our health if they go on for long enough. They would also make worse any health problem we already have.

It is clear that reducing stress can be a part of the treatment of a variety of conditions, eg heart disease, stomach ulcers, bowel disorders, chronic pain and cancer. Obviously, all these conditions also require medical treatment.

Fact 8: Stress can be caused by what happens to us

A lot of stress is caused by the things or life-events that happen to us. Here are some facts about life events:

- They can be good, eg getting married or having a baby or being promoted.
- They can be bad, eg being made redundant, having a heart attack.
- They can go on for a short time, eg moving house.
- They can go on for a long time, eg marital problems, money worries, having children.
- They can cause stress if they mean change, even good change. Getting used to anything new is tiring, it uses up energy physically and emotionally, eg going on holiday.
- They can cause stress if they are upsetting, eg being made redundant, marital problems, becoming ill.

In the examples I gave above (see Fact 2) John and Debbie, the newly weds, were the most obviously stressed because of life events. They had experienced redundancy, marriage, a house move, a baby, money problems and some marital problems. Janet, whose children had grown up, was stressed because of her son's wedding and her holiday.

Fact 9: Stress can be caused by our lifestyle

Here are some facts about our lifestyles:

- A stressful lifestyle can result from having too much to do. Too much can mean the quantity is too high, eg working long hours. It can also mean the quality is too complex, eg having to pay great attention to detail or having to deal with up-setting situations.
- If you rarely have time to sit down, are always on the go, you probably have too much to do - even if you enjoy it all!

- The body and mind need routines. Shiftwork can severely upset these and can be a source of stress.

- A stressful lifestyle can result from having too little to do.

- Even if you have lots of things to keep you busy, if they bore you, if you don't enjoy them, they will cause stress.

- Our environment is an important part of our lifestyle. An environment can be stressful, if it is noisy, smelly, poorly lit, too hot or too cold, dangerous or if it involves being in an uncomfortable position for any length of time. Our social environment can also cause stress, eg if it contains conflict, or people who are physically or emotionally needy.

Susan had one of the most stressful lifestyles in terms of the sheer quantity of work and its quality - as a mother and nurse having to deal with the emotional and physical needs of others. She also had to work shifts. Whilst Peter's job as a bank clerk involved a reasonable quantity of work, its quality was stressful - he couldn't afford to make a mistake with the bank's money. Janet's lifestyle was too boring, with too few sources of satisfaction. She was also left with too much time to sit and worry.

Fact 10: Some stress can be caused by the type of person we are

Everyone is different. Some people have a personality which makes it more likely that they will suffer from stress.

Some people are naturally more prone to worrying, being physically tense, rushing around, or hiding their feelings. It doesn't matter what happens or what they do, they will worry about it more, be more tense when doing it, or rush it more, or hide their feelings about it more.

To the person, they will feel the way they think or behave is normal. That something is wrong is usually more obvious to others. The person has got used to the way they are - they don't know any other way.

The way we are as people is a result of a number of things. The main ones include the way our parents bring us up, what happens to us as children and what our parents' personalities are like.

To a large extent we are not born worrying, tensing or rushing, or hiding. By being told to, by seeing others do it or because situations make us, we learn to worry, tense, rush or hide. Just as you learned to talk, walk and write in a certain way, you learn to think, use your muscles and behave in a certain way. This is why we often take after one or other of our parents. We learn from them.

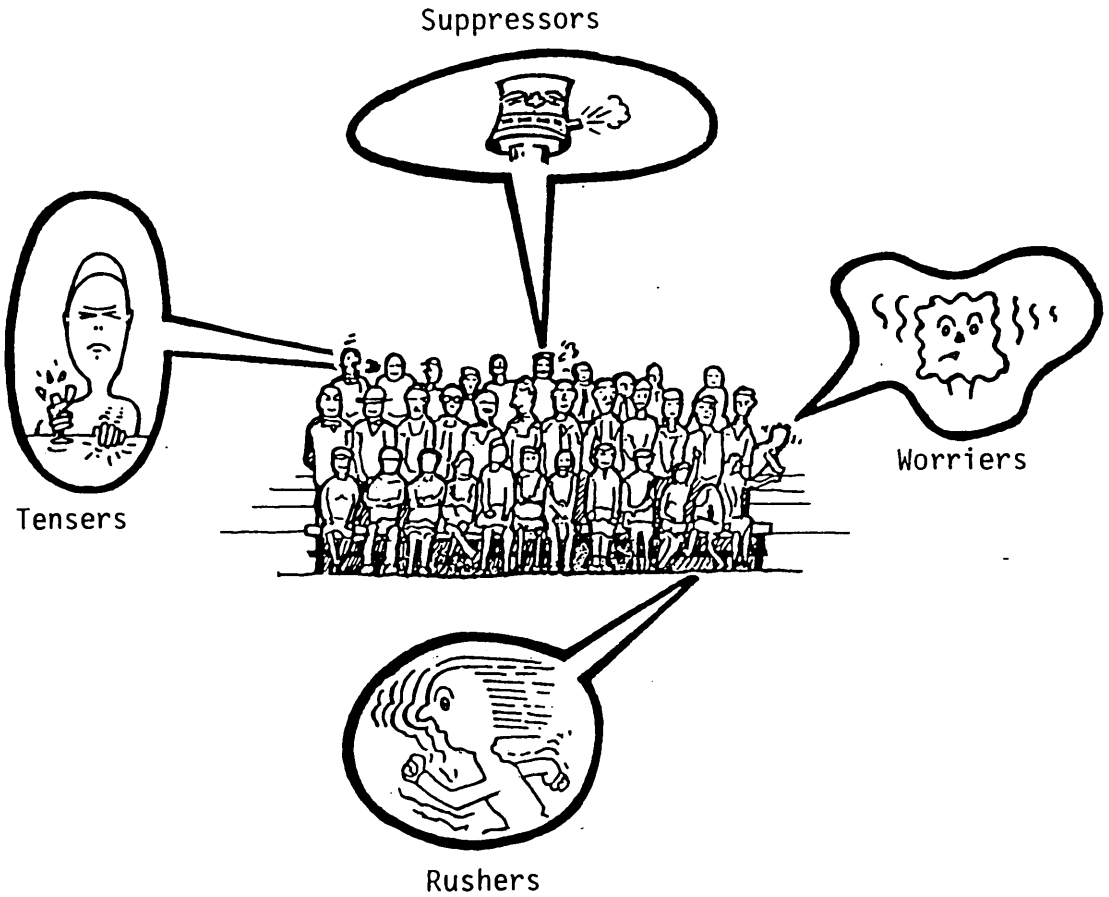
Janet, who was worrying about her holiday and son's wedding, was a good example of a "born worrier". She took after her mother who also worried a lot. Her mother could never go anywhere without worrying about it. No wonder Janet grew up to do the same. David, the production line worker, also tended to worry too much but he hid it, often even from himself.

Peter, the bank clerk was a good example of a tenser. Whatever he did, he was careful and slow. As he did things, he had learned to clench his teeth, frown and hunch his shoulders. As a child, certain events had happened to make him very cautious, in case something went wrong.

Susan, who had so many roles as mother, wife and employee, was a good example of a rusher. Not only did she have too much to do, she always did it as fast as possible. As a child she had been encouraged to help her mother a lot with her younger sisters. She had got into the habit of helping others a lot, feeling guilty if she didn't. You could even say she cared too much for others and not enough for herself.

Debbie, who helped everyone else, was a good example of a person who hid or suppressed her feelings. However upset she felt, she hid her feelings. If she didn't, she was scared she would upset someone else or cause an argument. As a child her parents never argued. Her father was very hot tempered and her mother had learned to hide her feelings to keep the peace. David was also an example of a suppressor, but for different reasons. Supressing feelings means they can build-up inside and cause tension. This will cause stress.

Most of us are not just a rusher, tenser or worrier or a suppressor. We can be a bit of all of them.



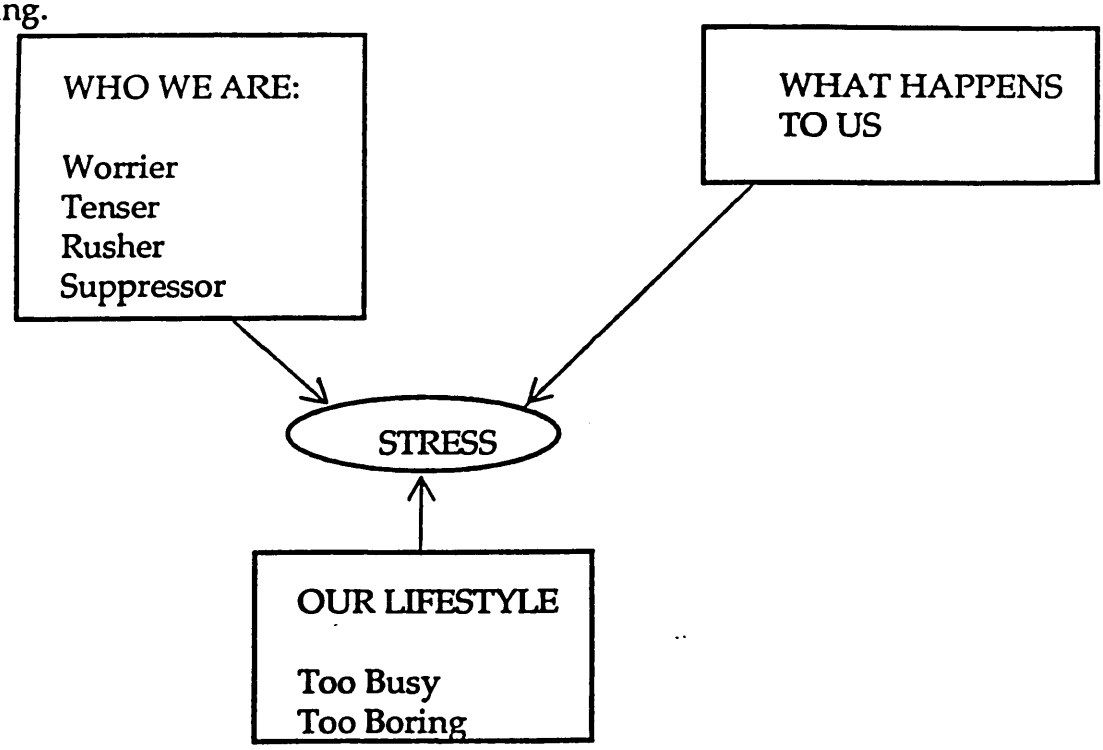
Fact 11: You cannot be blamed for who you are

So if you are a worrier, rusher, tenser or suppressor, at least some of your stress is because of your personality. This can cause people to think "It's my fault, I'm the cause of my problems". Fortunately, this is not true. We cannot blame ourselves for who we are. Our personalities developed when we were children and we had no say in what happened to us. This doesn't mean you cannot change your personality - you can. This programme will show you how to be less of a worrier, rusher, tenser or suppressor.

Fact 12: Most stress is caused by a combination of things.

Some stress is purely a result of who we are (Fact 10). Some anxiety is purely a result of the things that happen to us (Fact 8). Some stress is a result of our lifestyles (Fact 9). Most stress is a result of a combination of all these things.

Even a "born worrier" like Janet has to have a life event to worry about, eg the son's wedding.



Fact 13: You cannot just "shake yourself out of it" or "pull yourself together"

I wonder how often you've heard phrases like these from others or even used them on yourself? Usually they are used by people who do not understand the very complex nature of stress and what makes people tick. If you could just pull yourself together, wouldn't you have done it by now? Also, if it were easy, why would so many people suffer from it?

Fact 14: Stress can be managed.

Whilst stress can cause physical illnesses, it is not an illness itself. You cannot "catch" stress and then get rid of it by taking tablets. Stress is caused by a number of things including our lifestyle, any life-events we experience and/or how we do things.

Because some of these causes can be changed, to atleast some degree, we can do something to reduce any stress we experience - we can manage stress. This may involve changing our lifestyle, trying to reduce the number of life events we experience and/or even changing how we do things, eg trying to be less rushed, tense, worried or suppressed.

Not only can we manage stress by changing the causes, we can also do things to relieve the symptoms which result from the uncontrollable causes, eg having leisure activities to help us turn off and unwind or keeping fit.

Fact 15: Some stress is useful

We will all experience some stress much of the time. Some of this is useful. Up to a point stress helps us get things done and can make life more enjoyable. The stress involved in doing a difficult job can be more than rewarded by the satisfaction of succeeding in it. The stress involved in planning a holiday can again result in the relaxation and enjoyment of the holiday itself.

So stress can be useful. The skill is to manage stress, keeping it from going over the top and dominating or spoiling our successes or enjoyment. This is when we suffer from stress instead of gain from it. One famous writer on stress, Hans Seyle, distinguishes between good stress which he calls "eustress" as an euphoric and bad stress, called "distress".

2.2 SOME QUESTIONS ABOUT STRESS

Before I turn to the first way of managing stress, I want to tell you a few of the questions people have asked me over the years.

Q1. If it isn't an illness, why can drugs help?

Stress can cause physical symptoms because it increases your level of physical arousal - your heart and breathing speed up, your muscles become more tense. The drugs you may have been given can act to lower your level of physical arousal. This reduces the physical symptoms of stress.

Unfortunately, these drugs do not help with the causes of stress, only some of the symptoms. In addition, these drugs have less and less effect, the longer you take them. They can also be habit forming. In the short term, drugs can be useful. In the long term, learning skills to manage your stress is much more effective.

Q2 My G.P. said I was neurotic....what does that mean?

Health Professionals have a variety of technical names which they use to describe people suffering from stress and anxiety. Other names which you may have heard and which all mean the same thing include: neurotic disorder, psycho-neurosis, anxiety neurosis, anxiety reaction, nerves. All of us can be described as being a bit neurotic etc, from time to time.

Q3 Am I going insane?

Definitely not! You may feel as if you are. Your symptoms may be so horrible, so strong and frightening that you feel as if you are losing control.

Insanity is very different. People who are "mentally ill" can suffer from delusions, or may be imagining voices or objects that are not there. Such conditions are much much more severe and harder to treat. Stress does not cause Mental Illness.

Q4 What is a nervous breakdown?

I think this is a very confusing term. It sounds so final. It sounds as if something has been broken and cannot be fixed.

What people usually mean by nervous breakdown is that someone is finding it difficult to cope with their normal lifestyle. This might be becasue they feel anxious, depressed, angry, guilty or jealous. All these feelings can be caused by too much stress. With treatment, the stress can be reduced and this difficulty is temporary so their lifestyles can return to normal. It is not permanently broken.

Q5 If I wait, will I get better without treatment?

Possibly. If your stress is a result of a recent life-event, as time passes and you learn to re-adjust to any changes caused by it, your stress may reduce. However, most stress is caused by a combination of life-events, lifestyles and how we do things. So to reduce your stress, it can be useful to think about changing your lifestyle and/or how you do things. There may also be things you can do to cope better with any symptoms which result from the life-event is this is the main cause of your stress.

Q6 Will hypnotherapy or acupunture help?

If done well, they can help you to relax. Unfortunately, such ways of relaxing are not easily used in real life situations, eg when facing your boss. This programme describes a way of relaxing which you can use as often as you want, whenever you want.

Another problem with them is they do not look at the causes of stress, this programme will.

Thirdly, relaxation is very useful but on it's own it is not enough. This programme covers a number of ways of managing stress.

Q7 It's not just the stress, I've also been getting depressed - Why?

Depression can be caused by many things, including stress. All that worrying, rushing or tensing can simply wear you out - physically and mentally. Not only do you feel worn out, all the fun in life can disappear. What was once enjoyable is now a struggle, You may even avoid it, it's too much trouble. So you feel worn out, life is a struggle, there is little to enjoy. No wonder stress can cause some depression.

As your stress reduces, so will any depression caused by it.

The programme should help you to greatly reduce your stress. To make this happen you will need to stick with it and work hard. If it turns out that the programme helps but is not enough, your G.P. will be able to discuss what else may help you.

By the end, you should be in a stronger position. You will know more about stress and how to manage it than the average person. Having had problems will actually give you an advantage for the future.

2.3 WHAT IS STRESS - SUMMARY

Everyone has at least some stress because everyone has some problems. Problems cause stress.

For nearly half of the population, their stress can be so bad that their lives are badly affected by it.

Stress is a major cause of anxiety.

Worries about the symptoms of stress can make your stress worse.

Stress is not an illness, but it can cause physical symptoms.

Some stress is caused by too many life-events or a life-style which is too busy or boring.

Some stress is caused by the person you are - you may worry, tense or rush too much.

Most stress is caused by a combination of life-events, lifestyle and personality.

Stress cannot be reduced by pulling yourself together. It can be reduced b y learning to relax physically, worrying less and by changing your lifestyle.

Reducing your level of stress will reduce the amount of anxiety you suffer.

Stress cannot make you go insane. Even if you find you cannot cope with your normal life for a while, you can recover.

Sometimes stress can cause mild depression - it wears you down and makes life less enjoyable.

This programme will only be useful if you work at it. The more you practice, the easier you will find it to manage your stress.

2.3.1 QUIZ

QUESTIONS		ANSWER (circle which answer you think is correct)
1.	Most people never experience any stress.	True/False
2.	Some stress is useful.	True/False
3.	Being stressed can make you feel even more stressed - it is as if you are caught in a vicious circle.	True/False
4.	Stress affects your mind and body but not your behaviour.	True/False
5.	Stress often causes anxiety.	True/False
6.	Stress is not caused by your personality - it is totally a result of things going wrong in your life.	True/False
7.	You can cure stress with drugs.	True/False
8.	Some lucky people can simply pull themselves together and stop feeling stressed.	True/False
9.	No treatment will ever make you totally free of stress - some stress is inevitable.	True/False
10.	Stress can make you go insane.	True/False
11.	To cope with stress all you have to do is learn to relax.	True/False
12.	Sometimes stress can lead to mild depression.	True/False

2.3.2 ANSWERS TO QUIZ

1.	False - see Section 2.1	Fact No. 1
2.	True - see Section 2.1	Fact No. 15
3.	True - see Section 2.1	Fact No. 4
4.	False - see Section 2.1	Fact No. 5
5.	True - see Section 2.1	Fact No. 6
6.	False - see Section 2.1	Facts No. 8,9,10 and 11
7.	False - see Section 2.2	Question 1
8.	False - see Section 2.1	Fact No. 12
9.	True - see Section 2.1	Fact No. 1
10.	False - see Section 2.2	Question 3
11.	False - see Section 2.2	Question 6
12.	True - see Section 2.2	Question 7

Do not be surprised or upset if you have got any of your answers wrong. Do not expect to be perfect - no one else is! I am giving you a lot of new information so it will take time to understand it all.

If you have got some of your answers wrong, try going back and reading the sections mentioned above - this may help you to see the right answer.

2.4 CONCLUSION

Once you have read this far, it can help to go back and re-read the whole booklet at least twice more. Spend as long as you want to on this and make sure it has all sunk in before moving on to the next booklet. This section generally takes people at least 1 - 2 weeks.

Remember that showing others the booklet may help them to understand what you're going through.

SECTION 3

NORTH WARWICKSHIRE NHS TRUST

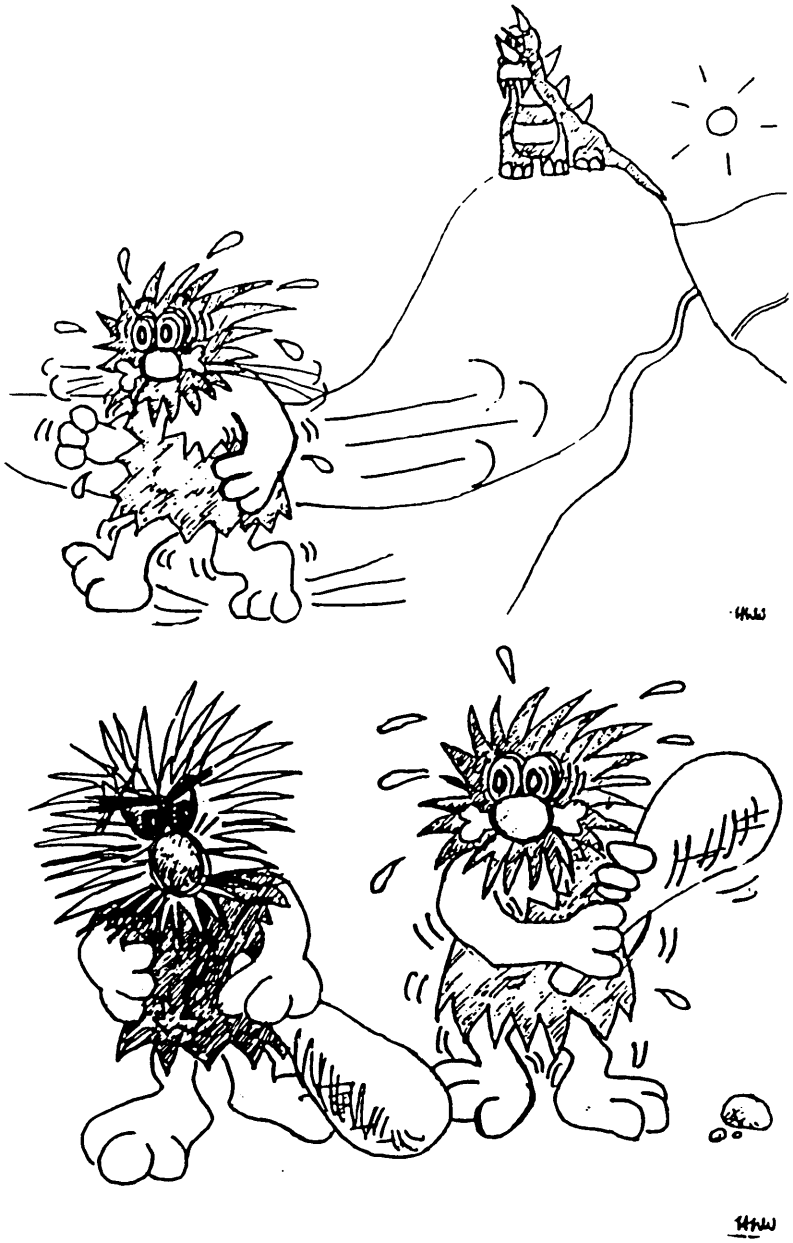
STRESS AND ILLNESS

Too much stress causes physical illness and emotional difficulties. This section helps you understand why. It also explains how the rest of the programme will help you to reduce such problems.

The section is divided up as follows:

3.1 THE FLIGHT OR FIGHT RESPONSE - WHAT IS IT?

Look at the following cartoons of a cave man:

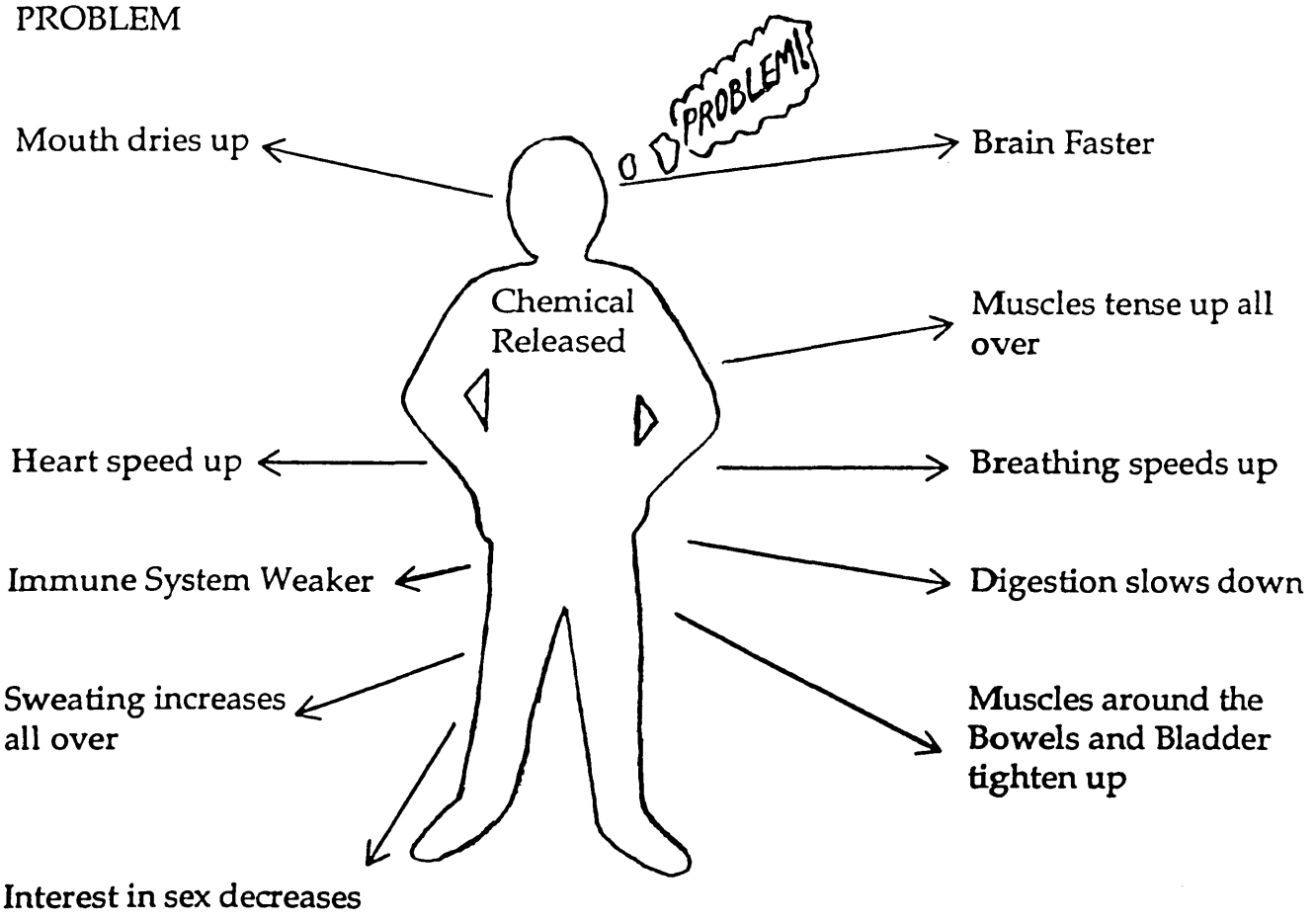


In both situations, the caveman is facing some kind of physically dangerous problem. He has two choices - to run or to fight. Which he chooses depends on how likely it is he can beat the problem.

These are examples of what is know technically as the "Flight or Fight Response" (FFR). When faced with a dangerous problem, all humans have the same two choices - to run (Flight) or Fight.

The FFR evolved in primitive humans like cave men and women. It helped them to cope with many dangerous problems they faced, eg attacks by wild animals or other humans. The quickest to react were the most likely to survive.

To help us run or fight, to prepare us for action, a number of changes occur automatically in our bodies. These changes are triggered by hormones released by the brain when it receives the message "danger" or "problem". These hormones include adrenalin. Here is what happens in the body:



All these physical changes help us prepare for action. Here's how the main changes help:

* Muscles tense up all over - to run or fight, our muscles need to be tense

* Breathing speeds up - muscles use up oxygen so the tenser our muscles, the more oxygen we need

* Heart speeds up - the muscles get the extra oxygen from the blood stream. So the more oxygen our muscles need, the faster the heart goes to pump it to them

* Sweating increases - as we use our muscles, we get hot. To stop us overheating, we sweat

* Brain speeds up - a faster, clearer brain helps us to react more quickly

All these increases could not occur unless other parts of the body slowed down. For example, our immune systen gets weaker, our interest in sex is lower, our digestion slows down and our mouths dry up. All these decreases allow the body to redirect scarce resources, ready for action.

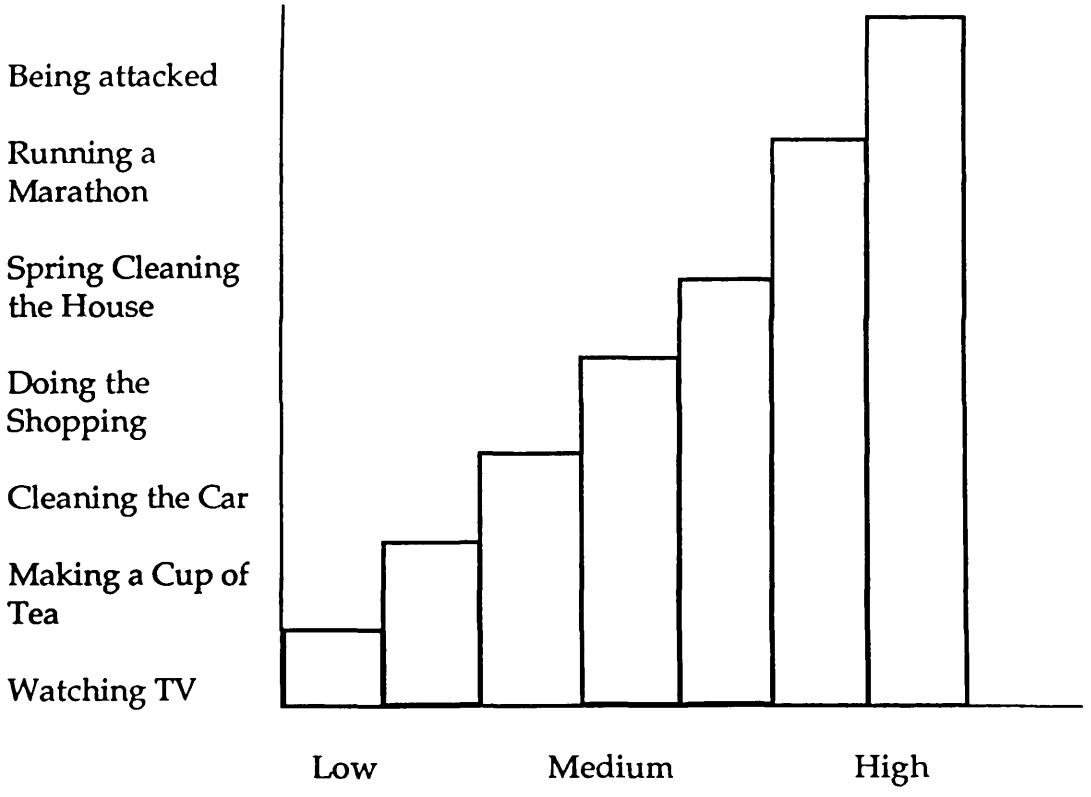
3.2 THE FFR TODAY - THE GOOD NEWS

So what use is the FFR today - after all, we do not face many sabre toothed tigers in the high street?

The FFR prepares us for action. So the FFR helps us to deal with any problem we face that requires physical action. This can be a small problem such as washing the car or cleaning the kitchen. Or it can be a large problem such as rushing an ill relative to the hospital or fighting off a mugger.

The bigger the problem, the more action that is required, the higher the FFR comes on. Look at the diagram below to see what I mean.

SIZE OF PROBLEM AND FFR



Watching TV requires very little activity - perhaps a little muscle tension in the neck to hold our head straight and in our arm to use the TV control. So our breathing, heart, etc speed up only a little. To do the weekly shopping requires a lot more activity. So our muscles tense up more, our breathing and heart speeds up more, etc. To fight off a mugger requires even more activity so our FFR is on high.

So the FFR is useful in modern society, it helps us to deal with any problems that require physical activity. Unfortunately, it's not all good news. Read on.

3.3 THE FFR TODAY - THE BAD NEWS

3.3.1 It comes on when we cannot use it

As a result of evolution, the FFR is now triggered in our bodies by any type of problem or challenge. As we have just seen, this is very useful when the problems we face need physical action, eg, washing the car or fighting off a mugger. Unfortunately, in dealing with some problems, physical action is not possible. As a result, the changes that occur in the body due to the FFR are not useful. In fact, if they are allowed to build up, they can cause problems in the body. Illness and emotional difficulties result.

Let's take an example. If you were told off rudely by your boss you might want to resign and run away, or stand and fight, perhaps getting into an argument. If you value your job, you'll probably control such urges to run or fight. Instead, you may end up sitting at your desk or work bench, silently fuming or hurting, fists and teeth clenched, breathing and heart faster, bottling your feelings and tensions up. Your FFR has been triggered, but because you can't use it, it builds up in your body. Your clenched fists and teethcould cause a headache. Your faster heart might cause palpitations. Your faster breathing could cause "Hyperventilation", a condition which can be one cause of panic attacks. You may become scared of losing control of your bottled up, suppressed feelings.

There are lots of situations in modern society where the FFR is triggered but we cannot use it. Examples include being stuck in a traffic jam, dealing with everyday problems like large bills, or family arguments, working at a boring or frustrating job, being married to the wrong person, a boring lifestyle or watching the bad news on TV everynight.

Another major cause of the FFR coming on when we cannot use it is when we worry. When we worry, we are thinking about how to solve the problem or what might go wrong. We are not doing anything physically. So when the FFR comes on, it just causes us to feel tense, on edge etc. Clearly people who are prone to worrying - the worried described in Section 2 - will have more problems with their FFR. They may frequently feel jittery, unable to relax, get headaches, have difficulties sleeping, have difficulties concentrating.

So too will the tensers. People who are prone to tensing up will have their FFR coming on more often than it needs to. The smallest problem will cause them to tense up. They too will suffer more stress symptoms due to their FFR.

3.3.2 It is on Too Long

The second major problem with the FFR occurs when it comes on usefully but it is on too long. The FFR is designed to be on for fairly short amounts of time, especially if it is on high. If it is on for too long, the body runs out of energy and starts to develop symptoms of stress.

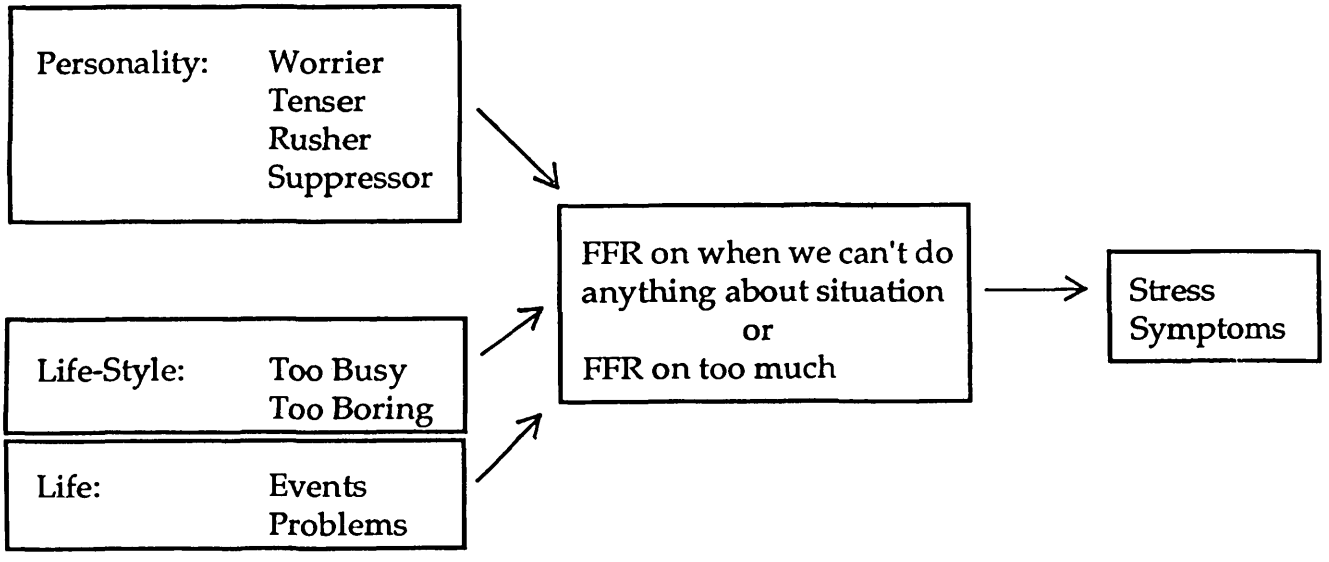
In Section 2, I gave an example of a person who had a very busy lifestyle. Susan never stopped - her FFR was on nearly all the time as she did the housework, looked after the children, did her part-time job, did the shopping etc.... The only time in the day when she stopped was when she collapsed, exhausted into bed every night.

Her stressed body became exhausted, she suffered regular headaches and back pains. One day it all became too much and she suffered a panic attack.

Your FFR will probably be on too much if you have a very busy lifestyle like Susan, or if you are a Rusher (see Section 2 where I describe Rushers), or if you face a lot of problems or life events that require action.

3.3.3 Summary of the bad news

If our FFR is triggered in the wrong situations or is on for too long, symptoms of stress result. The diagram below brings all these points together.



3.4 THE SYMPTOMS OF STRESS

In Section 2, I described how many and varied the symptoms of stress can be. They can affect our bodies, our behaviour and our minds. In general, the bigger the problems we have with our FFR, the worse the stress symptoms tend to be. So the more it comes on when we can't do anything, or the more it is on for too long, the worse the symptoms.

3.4.1 Physical Illnesses

As I have already described, during the FFR, many changes occur in the body. These include a weakening of the body's immune system and changes in the cardiovascular system.

It is thought that such changes can contribute to a variety of serious illnesses including cancer and heart disease. If you cope with your stress by drinking, eating or smoking too much, your health is going to be made even worse.

It is important to realise that such illnesses may take years to develop and high stress does not inevitably cause them. Nor can it ever be the only cause. However, there is strong evidence to show that stress does affect our physical health - in large and small ways.

3.4.2 Emotional Difficulties

The emotional difficulties that stress can cause include anxiety, panic attacks, phobias, irritability, guilt and low mood.

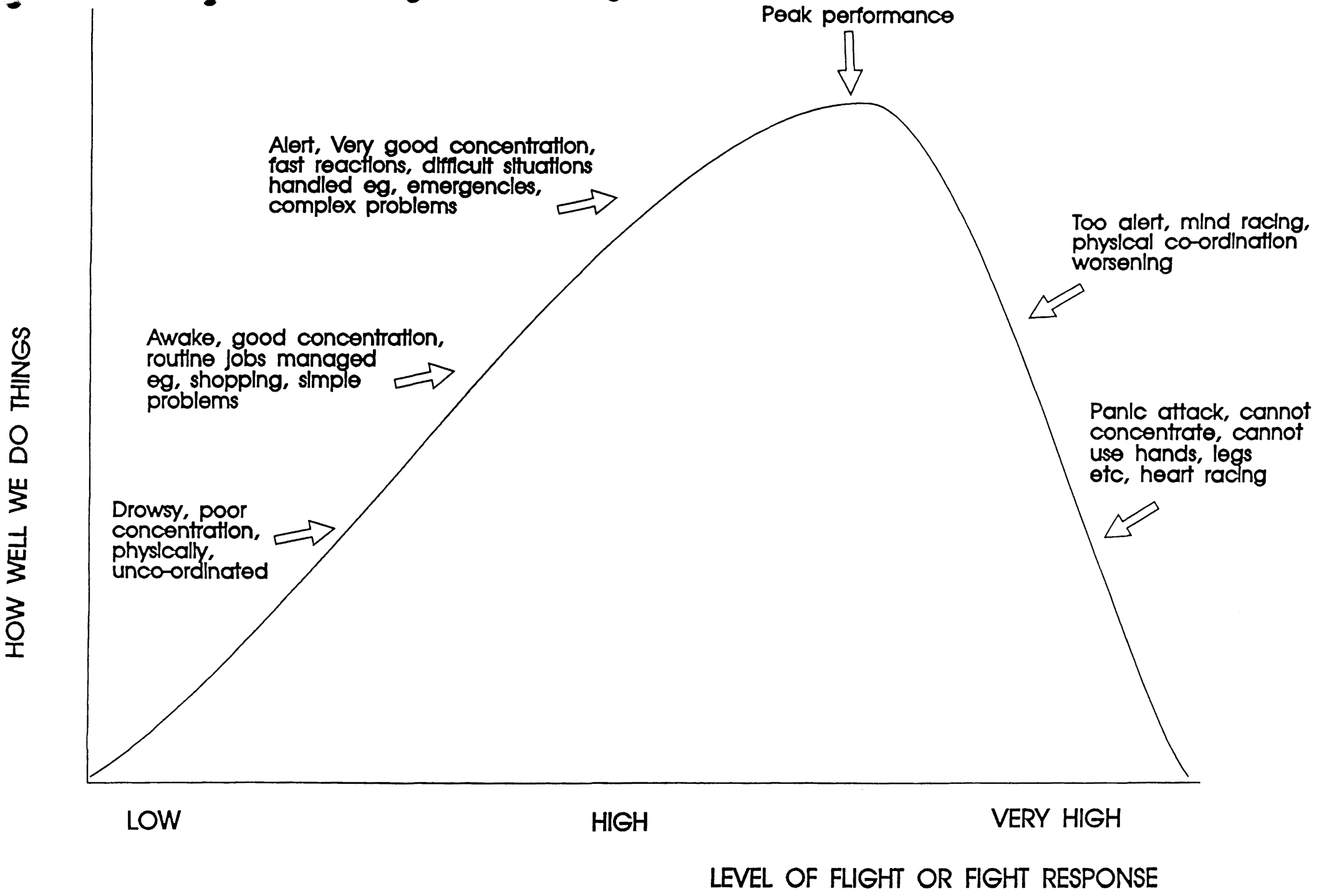
(a) Anxiety is typically caused by a person worrying too much, even about small things. As a result of all this worrying, their FFR is on most of the time - they are constantly ready for action. They may feel constantly on edge, be unable to relax, jump at the slightest noise, become irritable easily, have difficulties sleeping because of their over active brain, feel tired, be unable to concentrate for any length of time, or always want to be doing something to use up their nervous energy. People whose personality means they worry a lot tend to suffer from anxiety.

(b) Panic attacks are an extreme form of anxiety. A panic attack occurs when the FFR goes too high. The changes in the body are too big. If our muscles are too tense, they lock or turn to jelly. If our brain is too fast, we cannot think straight, if our breathing is too fast, we hyperventilate.

Hyperventilation causes many of the symptoms of panic attacks including dizziness and gasping for breath.

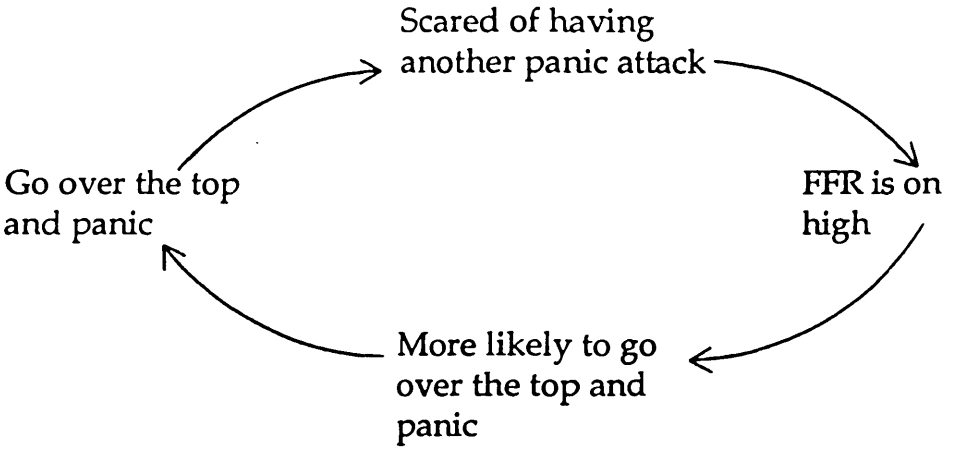
The diagram on next page shows what happens when we go over the top.

There are many reasons why the FFR may go over the top to cause a panic attack. The main one is that the sufferer's FFR is already on high and something happens to just push them that little bit higher and over the top. Their FFR may be on high in the first place for a number of reasons: their personality means that they worry, tense or rush a lot; they have a busy lifestyle; they face a lot of problems or life-events; or they feel upset or angry but bottle their feelings up.



THE FLIGHT-FIGHT RESPONSE AND PERFORMANCE

A common thing that pushes people over the top is being scared of their stress symptoms. Let's go back to the person sitting fuming over his boss's insults. As he sits at his desk or work bench, he may begin to feel dizzy or get a chest pain or palpitations. These are normal symptoms of the FFR being on when it can't be used. If the man doesn't know this he may wonder what's going on. An obvious and common guess is to assume he's having a heart attack - the symptoms are similar. Such worries may push him over the top into a panic. Indeed, once you've had a panic attack you are more likely to suffer another simply because you worry about it. The extra worry keeps your FFR on high. A vicious cycle is set up:



Often panic attacks appear to come out of the blue. This is usually because the sufferer is so busy before hand - worrying, tensing, rushing or suppressing. They only notice how tense they've been when the panic symptoms occur.

It is also important to emphasise that panic attacks are not dangerous. They are not a sign you are physically ill or going mad. They are a sign that the body's FFR is working normally. It is also true that panic attacks are very, very unpleasant and frightening.

(c) Phobias can result from panic attacks. A phobia is a very strong fear of something or some situations. Common examples include spiders, snakes, mice, open spaces, heights, shops, aeroplanes, trains, tunnels, the work place, interviews, or conflict situations such as dealing with a difficult boss or partner. When faced by the feared situation or object, the sufferer typically feels panicky and tries to escape.

Phobias develop for a number of reasons. Most of us are at least a little scared of something or somewhere. It could be that we have learned to be extra scared of it because we had a panic attack when we last faced it. Or it could be one of our parents was scared of the same thing and we learned it from them. Or it could be that we've heard of something terrible happening to someone else when they were faced by it, eg hearing about a plane crash.

(d) Finally, anxiety, panic attacks and phobias are not the only emotional difficulties stress can cause. People are often left feeling frustrated and angry by too much stress. This may be because of too many situations or problems where the sufferer feels unable to do anything to change them. This can also cause a person to feel low. They may also feel low simply because they are worn down, not just by their problems, but by their stress symptoms. No one enjoys a life full of headaches, stomach upsets, worrying, panic attacks etc. Guilt can also follow, perhaps because a person feels they are not coping well enough, are letting people down.

Perhaps we've dwelled enough on symptoms. Now let's move on to look at what you can do to reduce your symptoms - and how this programmes will help you.

3.5 WHAT CAN YOU DO ABOUT THE FFR?

So what can you do about your symptoms? The rest of this programme will help you to learn a number of skills. These will help you to manage stress better. With them you will be able to control your FFR. You will suffer fewer symptoms.

In Section 4, you will learn two ways of relaxing your mind and body. These will help you to control when your FFR comes on, and how high it is. Such control means you do things more efficiently, feel less stressed, suffer fewer and less severe symptoms.

In Section 5, you will examine your lifestyle from a number of angles. These include checking on whether you are a tenser or a rusher. If you are, I describe new skills which will help you to change. I also discuss the importance of talking about problems. Suppressing our feelings causes the FFR to come on and stay on. Talking can help to turn it off. Section 7 also describes how to express your feelings in an assertive way, without feeling guilt.

In Section 6, you will look at another major cause of the FFR coming on too much - worrying. We all worry in the wrong way some of the time. This causes needless stress. The skills in this section will help you to worry less. They will also help you to worry more constructively when worrying is inevitable.

3.6 SUMMARY

We have just covered a lot of information, much of it ver complex. Here's a summary to help you:

The FFR helps us prepare for action. In the extreme it helps us run from or fight the problem.

We all have the FFR built into our bodies by evolution. It comes on automatically whenever we're faced by a problem.

Many changes occur in the body during the FFR - these changes help us get ready for action.

The main changes are our muscles tense up, our heart and breathing speed up, and our brains can think more clearly.

The larger the problem we face, the higher the FFR comes on. It can help us to deal with large and small problems alike - so long as they need physical action.

There are two main problems with the FFR - it comes on when you cannot use it or it is on for too long.

In either case, stress symptoms are the result. These symptoms can include serious physical illnesses or emotional difficulties.

The skills covered in the rest of this programme will help you to learn to control your FFR. This will resolve any stress symptoms you suffer.

3.7 QUIZ

QUESTION		ANSWER
1.	The FFR evolved in primitive humans to help them survive.	True/False
2.	The FFR is not useful in modern society.	True/False
3.	The FFR is only useful when we are faced by a dangerous situation.	True/False
4.	To turn the FFR on, we have to stop and think about it.	True/False
5.	During the FFR, many changes occur in the body.	True/False
6.	The larger the problem we face, the higher the FFR comes on.	True/False
7.	Stress symptoms occur when the FFR is on for too long.	True/False
8.	Panic attacks happen because the FFR is on too low.	True/False
9.	There is nothing you can do about the FFR - it is uncontrollable.	True/False

3.8 ANSWERS TO QUIZ

1. True - see Section 3.1
2. False - see Section 3.2
3. False - see Section 3.2
4. False - see Section 3.3.1
5. True - see Section 3.1, 3.2, 3.4.1
6. True - see Section 3.2
7. True - see Section 3.3.1, 3.3.2, 3.3.3
8. False - see Section 3.3.2, 3.4.2
9. False - see Section 3.5

As ever, if you've got any of your answers wrong, try re-reading the relevant Section to see why. Then read the conslusions of this Section.

3.9 CONCLUSION

There was a lot of information in this Section. You will probably need to re-read it at least twice more to let it sink in. Spend about 1 - 2 weeks doing this. It will help to prepare you to learn the skills covered in the remaining Sections.

Once you're ready to move on, try Section 4. Good Luck!

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SECTION 4

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MANAGING PHYSICAL AND MENTAL TENSION

This section will help you to learn two methods of relaxing your body and mind. These will help you to reduce any symptoms of stress you suffer.

The section is divided up as follows:

4.1 THE RELAXATION RESPONSE

Earlier, I described how the flight-fight response can be useful but can cause problems. Below I describe how you can learn to control the flight-fight response using the relaxation response.

By learning the relaxation response you should be able to:

- greatly reduce physical symptoms, eg headaches, stomach upsets, palpitations, panic attacks, tiredness, poor sleep.
- greatly reduce emotional or mental symptoms, eg poor concentration, feeling low, irritability.
- remain calm in difficult, stressful situations.
- recover more quickly after stressful situations or long, tiring days.
- slowly reduce any tranquilisers you take, under the supervision of your GP.

The relaxation response helps you to do these things by lowering the flight-fight response. The table below shows how:

The Flight-Fight Response	The Relaxation Response
Muscles tense-up Brain faster Breathing faster Heart faster Sweat more Mouth dries-up	Muscles relax Brain slower Breathing slower Heart slower Sweat less Saliva returns

The relaxation response can lower all the changes caused by the flight-fight response. However, when you get very skilled at using the relaxation response, you can lower some parts of the flight-fight response whilst keeping others high, eg you can keep your brain fast and active whilst relaxaing your muscles. This means you can work on solving a problem such as a large bill or arument without all the physical tension that usually results!

In broad terms, the relaxation response helps you to:

- stop going "over the top". It will stop the flight-fight response from going too high and causing too much tension and panic.

- control which parts of the flight-fight response come on, allowing you to reduce the parts you don't need.

The relaxation response works in the same way as tranquillisers, relaxing the mind and body. However, it is much better than tranquillisers because:

- you can use it as often as you want
- you can use it anywhere that you want to
- you cannot become hooked on it
- there are no side-effects to the relaxation response

4.2 TYPES OF RELAXATION RESPONSE

There are a number of ways of learning the relaxation response. The most common ways include: yoga, transcendental meditation and jacobsian relaxation.

Through this programme you are first going to learn Jacobsian Relaxation. This is one of the most widely used and best researched way of relaxing. It is so effective that many large companies around the world are increasingly encouraging their staff to learn it. This is because research shows it greatly reduces staff illness - physical and psychological.

On the tape which comes with this programme, there are two sections on relaxation. The first describes how to relax deeply using the Jacobsian method. The second describes a quicker method of relaxing which you can learn once you have learned the Jacobsian method.

The Jacobsian Deep Relaxation Method:

- takes about 20 minutes to complete each time
- helps you to relax deeply
- is very useful at the end of a busy, stressful day, it helps you to turn-off and it helps the mind and body to recover.

The Quick Relaxation Method:

- takes about 5 minutes or less to complete each time
- does not make you as deeply relaxed as the deep method
- helps you to keep the Flight-Fight Response under control all day
- is very useful before and during difficult, stressful situations

4.3 HOW TO LEARN THE RELAXATION RESPONSE

To learn how to use the Deep and Quick methods, you will need to try and:

1. Just listen to both methods the first time - don't try the exercises, get a feel of what you will need to do.

2. Practice a lot - You will need to listen to the tape at least once and preferably twice a day. Like any skill, the more you practice, the quicker and better you will learn it.

3. Be patient - It can take upto two months of daily practice for many people to start to notice any gains. It can take another two months or more to beging to make large gains.

4. Get comfortable - To help you to concentrate on the tape, you need to be comfortable. Make sure your room is quiet and warm. Wear loose clothing. Sit in a comfortable chair or lie down on a bed. Do not practice if you feel very hungry or just after a meal. Once you have learned to relax, you will be able to relax anywhere, anytime.

5. Avoid interruptions - Interruptions will distract you so you cannot learn. They will also make you tense. Get a partner or friend to look after the children, tell everyone where you are going and ask them to give you 30 minutes to yourself - that's not much to ask!

6. Develop a routine - Setting aside a regular time every day will help you and others to remember about your practice session. Try not to squeeze the practice in between things. If you do, you may just sit there worrying about what you should be doing or what you have to do.

7. Accept that your mind will wander - This is one of the hardest parts of learning to relax. People who suffer stress and anxiety often have very busy minds that never seem to stop. As you begin to relax, it is almost certain your mind will wander onto problems, etc. At first this may happen for most of the practice session. Even when you get better at relaxing, your mind may wander for upto half the time!

   When your mind wanders - gently remind yourself it is inevitable
   - gently return your mind to the tape

   I say gently. The natural tendency is to tell yourself off, feel a failure or force your self to listen to the tape. All this does is make you tense - just as if someone else had told you off. Be easy on yourself - it will help you relax.

8. Start with the Deep method - You cannot learn the Quick Method until you have learned the Deep Method.

9. Spend at least three weeks, on each section - Spend at least three weeks on the Deep method, practising every day. Then you can move on to spend at least three weeks on the Quick method.

As you learn the Quick method, you can still use the Deep method whenever you want to. The aim is to use both methods - the Deep perhaps at the end of a hard day, the Quick throughout the day, especially before or during difficult situations.

10. Use the diary sheet - This is at the end of this section. Use it to record the day and time of each practice session and how it went.

11. Use the tape less and less - For the first three weeks learning each method, use the tape every practice session. After this, try using the tape every other time. This will help you to remember the instructions so you can relax without the tape eg in shops or at work. At first you will find it harder to relax and also to remember instructions. It gets easier with practice.

12. The tape is to keep for life - Even once you have learned the methods, it will be a good idea to listen to it from time to time. This will help you check you are using the right methods. Before you try the tape, try reading the rest of this section.

4.4 COMMON PROBLEMS RELAXING

At first, people using the tape often find it isn't working. Below are some of the main problems you may face. I also mention some ways of overcoming them.

1. I've tried it before and it didn't work

If you tried the methods on the tape before and they didn't work read on! It may be one of the common problems described below is the one you faced. In my clinical experience, the Deep and Quick Relaxation methods work - if practised in the way I have described.

2. I fall asleep when I relax

Great! That means it is working. It also shows how tired you are. The exercises will help you to sleep, if you are having difficulty sleeping at night. But if you are still learning the exercises, you'd best try and find a time during the day when you are not so tired you fall asleep whenever you try them. Otherwise you will never fully learn all the exercises.

3. I feel guilty taking time for myself

You are exactly the kind of person who needs to take a break because you are probably doing too much - usually for everyone else! Everyone needs a rest occassionally - even if it's only 30 minutes. If you don't you'll wear yourself out. then you won't be of any use to anyone.

4. When I try and relax I just get more tense

This may be because you're trying too hard. Remember it will take at least two months to begin to make any real gains. Another reason may be because you worry about losing control of your body by relaxing. This is a common fear. All I can say is that by learning to relax you are learning to control your Flight-Fight Response. This means you are actually learning to control your body rather than losing control of it.

A third reason for getting more tense is that you get scared by how strange your body may feel. Most people are frightened of anything different - especially anything to do with their body. Bear in mind that as you learn to relax, your body will have to feel different. This difference means the body is working better - not worse!

Finally, some people feel more tense simply beacuse they are becoming more aware of how tense they always have been. The Deep Relaxation method makes you more aware of how tense you are - it hasn't made you more tense.

5. It just doesn't work

This again is a common problem and it is caused by a number of things. The main ones are trying too hard, expecting too much too soon, not practising enough, or doing it when you feel too tired or uncomfortable to learn. The solutions to these very common problems are discussed in Section 4.3. If you are having problems, re-read this section carefully to check if there is anything you need to change.

6. It isn't enough

I agree. For some people, learning Deep and Quick relaxation is all they need to do to successfully manage their stress. For others, Deep and Quick relaxation help, but they need more in addition. Other ways of reducing stress and anxiety are covered in later sections of the programme.

4.5 SUMMARY

The Relaxation Response controls the FFR. It helps you stop going over the top.

By controlling your FFR you will improve your physical and emotional health.

The Relaxation Response will help you to deal with difficult situations with more confidence.

The Relaxation Response is a healthy alternative to drugs.

Learning the Relaxation Response is not easy. It can take up to 2 months before you feel any gains.

It is unlikely that the Relaxation response is enough to control your stress. The rest of the programme will also be necessary.

4.6 QUIZ

Question		Answer (circle which you think is correct)
1.	The relaxation response and the flight-fight response are the same thing.	True/False
2.	The relaxation response is only really useful to help you unwind at the end of the day.	True/False
3.	It not only helps you to reduce your stress, it also helps you to improve your physical health.	True/False
4.	It does not matter which order you learn Quick or Deep Relaxation.	True/False
5.	Quick Relaxation does not make you as relaxed as Deep Relaxation.	True/False
6.	It is easy to learn to relax.	True/False
7.	As soon as you start learning to relax you will feel better.	True/False
8.	As you practice the relaxation response, your mind will wander.	True/False
9.	Falling asleep is a sign that the relaxation response is working.	True/False
10.	Once you have learned the relaxation response and are managing your stress better, you can stop using it.	True/False

4.7 QUIZ ANSWERS

1. False - see Section 4.1
2. False - see Section 4.1
3. True - see Section 4.1
4. False - see Section 4.3
5. True - see Section 4.2
6. False - see Section 4.3
7. False - see Section 4.3
8. True - see Section 4.3
9. True - see Section 4.4
10. False - see Section 4.3

Very few people will get all or even most of the above questions right first time. As I have already mentioned, I am giving you a large amount of new information which will take time to understand.

If you have got some of your answers wrong, try and go back and re-read the sections mentioned above - this will help you to see the correct answer.

STOP: Now you have read this far, it can help to go back and read the whole section at least once more. Then, when you feel ready, move on to the exercises below.

4.8 STARTING TO RELAX

Exercise 1
Set aside about 40 minutes and listen to the whole of the tape. Do not try the exercises yet. Then move on to Exercise 2.

Exercise 2
Look again at the instructions in Section 4.3. Following the advice in these instructions, set aside about 30 minutes and listen to the Deep Relaxation exercises, trying them yourself. Fill in your diary sheet when you finish.

Try to practice your Deep Relaxation exercises at least once per day for the next 3 weeks.

When you feel ready, every now and again, try the exercises without the tape. This will help you to remember the exercises so you can use them when you are out of the house etc. At first it will be more difficult without the tape, your mind may wander or you may go too fast. With practice it will get easier. Once you have began to learn the Deep Relaxation exercises, you can move onto read Section5. Carry on practising the deep and after 2 -3 weeks, or when you feel ready, try Exercise 3 below.

Exercise 3
Re-read the instructions in section 4.3. Then set aside about 10 minutes and listen to the Quick Relaxation exercises, trying them yourself. There is no need to fill in your diary any more.

Practice your Quick Relaxation exercises at least once per day for the next 3 weeks. You should also continue to practice your Deep Relaxation exercises whenever you want to. If you have problems, re-read section 4.4.

When you feel ready, every now and again, try the Quick Relaxation exercises without the tape. At first it will not be so easy, your mind may wander or you may go too fast. With practise, it will get easier.

4.9 CONCLUSION

One final point on using the Deep and Quick methods. Once you begin to feel better, do not stop. Everyone needs to relax everyday. It is not something you do just when you feel bad. Doing it every day will help you prevent suffering severe difficulties again. Relaxing every day is something you will need to do for the rest of your life. I practise some form of relaxation or meditation nearly every day, and more frequently when things are very stressful.

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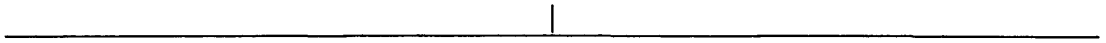
RELAXATION DIARY

Before and after each practice session you need to rate how tense you feel. Do this by deciding how tense your are using the scale:



0 — Not at all tense

50

100 — Extremely tense

Decide on your score, rating it out of 100 and put this score in the relevant columns.

In the final column make any comments you want to which relate to how your practice went, eg you were interrupted, had difficulty relaxing your back etc.

DAY	TENSION BEFORE	TENSION AFTER	COMMENTS

SECTION 5

LIFESTYLE AND STRESS

NORTH WARWICKSHIRE NHS TRUST

As we saw in Section 2, one major cause of stress can be a person's lifestyle. The aim of this section is to describe ways of reducing your stress by changing your lifestyle.

The section is divided up as follows:

5.1 Pacing Yourself

5.2 Leisure

5.3 Talking

5.4 Summary

5.5 Conclusion

5.1 PACING YOURSELF

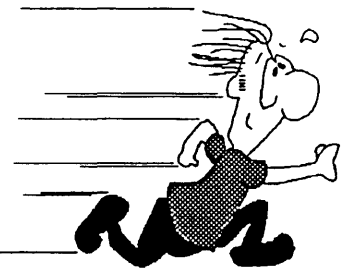
Look back to Section 2, fact 2. Susan was working to look after 2 young children, a home, a husband plus a job as a ward sister. She eventually began to suffer severe panic attacks. These were largely caused by her trying to do too much, too fast.

All her jobs meant that Susan's level of arousal was very high most of the time. Usually, this just meant she was very tired every night and suffered tension headaches. However, on one extra bad day her arousal level went over the top and her panic attacks began. What pushed her arousal over the top was the extra stress caused by an unusually busy day, plus the extra crowds in the shops that day due to a bank holiday, plus the worry caused by her son being ill.

A large part of therapy for Susan was helping her to take on a more reasonable amount of work and to rush less. This meant her arousal level was generally a lot lower, so going over the top was much less likely. She also found that she enjoyed life more and actually found she got as much done even though she rushed less. There's a lot of truth in the saying "Less Haste, More Speed".

5.1.1 Not going too fast

The faster you go, the higher your flight fight response (FFR) is on. The higher your FFR, the more stress symptoms you may suffer.



You may be able to keep up a fast pace for a number of years. Eventually though you may well pay the price in emotional or physical problems.

To pace yourself at a healthy, reasonable level, here are a few simple guidelines:

a) In every 1 hour of work, try to take a 1 - 2 minute break to sit down and rest or get up and stretch your muscles.

b) After about 2 hours of work, you need a slightly longer break for about 10 minutes, perhaps for a cup of tea or coffee. This is usually the mid-morning and mid- afternoon tea/coffee break.

c) After about 3 - 4 hours of work, you need an even longer break for food and general relaxation. This meal break needs to last between 30 - 60 minutes, with enough time to digest your food.

d) Whilst you write, carry, drive, shop etc, try and think how fast you are going. Are you: doing everything so fast that you are tripping over yourself; sitting at the traffic lights with your foot on the clutch and hand on the gear stick; driving faster than most other cars; pushing your shopping trolley as fast as you can; rushing around with your shoulders hunched, teeth clenched, fists clenched? If so, try to slow down and loosen up.

e) Have a cut off time, at least 2 hours before bed. When you reach this time, stop all work. The next 2 hours is to relax in, helping you unwind and prepare for sleep.

f) At the end of the week, you need at least one day spent mostly on leisure (see a later section).

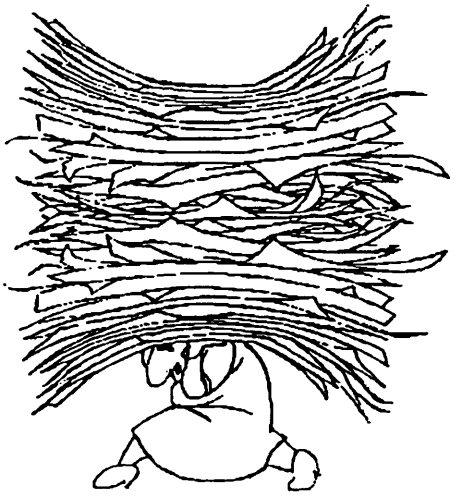
g) At least once a year, you need two weeks away from your normal routine, to go on holiday or have a break and more fully recharge your batteries.

These breaks are important, even if you don't feel you need them. Stress builds up slowly, bit by bit. The breaks help you stop it building up. This helps you work more efficiently when you have to work - so you can get as much done in less time.

5.1.2 Not doing too much

Not going too fast is almost impossible if youv'e got too much to do.

The main causes of having too much to do are:



a) You do everything you are asked to do. This may be because you have been told you have no choice, eg by your employer. Or it could be because you do not feel able to say "No" - perhaps because you would feel guilty at burdening someone else or anxious they'd be upset with you.

b) You cannot ask others for help. If you do, you feel guilty at burdening others, or because you think it's your job. Or you may be anxious they'll be upset with you.

c) Your standards are too high. You think that you must always do any job as well as you can - otherwise you feel unsatisfied or anxious, that it's not done properly. You may also avoid asking others to help because they won't do it as well as you.

d) You cannot turn-off from work. Either you feel bored if you aren't working or you feel anxious or guilty. Perhaps you are anxious about what others will think of you or you think you need to work as hard as you can to survive - keep your job, pay the bills etc.

e) You have too many roles. As society changes, so do our roles. Increasingly, women are working full-time and having careers. If they have children, they may take a brief break before returning whether full-time or part-time. Working full-time or part-time is stressfull enough. So too is being a mother, a housewife, a carer for elderly relatives. If the woman tries to do too many of these roles, she will probably be overloaded. If she has a partner and he tries to help out, he too may get overloaded.

f) You don't recognise it's too much. If you have a complicated job, such as working with people, especially sick or upset people, the quality of your job can cause stress. Even a small quantity of such work can be stressful.

If any of these reasons apply to you, changing the habits of a lifetime can be very hard to do. Here are a few tips which may help;

a) Keep Lists. Every day, draw up a list of the things you think you "have to do" that day. Include small and large activities. Is the list too long? Are you trying to do too much? If so, are there any activities you can leave to another day or pass on to someone else?

b) Everyone needs time to relax and unwind. All work and no play doesn't just make Jack a dull boy, it also makes him ill! We all need to relax to recover from work. This then helps us to work. Include in your daily list of activities: breaks for tea, lunch, dinner, leisure, relaxation exercises.

c) Most people are at least a little selfish. This means people will often take advantage of you if you let them. They will often leave you to do something rather that do it themselves - even if you are overstressed. They won't volunteer to do a job - you'll have to ask them. Further, if you do ask them, they may object - especially if you've usually done it. If they object - or you fear they will - ask yourself are you being reasonable in asking them to do the job? Discuss what you want with someone outside - get another opinion. Ask yourself are you doing your fair share - are they? Relationships are about giving and getting - it's two way. If you decide you're being reasonable and asking them reasonably and they still object they are being unreasonable. Learning assertiveness skills may help you get your message across. These are covered in Section 7.

At the end of the day, however assertive you are, the other person may continue to expect things from you which either you can't or don't want to give. If it's an employer, you may face the hard decision of choosing between your health and your job. If it is a friend or partner, it is even less easy. In the extreme, you may have to choose between your health or continuing in the relationship.

d) Avoid trying to be too many things to too many people. Carefully watch how many roles you're trying to fill - housekeeper, carer for children, carer for elderly relatives, carer for partner, employee. If you do work out of the home and have other roles, you may need to share these roles with a partner, if you have one. This may mean that men have to take on increased roles in looking after the house, the children and their partners. It may also mean that compromises have to be made between careers and family commitments, eg, working part-time rather than full-time, passing-up promotion because it would mean too much extra work, not trying to do everything as well as you can, deciding between having a family or a career. Such compromises can be very hard to make and live with. So too can too many roles.

e) Do you have to do everything as well as you can? Ask yourself, if you lower your standards, will others really object - will they even notice? Are you expecting too much of yourself? If you have new extra roles, can you do everything as well as you used to? Are you trying to impress or please people with everything you do?

To help you answer these questions, aim to be "good enough" rather than as good as possible. If you don't, ill health may force you to.

The above tips may prove enough to help you cut down on how much you do. If saying "No" or asking for help is a large problem for you, it may help to learn more about being assertive. Section 7 discusses Assertiveness more.

5.1.3 Exercise 1 on pacing yourself

As well as trying the tips described above, try this exercise on pacing yourself.

In this exercise, stop and look at what you do. People who are too busy don't have the time to stop and think "Am I going too fast?", "Am I trying to do too much?".

To help you stop and think, get the red spots you'll find at the end of this section. Take these and put them on objects you look at when you're busy, eg telephone, purse/ wallet, mirror, steering wheel, filing cabinet, machine at work, watch or clock, cooker, sink etc. Use all of them up.

When you see a red spot (or any red object for that matter) stop and think:

Am I tense? - quickly check all your muscles and breathing
Am I rushing?
Am I trying to do too much?

If you are, do something about it. Use your Quick Relaxation exercises - even if only for two minutes. Slow down, take a short break. Try and plan your day so you have less to do - use a list to help. The reminder card at the end of the section is to be put in your wallet or purse.

If anyone notices your red spots, tell them it's to remind you of something.

So, get the red spots and get thinking!

Once you have put all of them on a suitable place, move onto the next section.

5.2 LEISURE

5.2.1 Why leisure?

Above, I have mentioned how crucial taking regular breaks is, especially at the end of each day and at the end of the week.

These breaks can simply be an escape from work. This will help you recharge your batteries.

To get the most benefit from these breaks, it helps to have leisure activities to do in them. Leisure is not just a break from work. Leisure helps us to work. It is as important as work. A good leisure activity helps us to relax our mind and body because it:

1. Helps us to take our mind off our problems.

2. Can be enjoyable, stimulating and refreshing. It can leave us feeling we have achieved something.

3. Can help us to meet others - for a chat, a moan, a laugh.

4. Can help us to release pent-up physical tension and maybe even get a bit fitter.

5.2.2 What leisure?

Different people enjoy doing different things. As a general rule, we all need a mixture of leisure activities. When we are very tired, we need something physically and mentally easy, eg watching TV, knitting or reading. When we are bored or worried we need something stimulating, eg a hobby, evening class or going out somewhere. When we are unfit or tense, we need something physical, eg DIY, gardening, a jog or a swim.

Here's a list of possible leisure activities which can help you turn off and recharge the batteries:

Knitting
Reading
Gardening
Watching TV
Keeping a pet
Learning a foreign language
Yoga
Shopping

D.I.Y.
Travel
Playing a musical instrument
Listening to music
Going to a concert or disco
Cinema
Theatre
Eating out
Jogging
Going to the pub

Woodwork
Upholstery
Pottery
Art
Macrame
Car mechanics
Making jewellery
Walking
Sex
Swimming
Bingo
Snooker

Add to the list any others you can think of.

The aim should be to have a few leisure activities for when you are tired, worried, bored or tense. Activities which help you stay reasonably fit are also important. Research has shown that people who are fitter suffer fewer physical and emotional problems.

Avoid too much of any one activity, especially those that tire you out, keep you up late or involve too much alcohol or food. People often turn to drink or food when they are worried or depressed. It helps to comfort them and can cut off the pain for a while. Unfortunately, too much of either causes problems in the long run. Firstly, ill health will mean you have more to worry about and are less able to cope with your other problems. Secondly, side effects of too much alcohol include anxiety, depression and insomnia.

A safe level of alcohol recommended by the Health Education Authority is upto 21 units per week for a man and 14 for a woman (one unit = half a pint of beer, I measure of spirits or wine). Staying within these limits means you can enjoy the benefits of a drink, without the problems. For further information on a healthy diet and healthy drinking, local clinics and libraries should have leaflets on both. They are also available from the local Health Authority's Health Promotion Department at: 74 Bottrill Street, Abbey Green, Nuneaton, CV11 5JB, or ring them on (0203) 340035.

You also need to avoid too many activities which do not really distract you, especially if you are prone to worrying. It is very easy to sit and watch TV whilst also thinking about your problems.

5.2.3 More Leisure?

During the Pacing Yourself section, you may have spotted that you need to make more time for leisure. Remember, as a minimum, you should have:

* at least 2 hours per day, usually at the end of it

plus

* at least 1 day per week

plus

* at least 2 weeks per year

You may also have realised that you need to develop new leisure activities to fill that time - simply lying on a bed and recovering won't be enough!

Most people I see for therapy for stress and anxiety need to increase their leisure activities. This is never easy, especially if they have got out of the habit because they feel ill, tired or too busy. In the short-term, it may mean that they have to force themselves to make time for leisure and to use that time. This will mean that they feel more stressed - anything new causes stress, even good changes. However, in the long-term the leisure activities will mean less stress.

5.2.4 Exercise

If you think you need more leisure in your lifestyle, stop at this point to plan what you will do, how and when. Get a sheet of paper and a pen and jot down what you would like to do more of. Use the list in Section 5.2.2 to help you.

Then choose one or two activities you would like to start or restart. Plan how you are going to do this, bearing in mind the following tips:

* do not wait for the right moment, it never comes - try it now.

* try it with someone else for mutual support.

* join a club or a class, for mutual support, help and to meet more people.

* get into a routine so you begin to make it part of your life.

* stick with it, especially in the earlyweeks when you might find you give more than you get back.

5.3. TALKING

The final aspect of your lifestyle it can help you to think about is how much you talk to others. Earlier, I described how some people tend to repress their feelings. Bottling your feelings up means that your FFR stays on when it can't be used. This leads to a build up of tension etc, which can cause stress symptoms.

5.3.1 Why does talking help?

Talking to someone else about your worries, stresses etc, can help. In fact, research has shown that people generally find talking about difficulties one of the most important ways of reducing stress and anxiety. Much of psychotherapy is simply the patient talking to someone else - the therapist. The research shows that often a friend is as good or better at listening than a "trained professional".

There a 3 main ways that talking helps to reduce stress and anxiety:

(1) <u>It gets it all off your chest.</u> It frees pent-up tension. Hiding hurt can help in the short-term but in the long term it jut leads to a build up of tension.

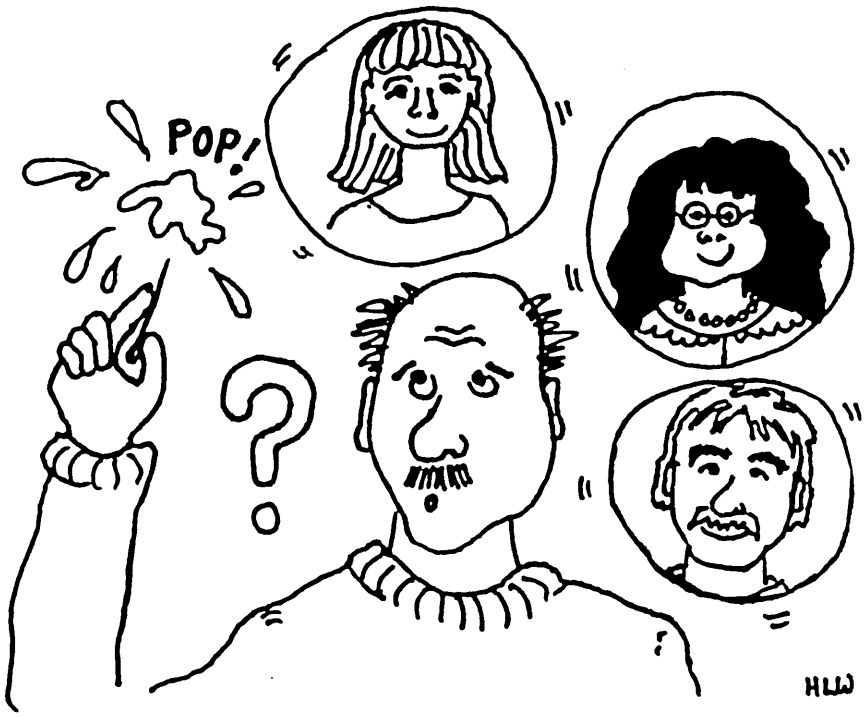
(2) <u>You can feel less alone.</u> We all need other people to some degree, especially those that say they don't! Talking to someone else can feel like sharing it with them.

(3) <u>It can help you solve a problem.</u> Hearing yourself talk about it out loud can make the problem - and its solutions - seem clearer. The other person may also be able to give advice and maybe practical help.

Talking can help a lot. However, it is not usually the total solution. You will usually need to talk <u>and</u> learn to relax, pace yourself better etc.. If nothing else, you can talk to someone about how hard the programme is.

5.3.2 Who can help?

Almost anyone can be useful as a listener, to some degree. Obviously, some people are better listeners than others. There are also some people we get on with better than others. However, no one person can listen all the time. The aim is to talk to different people, maybe having some for a general chat or moan and one or two special people for particular worries or troubles. The list of people who could help is long. However, the problem is not usually that you have no one to talk to. It is usually you don't feel you can talk to them.



5.3.3 Why we keep silent

Many of us keep things to ourselves when we have problems. This can be for a variety of reasons including:

1. Guilt — We worry we'll be a burden to others. We may think we're failing if we need to talk, it's wrong.

2. Anxiety — We worry others will get annoyed with us for not coping better or that others will think negatively about us or even gossip about us. Or we may fear that talking about things will only make them worse - we prefer to try and bury them, forget them.

3. Embarassment — We worry we'll get too upset if we talk, maybe even embarassing the other person.

4. Anger — We may be angry with ourselves for getting in to this situation in the first place. Or angry with someone for not helping enough.

5.3.4. How to talk

So talking is useful but it can also be difficult. How can you make it a bit easier? Here are some tips that may help:

a) Don't wait until you have problems before you talk to people. It often takes time to develop a relationship to the point where you feel safe discussing problems. Having leisure activities which involve meeting others can help, especially if you can have a chat and a laugh.

b) Don't wait for them to come to you. They usually won't.

c) Don't rely on just one person - they may get overloaded and back-off.

d) Try different people - some are better listeners than others.

e) Don't expect too much, too soon. Some people need time and practice to learn how to listen and support. A lot of counselling training is about "how to listen" - it doesn't come naturally to many people. It can take months or years! - be patient but keep expecting them to help. Don't expect too little either!

f) Try not to expect them to solve the problem for you. Sometimes all they may be able to do is listen and support you whilst you deal with the problem.

g) Make sure you give as well as take. If you also listen to others, you will feel less guilty when they listen to you. They will also feel more willing to listen.

h) If you're talking about problems, you will get upset. So may the other person. There's no real alternative - that's part of why talking helps.

i) It can help to remember that everyone has problems. Some just hide them better than others. Often it's the people who talk them over that can hide them best. I talk about mine with my partner, friends, my boss and my supervisor. Life involves problems. Talking about them is a sign you <u>are</u> coping.

j) Talking to someone about this programme can help. They may find it helpful for themselves. It may also help you to talk about what's happening to you. Reading it may help them to understand what's happening to you.

k) Finally, if someone does listen to you, try and remember to thank them. We all like some praise and are more liekly to listen next time.

5.3.5 Beginning to talk more

Go back and re-read Section 5.3 on Talking. Then, if you think you could talk more, try and decide how you will do this. The list of tips in Section 5.3.4 can help. Perhaps start by thinking of all the people that you currently turn to for help. Then ask yourself if there are others you could use. If there are, why don't you? A good way to break the ice is to discuss this programme with them.

If you do not think there are enough people to talk to, think how you can get more. Leisure activities are a good starting point. Good Luck!

5.4 SUMMARY

Going too fast or doing too much will cause physical illness and emotional difficulties. Then you end up doing too little.

People do too much for many reasons including guilt, a desire to please, boredom, they have too many roles or they have standards that are unrealistically high.

Leisure activities are a good way of relaxing mentally and physically.

They can take our minds off our problems, give us something enjoyable and refreshing to do, help us keep fit and help us meet other people.

Talking about your problems is one of the most important ways of coping with stress - it helps you get things off your chest, you can feel less alone and the other person may even be able to help you.

People often keep silent because of guilt, anxiety, embarassment or anger.

When trying to talk, try and have a mixture of people you can talk to. Don't rely on one person. Don't expect too much, too soon. Do listen as well as talk. Do expect to get upset.

5.5 CONCLUSION

By now you hopefully will have a better idea of the importance of pacing yourself, having leisure activities and talking to others.

All the exercises I've described - red spots, lists, new leisure activities - will take time and effort. In addition, you'll still need to be practising your Relaxation Exercises. So don't be too surprised if you feel a bit overwhelmed by this stage.

You need to spend at least 1 - 2 weeks looking at your lifestyle. The more time you can spend on it the better. Don't let your natural habit to rush or your keeness to feel better make you go too fast. Going too fast will mean you will only get less from the programme. You will probably then end up thinking either you or the programme are useless.

When you feel ready to, move on to Section 6. Continue to think about your pace, your leisure, talking and relaxing as you read Section 6.

PACING YOURSELF

Whenever you see a Red Spot, or any Red Object,

STOP AND ASK:

1. "Am I too tense?" - if yes, take 2 minutes to quickly relax and slow your breathing.

2. "Am I rushing too much?" - if yes, take 2 minutes to quickly relax, slow your breathing. Perhaps take a slightly longer break as soon as possible to turn-off for a while. Read Section 5.1.1.

3. "Am I trying to do too much?" - if you are, are you using the list? Try to only do the things you have to do. Leave other jobs to other people or another day. Make sure you're taking regular breaks, especially for meals and at least 2 hours at the end of the day. Read Section 5.1.2.

SECTION 6

NORTH WARWICKSHIRE NHS TRUST

CHANGING THE WAY YOU THINK AND FEEL

This section will help you to:

- learn the way your thinking affects the way you feel and behave.
- spot whether your thinking is too negative which means you will suffer too much stress and anxiety.
- change the way you think, making it less negative so that you suffer less stress and anxiety.

It is divided up as follows:

6.1 THOUGHTS AND FEELINGS

Here are two short stories:

Story 1 : John is sitting at home watching TV. It is 11.00pm. The telephone rings. He immediately thinks, "Who's that ringing at this time of night....maybe someone's ill - it's Dad, he's had a heart attack".

From the description given, how do you think John felt? Angry, depressed, anxious?.... Most likely he was anxious.

Now let's change the story a little bit.

Story 2 : John is sitting at home watching TV. It is 11.00pm. The telephone rings. He immediately thinks, "Who's that ringing at this time of night? How stupid of them, don't they know the baby's asleep!"

Now how do you think John felt?..... Most likely this time he was angry.

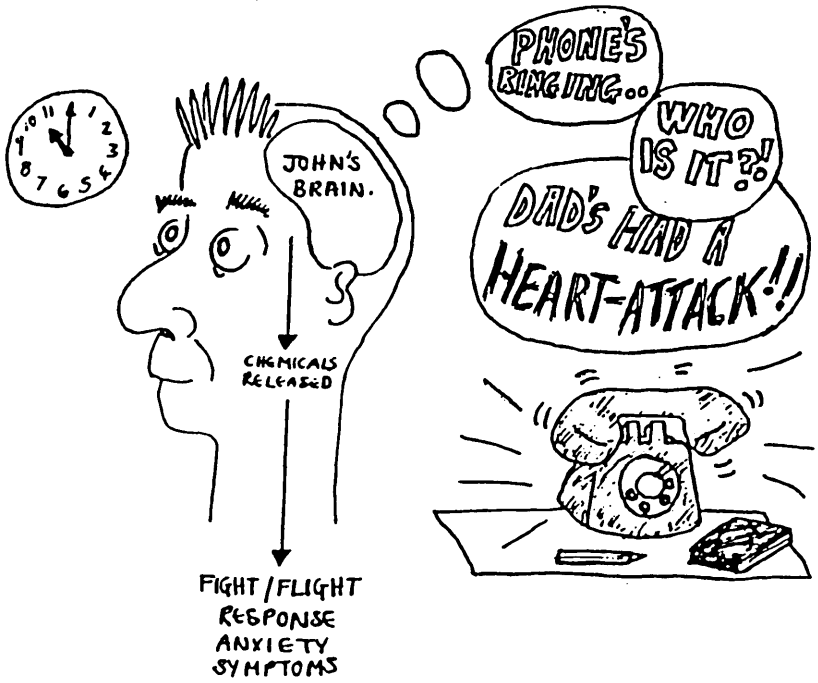
Most of us assume that the way we feel is a result of what happens to us:

EVENT		FEELING
Phone rings	⟶	Anxiety

It is actually a bit more complicated than this - that's what Psychology can seem to be about, making what seems obvious more complicated!

The way we feel is actually a result of what we think about what happens to us.

Information about the world goes into our brain, is thought about there, and then we react to it emotionally.



SITUATION ⟶	THOUGHTS ⟶	FEELINGS
Phone rings	"Who's ringing at this time of night? Maybe someone's ill - it's Dad, he's had a heart attack"	Anxiety

Change the way you think about the situation and you change the way you feel.

SITUATION ⟶	THOUGHTS ⟶	FEELINGS
Phone rings	"Who's that ringing at this time of night? How stupid of them, don't they know the baby's asleep!"	Anger

This is why different people react differently in the same situations. The person who enjoys aeroplanes or spiders thinks differently about them to the person who is terrified of them. Our personalities are a result of the way we think - about ourselves, others and the world in general. For example, a pessimist thinks his holiday is half over when the first week of the fortnight is over and feels fed up as a result. The optimist feels more cheerful because he thinks, "great, I've got another week to go".

So, different people feel differently about the same situation because they think differently about them.

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6.2 HOW WE LEARN TO THINK

Why are there differences between people in the way they think? Most people are surprised to discover that we actually learn how to think. Babies cannot think, anymore than they can walk, talk, read, write, etc. They learn to do it. Just as we all learn to walk and talk differently, we can learn to think differently. It's just easier to spot the differences between us in walking and talking because we can see and hear them.

So how do we learn to think as children? In a number of ways including:

1. From our parents' view of the world For example, if they have a generally negative view, worrying a lot about what might go wrong etc, it is likely we will learn to do the same. This is one reason we often take after one or both of our parents.

2. From our parents' view of us For example, if our parents praised us a lot, we are more likely to grow up thinking positively about ourselves, feeling self-confident.

3. From what happens to us For example, as children we all need a lot of love and security. If these needs are not met, we can grow-up thinking the world is unsafe, that we are unloveable, not good enough, that other's don't care enough.

We all have learned to think unrealistically at least some of the time. In later life this can lead to emotional difficulties.

6.3 THINKING UNREALISTICALLY AND REALISTICALLY

When our thinking fits the facts, we are thinking and feeling realistically. If we see a baby put her hand in an electric plug socket, it is realistic to think "that is dangerous" and to feel scared. So thinking negatively can be very realistic and sensible - if the facts are negative.

Sometimes what we think doesn't fit the facts - we have learned to think unrealistically in certain situations. Thinking unrealistically means we feel more upset by a situation than we need to. We can even create problems by thinking unrealistically.

Research has shown that we all think unrealistically some of the time. A lot of stress and anxiety is a result of thinking unrealistically. There are a number of ways in which thinking can be unrealistic. Here are the main ways:

1. Overgeneralising Because something may go wrong, you think it is very likely to go wrong, eg "the plane may crash" becomes "the plane will crash". "You may fail the interview" becomes "you don't stand a chance of getting the job and never will get one".

2. Magnifying If something goes wrong, you dwell on it and exaggerate it, eg you make a small mistake knitting a pullover and think "it's ruined" rather than "I've made a small mistake, how irritating, still the rest of it's OK". Or you have a panic attack and don't just think "This is terrible, I hate it", you go one step further and think, "I can't stand it, this is the worst thing that could ever happen to me, I'm going mad".

3. Minimising If something goes well, you reduce its importance or ignore it completely, eg you get a job and instead of thinking "I did well" you think "any one could have got it". Or you manage to cope with a panic attack and get into a local shop for the first time in a year. Instead of thinking "I managed it for the first time in a year - that's good" you think "this is no good, I'll never beat this, I'm still panicking and I still can't get into a supermarket".

4. Jumping to Conclusions If something happens to you, you assume it means something that is doesn't, eg palpitations means you have heart disease, you don't think about a more likely cause which is anxiety. Or John thinks the phone call is about his Dad rather than just a social call or a wrong number.

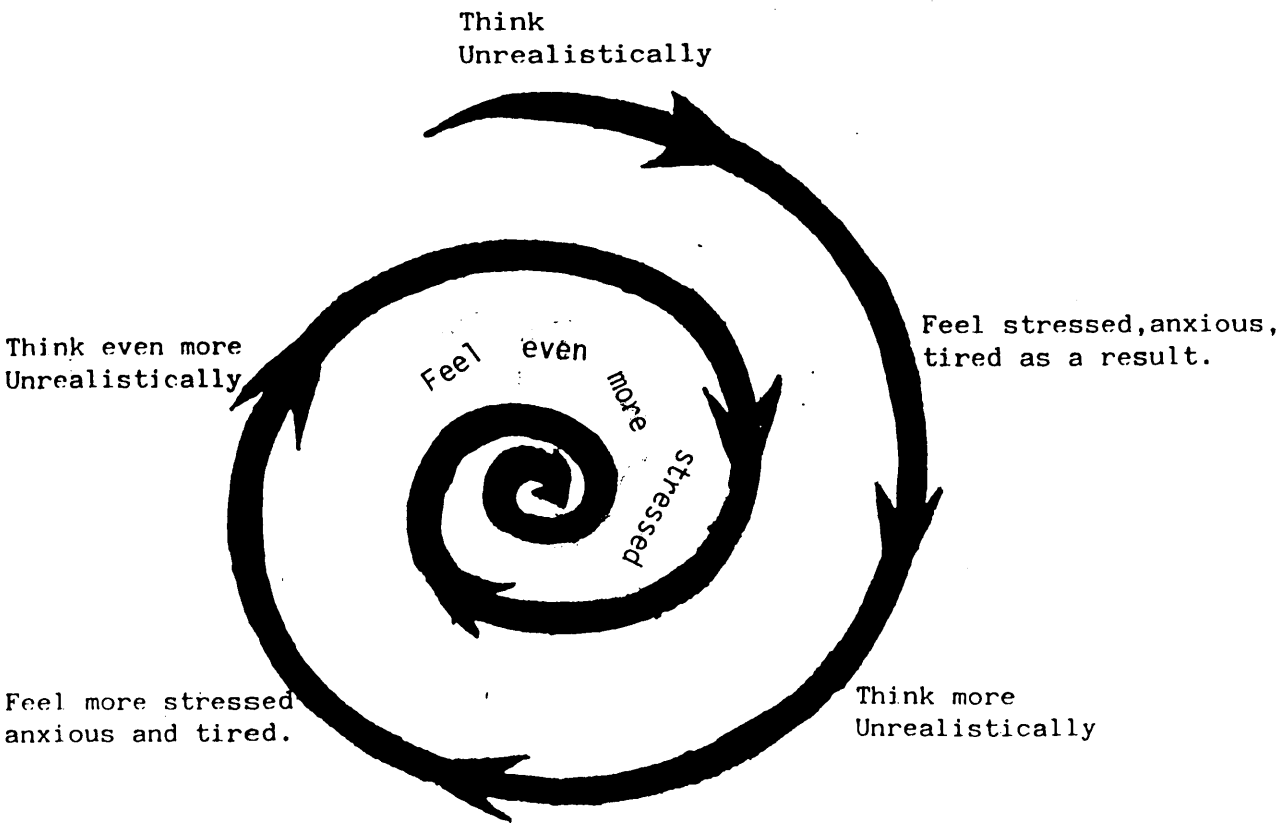
5. Shoulds/Oughts/Musts Instead of wishing for things to be different or trying your best, you expect yourself and others to be perfect. You order yourself and others to be different eg you think "I must finish this job tonight" instead I'll try my best to finish it but I need time to relax". Or you shout at one of your children and then think "I shouldn't have done that, good mother's don't shout, I should be able to control myslef" instead of "I wish I hadn't shouted but I'm not perfect, I was tired and Pete was being very difficult, better go and check he's not too upset".

Usually, we make more than one of these errors at a time.

If we make any of these errors, we will feel unrealistically anxious, angry, guilty, depressed, pressurised. If we don't make these errors, we may still feel anxious etc, but it will be realistic, in proportion to the event. For example, instead of feeling terrified because you think "the plane will crash", you feel anxious because you think "the plane may crash but it's actually safer than driving my car to work".

It is important to bear in mind that most unrealistic thinking contains a lot that seems reasonable. It is usually the case that 95% of an unrealistic thought is based on fact. This helps to convince us "it's true!". But it is the 5% that is unrealistic that causes the problems!

Finally, if we are feeling very stressed or very tired, our thinking usually becomes more unrealistic or negative. This is why it is usually a waste of time staying up late into the night trying to sort out a problem. The best thing to do is go to bed and rest - the next morning we can often see the solution (if there is one!) more easily because we're thinking more realistically. Tiredness or stress can set up a vicious spiral:



6.4 CHANGING THE WAY YOU THINK

We all learned to think as children. We all learned to make mistakes in the way we think - some more than others. We can change the way we think by learning new ways of thinking. Below I describe the 3 steps to changing the way you think.

Read these 3 steps and the rest of Section 6 before you try any of the suggestions. Once you have read through the whole of Section 6 a few more times, come back to steps 1 to 3.

6.4.1 Step 1: How do you think?

Unrealistic thinking is very hard to spot. This is because nearly all our thinking is automatic - we don't think about it any more than we think about the way we walk, talk, eat, etc. We just do it.

So the first step in changing the way you think is to find out what you are thinking This is very hard to do, especially when you are feeling stressed and anxious. Which means your concentration is poor.

The following tips may help you to learn what you are thinking about:

a) If feeling stressed, stop and practice your Quick relaxation. When you feel more relaxed, you may find it easier to concentrate on your thoughts.

b) Occassionally stop and ask yourself "What am I thinking about". Perhaps use the Red Spots to remind you to stop. Often it is when we are most stressed that we have the most difficulty stopping to ask this question. But this is when we most need to. It can help to jot your thoughts down on paper to see them more clearly. Perhaps use a daily diary.

c) In addition, are there particular situations that you often get stressed by, eg shopping, travelling, speaking to large groups, dealing with bills etc? If so, think back to the last time. What went through your mind beforehand or during it? Jot these thoughts down on paper.

d) Did your thoughts contain words such as "must, ought, have to, shouldn't, make a fool of, terrible, can't cope, useless, waste of time, hates me, will crash, will panic, can't stand it, will die?" These words usually mean you are thinking unrealistically.

e) Re-read the errors described in Section 6.3 Are you making any of these?

f) Remember that even unrealistic thoughts are realistic to some degree. Planes do crash, people can hate us, heart disease does occur. But just because it is possible doesn't mean it will happen.

g) There is a summary card at the end of Section 6. Carry this with you.

h) Spend at least two weeks on Step 1 before moving onto Step 2.

6.4.2 Step 2: Thinking more realistically

During Step 1 you may have come to realise that your thinking is sometimes unrealistic. If so, the next step is to try and change it. Often as soon as you see that you are thinking unrealistically, you automatically begin to think more realistically. Usually though you have to put in some extra work.

Here are some tips to help you change your unrealistic thoughts:

a) What errors are you making? Re-read the errors in section 6.3

b) Ask yourself:
What evidence do I have that.....will definitely happen?
Do I have a crystal ball?
What is the worst that could really happen?
Are there any other explanations for what's happened?
How likely is it that.....will happen?
Am I magnifying things?
Am I ignoring or minimising what I have achieved or could achieve?
Am I trying to be perfect?
What are the facts, what do I really know?

c) If another person came to you with the same thoughts, what would you say to them? Would you agree with them or could you point out the errors they were making?

d) What is it more realistic to think? Look at the list below to help you. I have listed some of the more common unrealistic thoughts that clients have spotted in themselves. I also list some of the main errors they made and the more realistic alternatives they came up with. These helped them to reduce their anxiety etc...to more bearable, more realistic levels.

UNREALISTIC THOUGHTS	ERRORS	MORE REALISTIC THOUGHTS
I can't do this, it's impossible!	Overgeneralisation Jumping to conclusions	I can do this but it's going to be hard.
I'm going to make a fool of myself. It will be terrible!	Jumping to conclusions Magnification	I'm probably going to make some mistakes but no one's perfect. A few mistakes don't make me a fool - just another human!
I'm never going to get better, this is a waste of time.	Jumping to conclusions	Getting better will take time and effort. If I give up now, I won't get better!
That was terrible, I did everything wrong!	Minimisation, Magnification	That was pretty bad. I'm glad it's over. I made some mistakes there to learn from but I also managed to do better than last time.
I'm losing control, going mad, they'll lock me up!	Magnification, jumping to conclusions	I'm feeling as if I'm losing control - it's a panic attack. I've gone over the top of the arousal curve. I need to relax and slow my breathing. It's stress not madness. They don't lock people up for stress.
I'm panicking, everyone can see I'm going red, they'll think I'm a looney. They'll laugh at me.	Jumping to conclusions Magnification	I'm panicking and going red. Most people probably haven't even noticed me - they're too busy with themselves. Even those that have noticed probably think I might be physically ill. No one's ever laughed before.
My heart's palpitating, there's something wrong with it!	Jumping to conclusions	It's the Flight-Fight Response. It shows my heart is actually healthy and responding as it's meant to.
So I got to the shops, I still can't go into town!	Minimization	That's the first time I've got into that shop in 6 months. It's a step in the right direction. It's frustrating to improve so slowly but what's the alternative?
I should never have said that to John. He's bound to be angry with me. He probably hates me now!	Shoulding, jumping to conclusions Magnification	It was a stupid thing to say but I wonder if he even noticed? He didn't look upset and said he'd see me tomorrow. Even if he did notice, I've said many more nice things to him in the past. If he hates me because of one mistake he's being a bit unreasonable himself. I'd better check next time I see him.

UNREALISTIC THOUGHTS	ERRORS	MORE REALISTIC THOUGHTS
I can't say that to Sue, she'll be really upset with me and we'll probably fall out. That would be awful!	Shoulding, jumping to conclusions Magnification	I'm fed up with Sue taking advantage of me. I need to say something to her about it. She may be upset by it but I'll try and say it, constructively. I'll also explain how much I value our friendship. That should soften the blow. If at the end of the day she hates me for it, she's being unreasonable.
Oh no, we're arguing. John's getting fed up with me. Our relationship's going to end. How will I cope?	Over generalisation Magnification Jumping to conclusions	I don't like arguments, they're upsetting. But any healthy relationship has arguments in it - they're inevitable. It doesn't mean the end of the relationship - it may even help clear the air.
How on earth can we pay this bill! Oh god, this is the end, I just can't cope anymore!	Magnification Minimisation	Oh no not another bill! We're going to have to sort this out, it's happening too often and it's really stressing me. I need to talk to someone about it - maybe Jane. Or what about going to the C.A.B. They help people with bills.
I must do this.	Shoulding	I'm just pushing myself again, rushing to get it all done. Why do I have to do it? What happens if I don't - the world won't end but I'm slowly wearing myself out. I'll try my best to do it today and if I can't, it'll wait until tomorrow. Maybe Pete can help.
No one cares, they're not bothered about me.	Over generalisation Minimisation	Most people are pretty selfish a lot of the time, or caught up in dealing with their own problems. I wonder if I'm expecting too much? Maybe they care but not as much as I want them to?
If I do this wrong, Anne will be really angry with me. I've got to do it well.	Jumping to conclusions Shoulding	Am I jumping to conclusions? Last time I did something wrong she was annoyed but she wasn't fuming. I can only do my best and if she's still really angry with me she's being very unrealistic herself!
If I muck this up, they won't respect me anymore. They'll think I'm useless.	Jumping to conclusions Overgeneralising	Talk about overgeneralising! If one mistake means they lose all respect for me, they can't respect me very much can they! I'm not useless - I'm good at many things. Maybe this is one of my weak spots.

UNREALISTIC THOUGHTS	ERRORS	MORE REALISTIC THOUGHTS
What am I going to do about all these problems? I'll never solve them. (as you twist and turn in bed at 3am).	Jumping to conclusions	Hang on. I'm tired and can't sleep because of all these problems churning around in my head. I'm not going to solve them tonight - I can't think straight. I'll think about them tomorrow - for now I'm going to distract myself.....

e) Does the list contain unrealistic thoughts you think you make? If so, jot these down, together with the more realistic alternatives. Put them on a piece of paper and carry it around with you.

f) Next time you get upset, take this piece of paper out and read it. Spot any unrealistic thoughts you're having now? If so, challenge them by reading the more realistic ones. Argue with yourself. Tell yourself you're being unrealistic.

g) Next time you are about to go into a situation you know will be difficult, take out your piece of paper. Read it. Go into the toilet and sit down to get some peace and quiet to read if necessary. Practice your Quick relaxation whilst you're about it.

h) Don't be unrealistic and expect miracles. Changing the way you think is harder than giving up cigarettes or any other drug. Changing the habit of a lifetime is very difficult - but not impossible. At first trying to be more realistic will probably only reduce your stress a little. The more you practice, the easier it will get to think more realistically.

i) You will need to watch for unrealistic thoughts for the rest of your life, whenever you get over stressed. We all think unrealistically from time to time.

j) We are all more unrealistic when we are tired or have been drinking. So be extra careful at such times. Sometimes the best thing you can do is try and forget your problems. See the next Section to see how.

k) Use the summary card at the end of Section 6 - carry it with you.

l) Spend at least 2 weeks on Step 2 before moving onto Step 3

6.4.3 Step 3: Knowing when to stop

In **Step 1**	you asked:	"What am I thinking! Am I being realistic?"
In **Step 2**	you asked:	"How can I be more realistic?"
In **Step 3**	I want you to try	"Even if I am being realistic, is thinking about it helpful?"

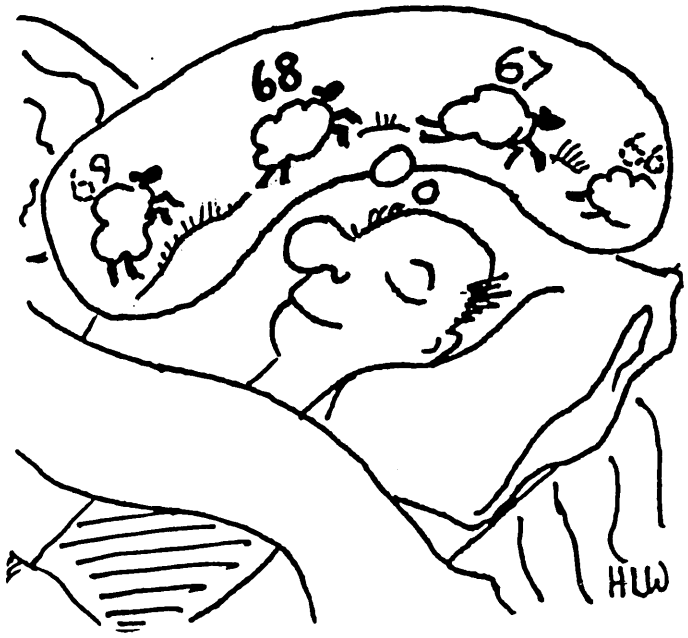
Earlier I said that everyone has problems. Thinking realistically about them helps us to solve them, eg worrying about the little girl putting her hand in the plug socket makes us stop her.

Sometimes, though, even if we are thinking realistically about problems it gets us nowhere we just go round and round in circles. A recent example was a client who was worrying about going to the dentist. He realistically thought that it was going to cause him some pain and was anxious as a result. The trouble was he kept on thinking about the pain for weeks beforehand and kept on getting anxious as a result. Such thinking, even though it was realistic, was a waste of time and energy. Instead of suffering one lot of pain, he'd managed to sufffer about 1000 lots - each time he thought about it!

To help him. I taught him to think about something completely different, to distract himself. This made him feel less anxious.

Another common example of thinking too much is when we're in bed. Often this is the first chance people have in the day to stop and relax. It's also the time when all their worries come flooding into their minds. To make matters worse, because they are tired they are more likely to think unrealistically - we all do when we're tired. In such situations, it is not a good idea to try and think realistically. It is better to try and turn your mind off problems, by distracting yourself.

There are a number of ways of distracting yourself. Some you probably already know about, eg counting sheep to help you sleep, or going for a walk to escape the family. Ever wondered why the dentist talks to you when he's got the drill in your mouth and you can't speak? It's to distract you from the drill. Increasingly in hospitals, surgeons are finding that they only need to use a local anaesthetic during minor operations, if they give patients music to listen to. This distracts the patient from the operation so they need less anaesthetic which means fewer side effects.



Here's a list of ways to distract yourself:

1. Do something else. eg a hobby, talk to someone, watch TV, read, dig the garden. Any leisure activity will help you turn off your thoughts from worries - realistic or unrealistic.

2. Practice your relaxation exercises. Concentrate on relaxing your muscles, slowing your breathing, or using the word "Relax" or "Calm" as you breathe out.

3. Look around you. eg Count the lamp posts, windows in houses, cracks in the ceiling, red cars on the road, women in blue dresses etc. Or you could try and memorise everything around you, what it is and where it is. Or you could play "I spy" with someone - a good one to distract children on a car trip.

4. Play mental games. eg recite the alphabet, imagine a relaxing scene from last year's holiday, in as much detail as possible including sights, sounds, smells and feelings; count backwards in 2's from 200, count sheep.

Which method you use depends on where you are. If you can change where you are or what you are doing, Method 1 is the best. But sometimes you cannot do something else because you are stuck in a situation eg in bed trying to sleep, in the dentist's chair, in a shop feeling anxious, about to go in for an interview etc. Then you need to use Methods 2,3 and 4.

When trying to learn distraction, it can help to bear the following points in mind:

a) Distraction is a skill and it takes time and practice to learn it.

b) You may find your mind keeps on wandering back to worry about your problem(s). When this happens, just gently remind yourself to try again to distract yourself. You will never be able to distract yourself all of the time.

c) Prepare for difficult situations by deciding in advance which type of distraction you will use.

d) If necessary, try more than one type of distraction to help yourself.

e) Don't use distraction everytime you worry. Remember, sometimes worrying is useful because it can help you to solve problems. They rarely go away if you ignore them completely.

f) Use the summary card at the end of Section 6 - carry it with you.

g) Spend at least two weeks on this section. Whilst you practise distraction, continue to think about your thinking and continue to try to think more realistically.

6.5 SUMMARY

Thinking unrealistically means you will suffer from too much stress and anxiety.

Unrealistic thinking is very hard to spot - most of our thinking happens without us noticing it.

To change the way you think you need to ask yourself 3 main questions:

* What am I thinking and is it realistic?

* What can I think that is more realistic?

and

* Even if it is realistic, is my thinking helping me?

To change the way you think you either need to think more realistically or distract yourself.

Changing the way you think is very hard and takes a lot of practice.
Read the rest of Section 6 before going back to try any of the tips suggested.

6.5.1 QUIZ

Questions		Answers
1.	The way we feel about something cannot be changed	True/False
2.	We all learn to think as children	True/False
3.	Thinking can be realistic or unrealistic	True/False
4.	Negative thinking is always unrealisitc - we should always think positively	True/False
5.	Most people always think unrealistically	True/False
6.	Stress can be caused by thinking unrealistically	True/False
7.	Sometimes, even if we are being realistic, it is a good idea to just turn off	True/False
8.	One type of unrealistic thinking is when we jump to conclusions	True/False

6.5.2 ANSWERS

1. False see Sections 6.2 and 6.3.
2. True see section 6.2
3. True see Section 6.3
4. False see Section 6.3
5. False see Section 6.3
6. True see Section 6.1 and 6.3
7. True see Section 6.5
8. True see Section 6.3

CHANGING THE WAY YOU THINK
SUMMARY

STEP 1 Use your Red Spots. ask yourself:

"What am I thinking about?"

"Am I being realistic?"

"Am I
1. Overgeneralising - because something may go wrong you think it will go wrong?
2. Magnifying - if something goes worng you exaggerate its importance or dwell on it?
3. Minimising - if something goes well, you reduce its importance or ignore it?
4. Jumping to Conclusions - you assume more than you know?
5. Shoulding - you expect or demand that you or others must be different?"

Use a pen and paper to help you see your thoughts.

STEP 2 Ask yourself:

What evidence do I have that.....will definitely happen?
Do I have a crystal ball?
What is the worst that could really happen?
Are there any other explanations for what's happened?
How likely is it that.....will happen?
Am I magnifying things?
Am I ignoring or minimising what I have achieved or could achieve?
Am I trying to be perfect?
What are the facts, what do I really know?

Use pen and paper to come up with more realistic alternatives. Talk it over with a friend - ask them how they see the situations. Use the list in 6.4.2.

STEP 3 Ask yourself

"Even if I'm being realistic, is this thinking helping me?"
"Am I going round and round in circles?"
"Do I need to turn off?"

If you need to turn off, try:

1. Doing something else, eg watch TV, gardening, go for a drink
2. Practice your relaxation exercises
3. Look around you, eg count lamp posts, red cars, cracks in the ceiling
4. Play mental games eg imagine a scene from last year's holiday, count backwards in 3's.

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SECTION 7

ASSERTIVENESS

This section will help you reduce your level of stress by being more assertive and less aggressive or submissive.

It is divided up as follows:

7.1 What is assertiveness

7.2 How to become more assertive

7.3 Summary

7.4 Putting it into practice

7.1 WHAT IS ASSERTIVENESS

There is often confusion about the differences between assertiveness, aggressiveness and submissiveness.

Here is a definition of each:

Assertiveness involves letting people know what you think, feel or want in a way which is direct, honest and unthreatening. When assertive, a person shows respect for the other person, talking and listening to them without physical or verbal abuse.

Aggression takes two forms - direct and indirect. **Direct aggression** involves letting the other person know what you think, feel or want in a way which is direct, honest but threatening. It usually involves a raised voice, being insulting, over critical or physically threatening. It does not usually involve listening to the other person.

Indirect Aggression involves letting the other person know what you think, or feel or want in a way which is indirect, which possibly denies your anger and which causes the other to be upset or annoyed. Common examples of this include being deliberately unco-operative, being sarcastic or gossiping, withdrawing from the other physically or emotionally, or trying to sabotage what they are doing.

Submissiveness occurs when you do not let people know what you think, feel or want. Instead you may assume they do know, should know, hope they will, or you think your views are unimportant.

7.1.1 Stress and Assertiveness

If you are aggressive you may get what you want in the short term, but at the cost of stressful arguments and upset. You are also unlikely to get what you want in the long-term because others will get fed-up of you.

If you are submissive you are likely to spend a lot of time sitting and waiting. At first you may feel hopeful. But as time goes on, you are likely to feel increasingly fed-up, angry and helpless. In time you may become aggressive. Or you may develop symptoms such as panic attacks as your angry feelings cause a build up of tension inside.

If you are assertive, you are likely to suffer all these causes of stress. In addition, you will be able to:

- say "No" to things you do not like, eg your partner's constant criticism, the extra jobs the boss gives you last thing at night, the neighbours noisy dog.

- ask for things you need, eg help with your work, support at times of crisis, time for relaxation.

- accept criticism, not automatically rejecting it or getting upset but deciding for yourself whether it is valid. If it is, you can learn from it.

- give criticism without getting aggressive, guilty or anxious.

- accept compliments, praise and rewards without feeling embarrassed, or guilty.

So being assertive can be a very useful way of reducing your stress level.

7.1.2. Blocks to being Assertive

Most of us are assertive some of the time, aggressive at other times and submissive at others. Here are some of the main reasons that stop us from being assertive all of the time:

Submissiveness or indirect aggression can be caused by:

- thinking you are less important than others
- worrying about the reactions of others
- being scared you will lose control of yourself
- believing anger is wrong or unhealthy

Aggresiveness can be caused by:

- a history of bottling your feelings up
- a belief you are more important than others
- a belief that others are wrong (and you are right)
- a belief that others should be perfect, never make mistakes

7.2 HOW TO BE ASSERTIVE

Becoming more assertive is not easy but the rewards are great. Here are 5 steps to follow when learning to be more assertive.

7.2.1 Step 1 - Overcoming the Blocks

If any of the blocks described in 7.1.2. apply to you, here are some facts to help you overcome them:

(a) You are as important as other people, with the following rights:

- for time off for rest and relaxation every day.
- for a fair share of the work.
- to express these freely (but assertively).
- to be listened to without interruptions or rude criticism.
- to make mistakes, to be human.
- to change your mind.
- to say "I don't know".
- to say "No".

When you assert these basic rights, it is obviously important to do so whilst respecting other peoples' rights to the same things.

As an adult, no one "has to" give you what you want or do what you want. They have the right to say "No" too. You also need to take responsibility for the results of your behaviour, thoughts and feelings.

(b) Others will probably get upset as you begin to say "No" or ask for more help, etc. They probably prefer the old, quiet, undemanding you. Try not to give in to them. Try and stay calm, use your Quick Relaxation exercises. Use the techniques described in Steps 2 and 3 below.

(c) Feeling angry is normal and healthy - it is a natural part of the Flight-Fight Response. It helps you to fight for your rights. It can be a sign that some thing may be happening that you do not like and need to try and change.

The problems with anger occur if you bottle it up or if you let it get out of control. If you bottle it up, you will probably end up being submissive or indirectly aggressive. If you let it get out of control, letting it control you, you will be directly aggressive. It is possible to be angry without being aggressive, without shouting or hitting or being abusive. Letting others know you are angry shows them how upset you are about something.

If you show your anger whilst controlling it, others are more likely to listen to why you are angry and perhaps do something about it. Step 2 describes how to do this.

(d) If you are feeling angry a lot of the time or an event makes you feel so angry you cannot control it, it can help to check your thoughts. As I described in Section 6, the way you think will affect the way you feel. Extreme anger can obviously be caused by extreme events, eg someone hitting you or stealing your car.

Feeling extremely angry in such situations makes sense, is realistic. However, we all think unrealistically some of the time and this will leave us feeling unrealistically strongly about something. Typical examples of unrealistic thinking leading to too much anger include: overgeneralising when your wife forgets for the first time in weeks to lock the back door at night, thinking "she's always doing that"; or shoulding about it, "she shouldn't have done it". Changing the way you think, making it more realistic, will reduce how angry you feel to a more realistic, more controllable level, eg "she normally remembers to lock it, she's only human and makes mistakes, still it is a little careless, we could have been burgled, although that's unlikely. Still, I wish she hadn't.

7.2.2 Step 2 - Getting your message across

There are 2 main techniques to use when letting others know how you feel and think.

(a) The FER technique can help you to describe how you Feel, Explain why you feel that way, and Request something to make you feel better.

F First describe how you feel, beginning "I feel....." rather than "You.....". A "You" statement often sounds attacking or accusing, putting the other person on the defensive. Try to be brief and clear, saying exactly how you feel, without sounding aggressive or apologetic. Try to avoid magnifying or overgeneralising - this would only overwhelm the other and/or make you sound unreasonable.

E Then explain why you are feeling like this. Again try to be brief and clear, stating the facts. Try to avoid using phrases like "You, never...." or "You always.....". If you do, you are probably overgeneralising and the other person is less likely to listen to you. Being reasonable encourages the other person to be reasonable. Try also to avoid criticising them or telling them off.

R Then request what you would like the other person to do - not what you do not want them to do. Be positive, stating exactly what you would like the other person to do. People find it easier to change if they know what they are expected to do. Try to ask not demand, avoiding words like should, must, have to, ought to. If they feel forced, they are less likely to do what you want them to.

(b) The Broken Record Technique involves sticking to your point, repeating it over and over again, like a stuck broken record. You do this calmly and firmly. You listen to the other person's point of view but return to your own point until they listen to you.

This technique is useful when the other person is ignoring your point, or quickly says "No" without discussion, or quickly gets upset, encouraging you to back off. Often unnassertive people do not get their requests met because they give up or give in too soon, as soon as the other says "No", changes the topic or gets upset.

As soon as you use words like "we" or "our", you make it a joint problem. This reduces the chances that the other person thinks or says "it's your problem - you change!"

At the end of the day, workable compromises are not always possible. You may end up feeling hard done by or mistreated. However, if you have been assertive, you can go away knowing you have tried your best, remaining calm and in control of yourself. You will have self-respect, you may even have the other person's.

Here's an example to show how the techniques described in Steps 2 - 4 can be used. Let's go back to John and Debbie in Section 2. If you remember, they had just got married, but John had recently been made redundant. One of the things that caused a lot of arguments was John's drinking and Debbie's smoking. Both of them felt very angry that the other was "wasting" money they didn't have on "luxuries" as they saw them. Over a couple of sessions with me, they worked hard at using the techniques described. Here, after a lot of shouting and swearing, is a summary of the conversation they finally managed to have. So as to save on space and highlight how to use the techniques, I've cut out the bits where things went wrong and they lost their tempers.

JOHN "I get really angry when I see you (Debbie) puffing away because it's costing us money we can't afford. I would like it if you stopped smoking". (F.E.R.)

DEBBIE "So you get angry when I smoke because of the cost, is that right?" (Active Listening)

JOHN "Yes, and I'd like you to stop" . (Broken Record)

DEBBIE "I smoke because I feel stressed out. What makes me really stressed sometimes is seeing you drink".

JOHN "Why does my drinking stress you so much? (Active Listening) I only drink what the rest of the lads drink, a few pints a night. I need to drink to relax. I haven't got a job you know!"

DEBBIE "That makes me see red. It seems really unfair to me that it's OK for you to drink to relax but not for me to smoke to relax. We need to talk more about both your drinking and my smoking". (F.E.R.)

(pause for John to breathe deeply)

JOHN "OK you get stressed out by my drinking and need to smoke to relax. (Active Listening) I can see how I might be being unfair. (Negative Assertion) What do you suggest we do about it?" (Workable Compromise)

DEBBIE "I'm not sure. I don't think I can give up smoking, not with all that's going wrong. I can see I've started to smoke too much. (Negative Assertion) Maybe I could cut down, especially if you cut down on some of your drinking. What do you think?" (Workable Compromise)

JOHN "I suppose I could try staying in with you a couple of nights a week, maybe getting a video or going out for a walk in the park. That would save a bit on beer and you might not feel so much like smoking if we're relaxing together". (Workable Compromise)

DEBBIE "Let's try that and see. If it doesn't work, we can always argue about it again!"

7.2.5. Step 5 - Changing the way you think

As you try out new ways of saying and doing things, you may begin to feel angry, guilty or anxious. If these feelings are stopping you from being assertive, they may be based on unrealistic thinking (Section 6). Look out for unrealistic thoughts such as:

I/he/she should, ought, must, have to

I/he/she shouldn't, oughtn't, mustn't

he/she may leave me, die, sack me, hate me

he/she is always, never

These are examples of the cognitive errors of shoulding, magnifying, jumping to conclusions and/or overgeneralising. Going back to Section 6 may help at this point.

7.3 SUMMARY OF ASSERTIVENESS

Stress can be caused by a lack of assertiveness - you may end up doing things you do not want to and/or not getting things you do want.

Assertiveness is not the same as being aggressive or submissive.

Being assertive increases the chances that you will be heard and responded to. It reduces the chances of conflict occurring although it may cause some at first. Anger is normal and healthy. It is possible to be angry without being aggressive.

There are 5 steps to becoming more assertive:

- removing your blocks including recognising your basic rights
- expressing yourself clearly using the FER and Broken Record Techniques

- listening to the other person using Active Listening and Negative Assertion
- reaching a workable compromise
- dealing with unrealistic thoughts which cause too much guilt, anger or anxiety

7.3.1. QUIZ

QUESTION		ANSWER
1.	Assertiveness is an important way of reducing stress.	True/False
2.	Lack of assertiveness can cause you to suffer panic attacks.	True/False
3.	Assertiveness means telling the other person what you want, even if you have to shout at them.	True/False
4.	Submissiveness usually gets you what you want in the end.	True/False
5.	Getting angry is always wrong.	True/False
6.	It is wrong to upset other people by saying how you feel, even if you do it assertively.	True/False
7.	Yours first responsibility is to other people.	True/False
8.	You are as important as anyone else.	True/False

7.3.2. QUIZ ANSWERS

1. True - see Section 5.1
2. True - see Section 5.1
3. False - see Section 5.2
4. False - see Section 5.2
5. False - see Section 5.3
6. False - see Section 5.3
7. False - see Section 5.3
8. True - see Section 5.3

7.4 PUTTING IT INTO PRACTICE

Before you try out the techniques covered in Steps 1 - 5, it may help to reread the whole of Section 7 atleast once more. Then when you feel ready, start putting the techniques into action. As you do so, bear in mind the following points:

(a) the skills are hard to learn requiring a lot of practice

(b) you will make mistakes but try to reduce them by preparing for difficult situations. Using pen and paper, jot down what you plan to say and do, practise them with someone if you can

(c) try to learn from your mistakes. What could you have said or done differently?

(d) don't jump in at the deep end. At first, try out the techniques in easier situations where you expect to meet with less resistance

(e) expect others to put up a fight and do not give in to them this time

As with all the other stress management skills, the more you practice learning to be assertive, the better at it you will become. There is no point at which anyone can say "I've learned it all". However, after you have spent atleast a couple of weeks on this Section, move onto read the programme's final Section.

Finally, if you would like to read more about assertivess, two good books to start with are:

"When I Say No, I Feel Guilty" by	Dr M J Smith	published by Bantam
		and
"A Woman in Her Own Right" by	Anne Dickson	published by Quartet Books

District Clinical Psychology Service
North Warwickshire NHS Trust

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SECTION 8

WHAT NOW?

This is the final section of the programme. It describes how you can fit together all the separate stress management skills you have begun to learn. It also describes how to sleep better, reduce panic attacks and deal with difficult situations. The section ends by discussing how to prepare for future stress.

It is divided up as follows:

8.1 Putting it all together

8.2 Sleep

8.3 Panic Attacks

8.4 Avoidance

8.5 The Future

8.1 PUTTING IT ALL TOGETHER

This programme has now covered a large amount of information about stress, including a number of stress management skills.

So far, I have described each skill in a separate section. In reality, dealing with stress often means you need to use more than one skill at a time. To show you how this can be done, I describe below how to combine your skills to deal with three very common stress problems - poor sleep, panic attacks and avoidance. Even if you do not suffer from such problems, it can help to read the sections below. This may help you avoid suffering from such problems in the future. It will also show you how to bring together different skills to deal with any problem.

8.2 SLEEP

Poor sleep is a very common stress symptom. About one third of all people say this is their most serious problem. Sleep helps the mind and body relax and recover. Some sleep is essential for good health. The body's natural mechanisms will make sure we all sleep enough to remain healthy. So poor sleep will not damage our health but it will make us feel tired, worn out, we will think more negatively and then feel more anxious, irritable, low etc.

8.2.1 Sleeping better

Many of the tips to sleeping better are based on the simple rules used by parents with their children. These rules apply just as much to adults.

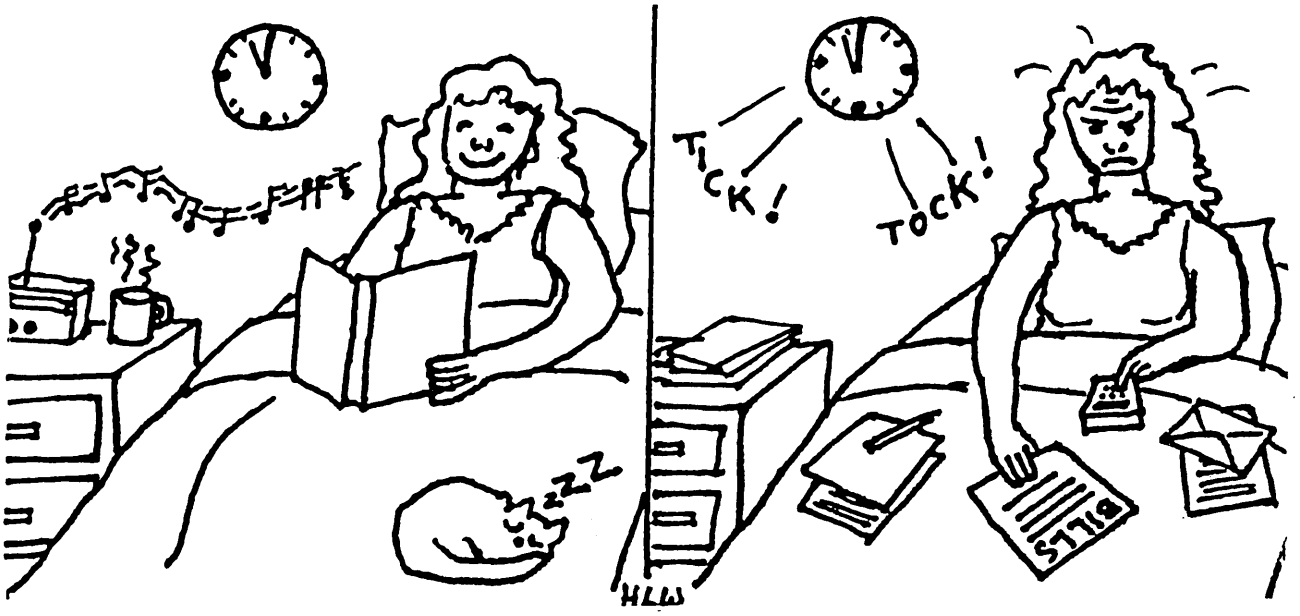
1. Be sure you have a problem. Firstly, not every one needs 8 hours sleep. This is just what most people need. Margaret Thatcher only needs 3 -4 hours per night. Secondly, are you tired because you are doing too much, not because you have poor sleep? Thirdly, the older we get, the less sleep we need and our sleep tends to be lighter, more easily disturbed. There is nothing we can do about that. Finally, research has shown that we all exagerate how much time we spend awake at night. Time seems to pass more slowly as we twist and turn - 15 minutes feels like 60.

2. Try to avoid worrying at bedtime about your poor sleep. Worrying about anything at bedtime will turn on the FFR and make sleep impossible. So if you worry about not sleeping you are less likely to sleep. Try to avoid clock watching. It is easy to become obsessed with how long you have been awake - such obsession will only keep you awake longer.

3. Try to avoid sleeping during the day. The body needs so much sleep to survive and if it does not get it at night, it will try to get it during the day. Unfortunately, day time sleeping will make it harder the following night.

4. Try to develop a regular time to go to bed and get up. The body's clock needs a sleep routine, just as it does for eating. Getting up at about the same time each day means it is getting ready to sleep at about the same time each night.

5. Try to develop a relaxing bedtime routine. To sleep, your FFR needs to be very low. So last thing at night, try to avoid rushing around; having serious conversation; taking too much tea, coffee or cigarettes which contain stimulants. Instead, have a hot bath, read a good book, make love, practice your Deep Relaxation Exercises (Section 4), have a hot milky drink. Make sure your bedroom is quiet and warm with a comfy bed and pillows.



6. Try to leave the worries of the day outside of the bedroom. This is easier said than done, especially if you are so busy during the day you do not have time to think. Before bedtime, try and:

(a) make time during the day to think and talk about problems, to plan things. Before bedtime, draw up your list of things to do for the next day (Section 5).

(b) keep a diary. Put the day's events in it and then close it, imagining you are closing your mind at the same time.

(c) remind yourself that you cannot solve problems or plan clearly when you are tired - your thoughts will be too jumbled and negative. Try saying "No" or "Stop" gently to the intrusive thoughts. You may need to do this many times during the night as your mind wanders to and fro. If you have a particular problem to sort out, promise yourself you will do it tomorrow.

(d) distract your mind form serious topics (Section 6). Counting sheep is an age old method of distracton. Another would be practising your Deep Relaxation Exercises in bed.

7. If you cannot get to sleep after 30 - 45 minutes, get up again. This applies when you first go to bed or if you wake during the night. Twisting and turning, trying to get to sleep will only keep you awake. So wrap up warmly, go downstairs, get a good book and a hot milky drink and settle down for a while. Eventually you will begin to relax - as soon as you feel sleepy, go slowly back to bed.

8. If you take sleeping tablets regularly, do not miss a night. This just causes the level of chemicals in your blood to go up and down making your sleep worse. If you want to reduce your tablets, talk to your G.P.

9. Finally, remember you cannot force yourself to go to sleep. The more you try, the less you will. At the very worst, sitting reading or lying relaxing in bed for 8 hours will refresh your body and mind enough for the next day.

8.2.2 Sleep Exercise

If you suffer from poor sleep, try taking a sheet of paper and a pen. Go back over Section 8.2.1. and jot down all the things you could do to improve your sleep. Then, starting tonight, use the list to check you are doing all you can to improve your sleep. When you have drawn up your list, read on.

8.3 PANIC ATTACKS

As we saw in Section 3, panic attacks are another common stress symptom. If you suffer from them, it will help to go back and re-read Section 3, especially 3.3. and 3.4. then look at the tips below:

8.3.1 Controlling panic attacks

The main skills to use are:

- pacing yourself (Section 5)
- physical relaxation via exercises (Section 4) and leisure (Section 5)
- thinking less negatively (Section 6)
- asserting yourself (Section 7)

Each of these skills needs to be used at 3 different times - before, during and after a panic attack. Here is what you can do at each stage.

BEFORE you enter a situation where you think you will panic:

1. try to avoid rushing around too much, keep your arousal low
2. take regular breaks, especially for food
3. practise Quick Relaxation a few times each day, especially when feeling tense, use your Red Spots to remind you to stop and check
4. use your assertiveness skills to say "No" to to ask for help or to make time to relax or to stop your feelings building up inside
5. do not dwell on what might happen, try using distraction
6. if you think about the situation, try to make your thoughts realistic - how likely is it you will really panic, is it really the worst thing that could happen to you and how have you managed to cope so far? Go back to Section 6 and check on how to make your thinking more realistic. Write your more rational thoughts down to help you remember them.

DURING the difficult situation:

1. take things slowly, do not rush around, keep your arousal low
2. practise your Quick Relaxation, may be go out and sit in the toilet for 5 minutes to do so
3. try the STOP technique. Say "STOP" firmly to yourself. Take a deep breath through your nose and hold it for 2 seconds. The let it out slowly, through your mouth, thinking slowly the word "RELAX" as you do so. After exhaling completely, do it all again one or two times.
4. try using distraction to stop yourself thinking about panicking
5. if you do think about panicking, try to think as realistically as possible. Remind yourself that if you practise the above skills, you are less likely to panic, that even if you do panic, these skills will make it shorter and less severe.

6. try to accept the panic attack and not fight it. Remember it will pass after 5 - 15 minutes, that you have coped with them in the past and are now even better able to do so. Go back to Section 6 and check on how to make your thinking more realistic. Carry a list of these thoughts with you to read in the situation.

AFTER the difficult situation:

1. take it easy for an hour or so, you have been through a very tough time. Practise your Deep relaxation Exercises as soon as you can.
2. try to remember what you did well, what worked. Was the attack shorter or less severe, even a little? Could it have been worse? Do not minimise your success. Do not expect too much, too soon. Panic attacks take a long time to fully master. Praise yourself for even attempting the difficult situation - it takes courage.
3. if you had a panic attack, try and learn from it. What could you do differently next time?

8.3.2 Exercise - Panic Attacks

If you suffer from panic attacks, try this exercise. If you do not, move on to the next part.

Think of a recent panic attack. On a spare sheet of paper, write down all the thoughts you had before, during and after the panic. Now re-read Section 6 and the tips above.

Then, try and come up with some more realistic thoughts to challenge your original thoughts. Get someone else to help you if you get stuck. It is not easy.

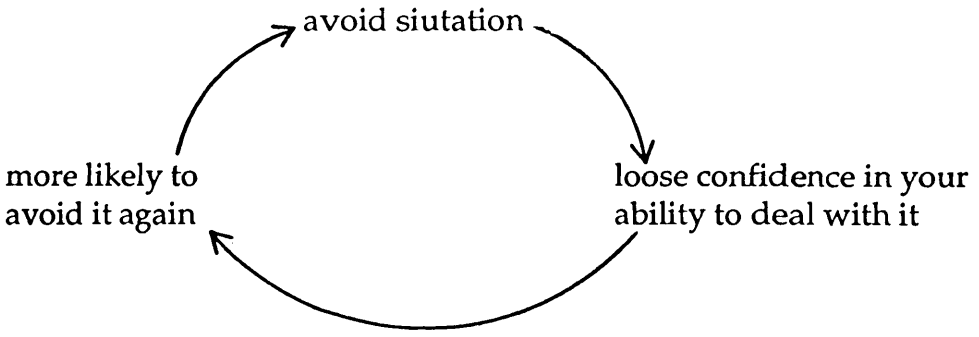
Now, take the PANIC CONTROL sheet you will find at the end of Section 8. On it is a summary of the tips given above. There are also spaces to fill in realistic thoughts to have before, during and after a panic attack. I have given you a few in each section which may help but try to add some of your own.

When you have done this, carry this sheet around with you. Reading it before, during and after a panic attack may help you to remember what to do and think. Finally, it is important to try and be patient when learning to control your panic attacks. You may need to suffer quite a few more before you feel you are mastering them. If you practise as described, your attacks will slowly become less severe, shorter and happen less often.

8.4 AVOIDANCE

People begin to avoid situations if they fear what will happen in them. Common things people fear happening include having a panic attack or dealing with something they hate, eg spiders, heights, open spaces, being trapped, or making a fool of themself, eg in a social situation.

In the extreme such fears can become a phobia, a person's confidence usually drops, making it even harder to go back to it next time. Another vicious cycle is set up.



In the short term avoidance helps because it reduces a person's level of anxiety. In the longer term avoidance makes things worse - their confidence drops and their lifestyle can become very limited, feeling helpless and low as a result.

8.4.1. Overcoming avoidance

If you would like to go back into avoided situations, try these tips:

1. Define very clearly the situation you would like to face. Where do you want to go, when and with whom?, eg "I want to shop in M & S in Birmingham on a Saturday on my own" or "I want to learn to assertively tell John when he's upset me".

2. Break your target down into as many smaller steps as you can. eg, The target of going shopping in M&S in Birmingham on your own can be broken down into hundreds of smaller steps, perhaps starting with going into a local shop when it is empy, bringing a friend with you. Then perhaps going into the local shops when there are people in it, again with your friend. Moving on a few steps, going to M&S in Nuneaton during the week, again with a friend. Then a few steps later, going into M&S in Nuneaton on a Saturday on your own. In the end, you reach your final step of going to M&S in Birmingham on your own.

Any target can be broken down - you may need to use some imagination and get someone else to discuss it with.

3. Put your steps into a list. Starting with the easiest and ending with the hardest.

4. Work through your list one step at a time. Do not run before you can walk. Slowly take one step at a time, gradually rebuilding your confidence as you go. As soon as you feel comfortable with a step, move onto the next hardest one.

5. At each step practise your stress management skills. This is exactly as I described earlier when discussing panic attacks. Before, during and after entering the difficult situations you need to pace yourself, practise your relaxation exercises and think more rationally. Re-read Section 8.3.1. to see what to do.

If your situation is related to expressing your feelings, asking for something or saying "No", the key skills to use are those described in Section 7 on assertiveness.

6. Do not wait until you feel ready to take each step. You will always feel anxious at first. It will only become easier once you have taken the step.

7. Try not to leave the situation because you feel too anxious. If you do, you will not get enough practise at using your stress mangement skills. You will also knock your confidence. If you do find a situation too difficult, you may have tried to take too big a step at once. See if you can find smaller steps to take.

8. Expect to make mistakes. As you try anything difficult, you will make mistakes. Success comes by learning from your mistakes. Sit down afterwards, perhaps with someone else, and think what you did wrong and what you will do differently next time.

9. Remember the costs of avoidance. You will be tempted to take the easy way out and avoid it. To help you resist the temptation, remember how avoidance knocks your confidence, limits your life, makes you feel helpless, low etc.

10. When you make progress, however small, notice this and praise yourself. May be buy yourself a special treat.

8.4.2. Exercise on avoidance

If you are avoiding something, get another one of those pieces of paper and a pen. Then, re-read Section 8.4.1. Now, try going through each tip in turn and doing as it suggests.

When you get to tip 5, use the Summary Sheet on Panic Control/Avoidance to remind you what to do. Carry this sheet with you. The stress management skills for controlling Panic Attacks and dealing with difficult situations are very similar. When you feel ready to, move on to the final part of the programme.

8.5. THE FUTURE

You are now approaching the end of this programme. Congratulations on working so hard to get this far. Research has shown that up to two thirds of people drop out of self-help programmes like this. So you are part of a small, successful group!

Now is the time to review how well you are doing. Since you began the programme:

1.	Is your level of tension a bit lower?	YES/NO
2.	Do you suffer from fewer headaches, palpitations, indigestion etc?	YES/NO
3.	Do you generally feel less tired?	YES/NO
4.	Are your panics shorter, less severe or less frequent?	YES/NO
5.	Do you spend less time worrying about things?	YES/NO
6.	If you do worry, does it feel more useful?	YES/NO
7.	Can you say "No" more easily?	YES/NO
8.	Can you ask for things more easily, including help?	YES/NO
9.	Can you sleep any better?	YES/NO
10.	Has your self-confidence increased at all?	YES/NO
11.	Are you more relaxed in difficult situations?	YES/NO
12.	Do you generally feel less stressed?	YES/NO

If you can say YES to ANY of these questions, you have improved. Any gains you have made to date are totally due to your own efforts. Whilst the programme will have guided your efforts, the hard work has been all yours.

8.5.1. No Progress?

If you do not feel you have made any progress at all, it is for one of the reasons described overleaf.

1. Have you forgotten how bad you once felt? Whenever we recover from an illness or leave a problem behind, it can be very hard to remember how bad it felt, even a few days later. Check with a friend or a relative. Ask them if they have noted a change in you. They may find it easier to spot from the outside.

2. Are you expecting too much? There is no cure for stress. The aim is to manage it, not get rid of it. We will all suffer the occasssional headache, bout of palpitations, night with disturbed sleep, period of feeling very angry, anxious, guilty or low.

It may be you have managed to reduce how severely these problems are when they occur, or they last for a shorter amount of time, or they occur less often. Such improvements are important gains. Further practice of your stress management skills will lead to greater gains.

3. Are you practising the stress management skills often enough? They do require a lot of practice and improvements will be slow. The more you put in, the more you will get out.

4. Are other people preventing you from changing? They probably have gotten used to the old, stressed, unassertive, worried you. May be they prefer you that way. As you change, they may need time to adjust, or they may not want you to - try explaining why you are trying to change. If they are being selfish, do not give in to them, assert your right to reduce your stress - even if it means they have to do more as a result!

5. Is this programme enough? The skills in this programme, if practised as described, should lead to atleast some improvements in your level of stress. For many people, this is all they need. For some, they may need extra help to reduce their difficulties. If by this point you feel you need extra help, have a chat with your G.P. to see what else is available locally. Having gotten this far in the programme is a very good starting point.

8.5.2. Continued practise

Continued practise of your stress management skills will help you to:

- improve your skills
- prevent stress becoming a major problem for you again
- deal with new problems as and when they arise

Continued practise means:

- using your Deep Relaxation Exercises whenever you feel very stressed or tired.
- using your Quick Relaxation Exercises from time to time during each day to keep your arousal level low.
- pacing yourself reasonably, taking breaks, especially for meals, using lists to plan, doing all this everyday.
- having time everyday for leisure activities to relax and unwind and to keep you fit.
- avoiding too much alcohol as an escape from stress; it causes stress in the long run.
- asserting yourself everyday, preventing your feelings building up in side, preventing people using you.
- asserting yourself everyday, asking for reasonable amounts of help and time for yourself.
- talking to others about problems whenever they arise, not struggling on your own.
- constantly checking you are not making problems worse by thinking irrationally about them or dwelling on them for too long. If you ever feel very upset about something, sit down with a pen and paper and check your thoughts.
- have a ready for bed routine every night, not just when your sleep is disturbed.
- occassionally, say every 6 - 12 months or so, re-reading the programme. It will help you remember how to manage stress and prevent you slipping back into old habits. It may also help you deal with new problems.

8.5.3 Relapses

At some future point, you may get worse, may be feeling as bad as you ever did. It would be tempting then to think "I'm back where I was - the programme hasn't helped!. This is terrible! I'll never be right again!".

Well, if such thoughts are true, you do have a problem. Naturally enough you will feel helpless, anxious, low. But are such thoughts accurate? Let's look at each in turn:

Are you back where you were? No - you cannot forget the skills you have learned although you can forget to use them.

Has the programme helped? Yes - you improved for a while so it does work. But for it to continue to work you have to continue to follow it's advice.

Is it terrible? It probably does feel terrible to be back feeling really stressed.

Will you ever be right again? Yes - if you managed to reduce your stress before, you can do it again. You will need to sit down and work out the causes of your current stress. Then work out which skills you need to practise to reduce it. If it is a new problem, you may need to go back to the programme for new skills. If it is an old problem, you may simply need to start practising old skills again. As ever, discussing it with someone else may help make the situation clearer.

Hopefully you will never go back to feeling as bad as you once did. But you will probably still have bad days. Each time you have a bad day, try and learn from it. What could you do differently next time? A daily diary can help you to work this out.

8.5.4. What now?

Well this is the end of the writing, the theory. I hope you have found the programme useful. Ths skills you have begun to learn will stay with you for the rest of your life. Like learning to ride a bike, once learned, you can forget to practise or use them but you cannot forget them.

At this point, as well as continuing to practise your skills, it may be helpful to re-read parts of the programme. Perhaps, there were parts you did not fully understand or parts that particularly applied to you.

Congratulations once again on reaching this far and on all your hard work.

As I said at the beginning of the pack, for some people, this programme is enough to help them cope better with their stress. It is one of the aims of this research project to see just how much help the pack is. Hence, about 3 months after you first receive this pack, one of us will be back in contact with you. This will be to check how you are and

also what, if any, extra help we can offer you. If you need counselling or therapy, this will be arranged as soon as possible.

Meanwhile, whilst you are waiting to be contacted, if you feel you have got worse and can't cope any longer, please contact the clinician who originally assessed you. He or she can then discuss how we can help you.

PANIC CONTROL/AVOIDANCE

If you suffer from panic attacks or avoidance due to anxiety, carry these 2 sheets with you. It may help to read them before, during and after facing a difficult situation.

BEFORE

- are you rushing, have you taken a meal break in the past 3 hours?
- are you tense? Try your Quick Relaxation Exercises.
- are you dwelling on how awful the situation may be? Try distraction exercises. Or try replacing your negative thoughts with these:

1. I've survived before, feeling anxious or panicky is horrible but worse things could happen to me.
2. My new skills will help me control my anxiety symptoms or panic attacks if they happen.
3. Worrying in advance will only make it more likely that I'll have problems. Such worry is pointless.
4. It is not definite I'll have problems - I used to deal with this situation with out any.
5.
6.
7.

DURING

- are you rushing? Try and take things slowly.
- practise your Quick Relaxation Exercises - go into the toilet for a few minutes if that helps, then come back.
- practise the STOP technique, say "STOP" taking 2 - 3 deep breaths, in through your nose, hold, and out slowly through your mouth, thinking the word "RELAX" slowly.
- try distracting yourself, don't dwell on how you are feeling.
- try replacing your negative thoughts with these:

1. I can control my anxiety, I have the skills now.

2. Practising my Quick Relaxation Exercises or the STOP technique will help.

3. These symptoms are not dangerous - it is just the FFR on too high, it's working well.

4. I'm not going mad, having a heart attack or losing control.

5.

6.

7.

AFTER

- you did it, you coped with the situation even though it was (very) difficult. Well done!

- was it any easier this time, were your symptoms less severe, did they last less time?

- what could you do differently next time?

- take it easy for an hour or so, try your Deep Relaxation Exercises - you deserve it.

- try to be patient with yourself; you will not easily or quickly learn to control your panic attacks or deal with difficult situations. With practise you will get there!

- reward yourself for dealing with the situation by doing something you really enjoy.

APPENDIX 6

MEASURES USED - STAGE 2

General Health Questionnaire

The questions below relate to your general health. Your answers, as for all the questionnaires, are totally confidential and will be recorded anonymously.

1. In the past 2 months about how many days sick leave have you had to take ? _____ days.

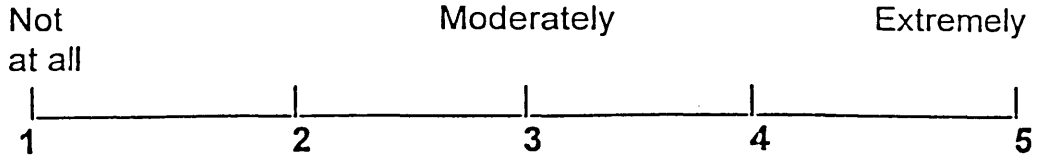
2. In the past 2 months, about how many times have you visited your G.P. for any reason ?_____ times.

3. a) Are you **currently** taking any medication for any reason? Yes/NO

   b) If Yes, please say what you are taking and how much.

.....

4. Over the past 1 month how stressed or anxious would you say you have generally felt? (circle the relevant number)



5. Please rate the general quality of your life during the past 1 month in the following areas.

	1 Extremely bad	2 Bad	3 Moderate	4 Good	5 Extremely good
WORK (include domestic work)	1	2	3	4	5
LEISURE ACTIVITIES (e.g. going out with friends, reading, sport)	1	2	3	4	5
FAMILY RELATIONSHIPS (e.g. with parents, spouse children, family outings)	1	2	3	4	5
INTIMATE RELATIONSHIPS (e.g. giving and receiving affection, sexual relationships)	1	2	3	4	5

Research use only
code : *date sent:*
stage: *date returned*

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NAME _____ DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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H.A.D. Scale

Below is a list of common symptoms of anxiety and depression. Please carefully read each item in the list. Then **underline** the reply which comes closest to how you have been feeling in the past week.

1. I feel tense or 'wound up':
   - Most of the time
   - A lot of the time
   - From time to time, occasionally
   - Not at all

2. I still enjoy the things I used to enjoy:
   - Definitely as much
   - Not quite so much
   - Only a little
   - Hardly at all

3. I get a sort of frightened feeling as if something awful is about to happen:
   - Very definitely and quite badly
   - Yes, but not too badly
   - A little, but it doesn't worry me
   - Not at all

4. I can laugh and see the funny side of things:
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

5. Worrying thoughts go through my mind:
   - A great deal of the time
   - A lot of the time
   - From time to time but not too often
   - Only occasionally

6. I feel cheerful:
   - Not at all
   - Not often
   - Sometimes
   - Most of the time

7. I can sit at ease and feel relaxed:
   - Definitely
   - Usually
   - Not often
   - Not at all

8. I feel as if I am slowed down:
   - Nearly all the time
   - Very often
   - Sometimes
   - Not at all

9. I get a sort of frightened feeling like 'butterflies' in the stomach:
   - Not at all
   - Occasionally
   - Quite often
   - Very often

10. I have lost interest in my appearance:
   - Definitely
   - I don't take so much care as I should
   - I may not take quite as much care
   - I take just as much care as ever

11. I feel restless as if I have to be on the move:
   - Very much indeed
   - Quite a lot
   - Not very much
   - Not at all

12. I look forward with enjoyment to things:
   - As much as ever I did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

13. I get sudden feelings of panic:
   - Very often indeed
   - Quite often
   - Not very often
   - Not at all

14. I can enjoy a good book or radio or TV programme:
   - Often
   - Sometimes
   - Not often
   - Very seldom

Now please check you have answered all questions.

WORRY QUESTIONNAIRE

Below are a number of statements describing the way people can worry. Please read each one and then rate how much **each** description fits you. Please answer each question. When answering, think of how you have been over the past few months.

For example, if you think that you have been worrying all the time in recent months, circle the scale as shown below:

	Not at all typical of me				very typical of me
I worry all the time	1	2	3	4	(5)

Try not to spend too much time on each statement - just give the answer that feels about right to you now.

Over recent months, how typical of you are the following descriptions:

	Not at all typical of me				very typical of me
1. If I do not have enough time to do everything, I do not worry about it.	1	2	3	4	5
2. My worries overwhelm me.	1	2	3	4	5
3. I do not tend to worry about things.	1	2	3	4	5
4. Many situations make me worry.	1	2	3	4	5
5. I know I should not worry about things, but I just cannot help it.	1	2	3	4	5
6. When I am under pressure I worry a lot.	1	2	3	4	5

9.	As soon as I finish one task, I start to worry about everything else I have to do.	1	2	3
10.	I never worry about anything.	1	2	3
11.	When there is nothing more I can do about a concern, I do not worry about it any more.	1	2	3
12.	I have been a worrier all my life.	1	2	3
13.	I notice that I have been worrying about things.	1	2	3
14.	Once I start worrying, I cannot stop.	1	2	3
15.	I worry all the time.	1	2	3
16.	I worry about projects until they are all done.	1	2	3

COPING QUESTIONNAIRE

ease think back over the past few months to any difficult situations or problems, large or small, at you have had to deal with. How often have you used the following responses when dealing h them?

lease answer by circling the appropriate number)

	NO	YES Once or twice	YES Sometimes	YES Fairly Often
Tried to find out more about the situation	1	2	3	4
Talked with spouse or other relative about the problem.	1	2	3	4
Talked with friend about the problem	1	2	3	4
Talked with professional person (e.g. doctor, lawyer, clergy)	1	2	3	4
Prayed for guidance and / or strength	1	2	3	4
Prepared for the worst	1	2	3	4
Took it out on other people when I felt angry or depressed	1	2	3	4
Tried to see the positive side of the situation	1	2	3	4
Got busy with other things to keep my mind off the problem	1	2	3	4
0. Made a plan of action and followed it	1	2	3	4
1. Considered several alternatives for handling the problem	1	2	3	4
2. Drew on past experiences; I was in a similar situation before	1	2	3	4
3. Keep my feelings to myself	1	2	3	4
4. Took things a day at a time, one step at a time	1	2	3	4

	NO	YES Once or twice	YES Sometimes	YES Fairly Often
5. Tried to step back from the situation and be more objective	1	2	3	4
6. Went over the situation in my mind to try to understand it	1	2	3	4
7. Tried not to act too hastily or follow my first hunch	1	2	3	4
8. Told myself things that helped me feel better	1	2	3	4
9. Got away from things for a while	1	2	3	4
10. I knew what had to be done and tried harder to make things work	1	2	3	4
21. Avoided being with people in general	1	2	3	4
22. Made a promise to myself that things would be different next time	1	2	3	4
23. Refused to believe that it happened	1	2	3	4
24. Accepted it; nothing could be done	1	2	3	4
25. Let my feelings out somehow	1	2	3	4
26. Sought help from persons or groups with similar experiences	1	2	3	4
27. Bargained or compromised to get something positive from the situation	1	2	3	4
28. Tried to reduce tension by:				
(a) drinking more	1	2	3	4
(b) eating more	1	2	3	4
(c) smoking more	1	2	3	4
(d) physically exercising more	1	2	3	4
(e) taking more tranquillising drugs	1	2	3	4
(f) using relaxation exercises	1	2	3	4

	NO	YES Once or twice	YES Sometimes	YES Fairly Often
29. Tried to pace myself better, e.g. by using lists or taking regular breaks	1	2	3	4
30. Tried to limit how much I had to do by saying "No" or asking for help	1	2	3	4
31. Please list up to 3 other methods you use to cope which are not listed above and indicate how often you use them				
(a).....	1	2	3	4
(b).....	1	2	3	4
(c).....	1	2	3	4

32. Please list the 3 methods you use most often

(a).....

(b).....

(c).....

EXPECTATIONS ABOUT YOUR HEALTH QUESTIONNAIRE

Below is a list of beliefs that people sometimes hold about their health and the types of symptoms, physical or emotional, you may have been experiencing recently, e.g. frequent headaches, palpitations, disturbed sleep, worrying a lot, feeling anxious.

Please read each statement carefully and decide how much you agree or disagree with each statement. Then tick the scale at the point that best describes your answer. Your answer should describe the way you think MOST OF THE TIME.

		Totally Disagree						Totally Agree
1.								
a)	My symptoms are a sign I'm going mad or cracking up.	1	2	3	4	5	6	7
b)	My symptoms are a sign there's something seriously wrong with me - physically or mentally.	1	2	3	4	5	6	7
c)	I worry about what my symptoms are caused by.	1	2	3	4	5	6	7
d)	My symptoms make me feel I'm losing control of things - it can only get worse	1	2	3	4	5	6	7
2.								
a)	Action is useless - worriers are born not made - no one can change their personality	1	2	3	4	5	6	7
b)	There is nothing anyone can do to reduce such symptoms	1	2	3	4	5	6	7
c)	Such symptoms are caused by what happens to you - there's nothing anyone can do to change them	1	2	3	4	5	6	7
d)	Such symptoms can be managed using the right techniques or approach	1	2	3	4	5	6	7

		Totally Disagree						Totally Agree
3.								
a)	My symptoms are a sign I can't cope - I'm weak	1	2	3	4	5	6	7
b)	I can manage my symptoms to at least some degree - using the right technique or approach	1	2	3	4	5	6	7
c)	I can do something about the causes of my symptoms	1	2	3	4	5	6	7
d)	These symptoms are just a sign I can't cope normally with life, unlike other people	1	2	3	4	5	6	7
e)	I can cope with any stress or worry I experience - whatever it's cause	1	2	3	4	5	6	7
f)	I am more vulnerable to stress than other people	1	2	3	4	5	6	7

National Adult Reading Test (NART)

Answer/Record Sheet

ime ..... Date of test .....

Errors

1ORD.....
:HE.....
:POT.....
SLE.....
JUQUET.....
3ALM.....
APON.....
ENY.....
AUSEA.....
EBT.....
)URTEOUS.....
IAREFY.....
QUIVOCAL.....
IAIVE.....
:ATACOMB.....
3AOLED.....
HYME.....
1EIR.....
RADIX.....
ASSIGNATE.....
HIATUS.....
SUBTLE.....
PROCREATE.....
SIST.....
SOUGE.....
SUPERFLUOUS.....
SIMILE.....
ANAL.....
QUADRUPED.....
:ELLIST.....

Errors

ZEALOT .....

DRACHM .....

AEON .....

PLACEBO .....

ABSTEMIOUS .....

DETENTE .....

IDYLL .....

PUERPERAL .....

AVER .....

GAUCHE .....

TOPIARY .....

LEVIATHAN .....

BEATIFY .....

PRELATE .....

SIDEREAL .....

DEMESNE .....

SYNCOPE .....

LABILE .....

CAMPANILE .....

EXPECTATIONS ABOUT THE PROGRAMME

You have just received your copy of the anxiety/stress self-help programme. To help us understand how you feel about receiving the programme, please answer the questions below. Do this once you have briefly looked at the programme.

Try not to spend too much time thinking about each question - just give the answer that feels about right to you **now.**

Answer by circling the number on the scale which most closely fits your current feelings. For example, if you feel only quite confident you will be helped by the programme, mark the scale as shown:

0 1 2 (3) 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

A. How confident are you now that reading and using the programme you've been given will:

(a) help you to reduce your level of anxiety or stress

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

(b) help you to cope better with the anxiety or stress you suffer

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

(c) please describe briefly your answers to (a) and (b) above

B.

(a) Do you **intend** to try and read the programme and follow it's advice?

0	1	2	3	4	5	6	7	8	9	10
No not at all										Yes, very much

(b) Please describe briefly your answer to (a) above

C.

(a) Overall, how confident are you now that you have the **ability** to use the programme, being able to read and understand it and follow its advice?

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										Extremely Confident

(b) Please describe briefly below your answer to (a) above.

D. To get the most from the programme there are certain skills you need to have and certain situations you will probably face which will test your ability to use the programme. These are listed below.

How confident are you that:

(a) you **can** read all of the programme over the next 3 months

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										Extremely Confident

How confident are you that:

(b) you **can** set aside at least about 30 minutes on most days to read it.

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

(c) you **can** understand what the programme says

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

(d) you **can** set aside time to read it even when you're feeling tired, e.g. after a hard day's work

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

(e) you **can** set aside time to read it saying "No" to any other demands on your time, e.g. the children or work piling up

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

(f) you **can** set aside time to read it when all you really want to do is sit and relax or go out

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

(g) you **will be able to** try the quizzes at the end of each section

0 1 2 3 4 5 6 7 8 9 10

Not at all confident — Extremely Confident

How confident are you that:

(h) you **can** encourage yourself to continue reading the pack even when it doesn't seem to be helping

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										Extremely Confident

i) you **will be able to** stick with it and read it even when you're feeling anxious and uptight

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										Extremely Confident

j) you **can** continue reading it even if it doesn't seem to be making sense at the time

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										Extremely Confident

k) you **will be able to** try the exercises it suggests, e.g. regularly practising the relaxation exercises on the tape (if you don't have a cassette player, leave this question)

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										Extremely Confident

USE OF THE INFORMATION BOOKLETS

We are interested in what you thought of the booklets and how much you used them. This is to help us see if there are any ways in which we can improve them to make them more useful to people. So please feel free to be as open in your answers as possible.

SECTION 1 - USE

To answer questions in this section, please circle the number that most closely fits your views.

1. How much of the booklets did you read? None of them 0 1 2 3 4 5 6 All of them

2. How often did you read the booklets? Never 0 1 2 3 4 5 6 At least daily

3. How useful did you find the booklet? Not at all useful 0 1 2 3 4 5 6 Very useful

4. How easy to understand did you find the booklets? Not at all easy 0 1 2 3 4 5 6 Very easy

5(a) Have you kept the programme? YES / NO

(b) Do you intend to read it in the future? YES /NO

6. What, if anything, did you find useful about the booklets?

USE OF THE PROGRAMME

We are interested in what you thought of the programme and how much you used it. This is to help us see if there are any ways in which we can improve it to make it more useful to people. So please feel free to be as open in your answers as possible.

SECTION 1 : PROGRAMME USE - OVERVIEW

To answer the questions below, please circle the number that most closely fits your view.

1.	How much of the programme did you read?	None of it	0 1 2 3 4 5 6	All of it
2.	How often did you read some of it?	Never	0 1 2 3 4 5 6	At least daily
3.	How many of its suggestions did you try?	None of them	0 1 2 3 4 5 6	All of them
4.	How often did you try at least some of these suggestions	Never	0 1 2 3 4 5 6	At least daily
5.	How many of the quizzes did you try	None of them	0 1 2 3 4 5 6	All of them
6.	Overall, how useful did you find the programme	Not at all useful	0 1 2 3 4 5 6	Very useful
7.	Overall, how easy to understand did you find the programme	Not at all easy	0 1 2 3 4 5 6	Very useful

8. (a) Have you kept the programme? YES/NO

   (b) Do you intend to use it in the future? YES/NO

SECTION 2 : PROGRAMME USE - SPECIFICS

1. Thinking of each section of the programme, how often did you read each one? (Please tick the relevant answer.)

	Never	Once	Twice	Three times	Four or more times
How to use the programme	☐	☐	☐	☐	☐
What is stress	☐	☐	☐	☐	☐
Stress and illness	☐	☐	☐	☐	☐
Managing Physical and Mental tension	☐	☐	☐	☐	☐
Lifestyle and Stress	☐	☐	☐	☐	☐
Changing the way you think and feel	☐	☐	☐	☐	☐
Assertiveness	☐	☐	☐	☐	☐
What now?	☐	☐	☐	☐	☐

2. (a) How easy was each section to understand? (Please circle the number that most closely fits your view).

	Not at all easy						Very easy
	0	1	2	3	4	5	6
How to use the programme	0	1	2	3	4	5	6
What is stress	0	1	2	3	4	5	6
Stress and Illness	0	1	2	3	4	5	6
Managing physical and mental tension	0	1	2	3	4	5	6
Lifestyle and stress	0	1	2	3	4	5	6
Changing the way you think and feel	0	1	2	3	4	5	6
Assertiveness	0	1	2	3	4	5	6
What now?	0	1	2	3	4	5	6

2 (b) Do you have ideas as to how any of the sections could be made easier to understand?

3 (a) How useful was each section ? (Please circle the number that most closely fits your view)

	Not at all useful						Very useful
	0	1	2	3	4	5	6
How to use the programme	0	1	2	3	4	5	6
What is stress	0	1	2	3	4	5	6
Stress and Illness	0	1	2	3	4	5	6
Managing physical and mental tension	0	1	2	3	4	5	6
Lifestyle and stress	0	1	2	3	4	5	6
Changing the way you think and feel	0	1	2	3	4	5	6
Assertiveness	0	1	2	3	4	5	6
What now?	0	1	2	3	4	5	6

(b) Do you have any ideas as to how any of the sections could be made more useful?

SECTION 3 : COPING TECHNIQUES

The programme makes a number of suggestions of ways in which you could reduce your level of stress/anxiety. In this section, we are interested in which of these you tried and how useful you found them. When answering, please think about what you have done in the LAST 3 MONTHS AS A RESULT OF READING THE PROGRAMME.

(a) How often have you listened to the relaxation exercises? Never 0 1 2 3 4 5 6 At least daily

(b) How useful have you found them? Not at all useful 0 1 2 3 4 5 6 Very useful

(c) Are you still using them? YES / NO

(a) Have you tried to increase your leisure activities (e.g. hobbies, reading)? YES / NO

(b) If Yes, what have you tried?

(c) How useful have you found this? Not at all useful 0 1 2 3 4 5 6 Very useful

(a) Have you tried to pace yourself better? (e.g. Did you use the red spots?) YES / NO

(b) If Yes, how?

(c) How useful have you found this? Not at all useful 0 1 2 3 4 5 6 Very useful

(a) Have you tried to cut down on your work load? YES / NO

(B) If Yes, how?

9 (b) If Yes, how useful did you find it?

Not at all useful 0 1 2 3 4 5 6 Very useful

10 (a) If you have been avoiding difficult situations, did you try the advice in Section 8?

YES / NO / NOT APPLICABLE

(b) If Yes, how useful did you find it?

Not at all useful 0 1 2 3 4 5 6 Very useful

11 (a) As a result of reading the programme, are you doing anything else differently to try and manage your stress and anxiety?

YES / NO

(b) If Yes, what?

(c) How useful are you finding it?

Not at all useful 0 1 2 3 4 5 6 Very useful

12. As a result of using the programme, do you:

(a) understand your difficulties and symptoms better?

Understand no better 0 1 2 3 4 5 6 Understand much better

(b) feel less anxious or worried about your difficulties or symptoms

Feel no less anxious 0 1 2 3 4 5 6 Feel much less anxious

(c) believe you can cope better with your difficulties or symptoms when they occur

Cope no better 0 1 2 3 4 5 6 Cope much better

13. How confident are you that using the programme will help you in the future to cope better with your difficulties / symptoms?

Not at all confident 0 1 2 3 4 5 6 Very confident

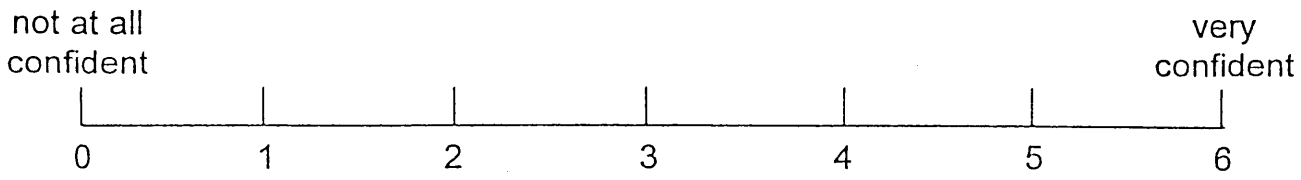
4. Finally and overall, how do you think the programme has helped you?

Thank you for your time and effort spent in completing this questionnaire.

Client Code:
Date:

EXPECTATION ABOUT THERAPY

Once your name reaches the top of the team's waiting list, how confident are you that therapy will be able to help you?



client code :

date :

EDUCATION CODES

1	=	No Qualifications
2	=	GCSEs
3	=	O Levels Engineering Certificate B.Tech. RSA City & Guilds
4	=	A Levels B.Tech.Nat.Dip. CNC Advanced Programming Part 1 ONC Chiropody
5	=	Degree HNC
6	=	Post.Grad. Grad.Dip. Dip.Management NVQ 5 Med. Dip.Soc.Studies

APPENDIX 7

INFORMATION ABOUT THE PROJECT FOR REFERRERS AND PATIENTS

WORRIED?

Do you have a mind that always seems busy and is hard to switch off? Or do you find yourself worrying more than you're happy with, over large or even small things?

Do you also ever suffer from difficulties falling asleep, headaches, muscle tension and tiredness, or restlessness?

If you experience any of these everyday difficulties, we may be able to help you. We have developed a health promotion programme that you can use totally at home. Initial results show that the programme can greatly help people reduce such difficulties.

To measure how helpful people find the programme and to see if it can be improved in any way, we are currently running a project in the surgery. ***If you would like to find out more about the programme and the project, please discuss it with your GP at your next appointment.***

NORTH WARWICKSHIRE NHS TRUST

Some people will receive it almost immediately, others will have to wait 3 months. This is to allow us to see whether people with it are helped by the pack - a lot of people's stress simply reduces with time.

- to see if it helps you, you will meet with a Research Psychologist twice. This can be in your surgery, or elsewhere if more convenient.

- she will give you some standard, simple questionnaires to fill out. All your answers will be completely confidential, as will your membership of the project.

- in response to your questionnaire the Research Psychologist will be able to advise you if you wish on how well you are currently coping with stress and how much stress you are experiencing.

- you can leave the project at any time, and keep the programme pack.

- if after using the programme you want advice on other help available, we can give you this too.

INTERESTED?

Are you interested in finding out more about the programme and the project? Please leave your name and details of how to contact you with Emma Brookes at your surgery. Alternatively you may ring Angelina Evans at Combe House, George Eliot Hospital on 01203 350111.

STRESS EDUCATION PROGRAMME

STRESS EDUCATION PROGRAMME

STRESS AND YOU

If your G.P. has given you this leaflet to read, it is because he or she thinks you are suffering from too much stress. We all suffer from stress from time to time. Common symptoms include :

- difficulties falling asleep
- palpitations
- dizziness
- blushing
- sweating excessively
- headaches
- muscle tensions and tiredness
- restlessness
- worrying too much
- a mind which is too busy or hard to switch off?

If you are experiencing these or similar symptoms, we may well be able to help you.

THE STRESS SELF-HELP PROGRAMME

Over the past 5 years, the North Warwickshire NHS Trust Psychology Service has developed a self-help education and training programme which helps people to :

- understand what causes such symptoms or difficulties.
- understand what they can and cannot do to you in the long term - physically, mentally and emotionally.
- learn how to control or remove such symptoms.

The programme consists of 8 booklets with an accompanying audio tape. These cover every aspect of stress and its management. It is designed for use on your own at home - allowing people to work at their own pace without the inconvenience of visits to the surgery.

A RESEARCH PROJECT

Already tried and tested as being very useful for people experiencing a wide range of difficulties, we now want to see if it is useful to the large number of people who present to their GPs with stress related difficulties.

To do this, if you are experiencing symptoms like those above, you are invited to join our project. Here is what is involved :

- if suitable, you will receive a copy of the programme. This will be free and yours to keep.

STRESS AND ANXIETY INFORMATION PROGRAMME

Procedure for Primary Care Use

1. Selection by G.P's in normal surgery of patients suffering a primary diagnosis of Generalised Anxiety Disorder (GAD) - see overleaf.

   Excluded are patients who would normally be referred to the CMHT. Please refer these as usual where they will automatically be considered for the project.

2. Invitation by GP to patient to join the project. If interested, GP gives patient the leaflet describing the project.

3. Interested patients contact Research team at Psychology Department, George Eliot Hospital or leaves name/number at surgery reception.

4. Research Psychologist (RP) arranges appointment with patient to discuss the project.

5. Interested patients undergo a structured interview based on DSM IV, (ADIS, Brown et al, 1996), to confirm primary diagnosis of GAD. (Time taken 20-30 minutes). Suitable patients then complete a range of standardised psychometric and process measures e.g. Beck Anxiety Inventory, Moos et al Coping Style Inventory. (Time taken 20-30 minutes).

6. Patient is randomly assigned by RP at interview to one of 3 conditions and receives programme if relevant.

7. All patients contacted 3 months later and re-assessed using measures administered at stage 5. Patients who didn't previously receive the full pack do so at this stage. They will also receive, if requested, feedback on the results of the measures completed at stages 5 + 7, e.g. level of anxiety, efficacy of coping strategies adopted.

8. At any stage, a patient may withdraw from the project, without explanation, keeping the programme if already received. Further, if at any stage the patient's condition gives the RP cause for concern, she will contact the relevant GP or supervising Clinical Psychologist, as appropriate. This includes at the end of the trial, giving feedback to the referring GP on the patient's current level of distress.

Brian Kiely
November 1996

STRESS AND ANXIETY INFORMATION PROGRAMME

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