PHD

Research Portfolio Submitted in Part Fulfilment of the Requirements for the Degree of Doctorate in Clinical Psychology

Brammer, Faith

Award date:
2019

Awarding institution:
University of Bath

Citation for published version:
Brammer, F 2019, 'Research Portfolio Submitted in Part Fulfilment of the Requirements for the Degree of Doctorate in Clinical Psychology', Doctoral, University of Bath.

Publication date:
2019

Research Portfolio Submitted in Part Fulfilment of the Requirements for the Degree of Doctorate in Clinical Psychology

---

Faith Brammer

Doctorate in Clinical Psychology

University of Bath
Department of Psychology

May 2019

(Page left intentionally blank)

Word Counts

Literature Review

The Role of Excessive Reassurance Seeking in Depression in Children and Adolescents: A Meta-Analysis: **5794**

Service Improvement Project

A Qualitative Study Investigating the Transition between Adult Eating Disorder Inpatient Care and Community Services: **5360**

Main Research Project

The Impact of a Mental Health Diagnosis on Mental Health Professionals' Judgments of Colleagues: An Experimental Study: **5500**

Executive Summary: **715**

Connecting Narrative: **2825**

Total: 20,194

(Page left intentionally blank)

Table of Contents

(Page left intentionally blank)

List of Tables

The Role of Excessive Reassurance Seeking in Depression in Children and Adolescents: A Meta-Analysis

A Qualitative Study Investigating the Transition between Adult Eating Disorder Inpatient Care and Community Services

The Impact of a Mental Health Diagnosis on Mental Health Professionals' Judgments of Colleagues: An Experimental Study

List of Figures

The Role of Excessive Reassurance Seeking in Depression in Children and Adolescents: A Meta-Analysis

The Impact of a Mental Health Diagnosis on Mental Health Professionals' Judgments of Colleagues: An Experimental Study

Abstracts

The Role of Excessive Reassurance Seeking in Depression in Children and Adolescents: A Meta-Analysis

The interpersonal theory of depression (Coyne, 1976) suggests there will be a positive relationship between high levels of excessive reassurance-seeking (ERS) and depression. This has been supported by previous research, which was last summarised by Starr and Davila (2008), using largely adult samples. This review aimed to add to previous research by investigating whether cross-sectional and prospective associations between ERS and depression are also present in young people. A systematic literature search identified 10 articles (including 9 cross-sectional data sets and 4 prospective data sets), which were synthesised using meta-analysis. A small positive association (0.28) was found between cross-sectional ERS behaviour and levels of depression. Additionally, a small positive association (0.11) was found between prospective ERS behaviour and levels of depression. This suggests that the interpersonal theory of depression can be applied to younger populations, and that ERS behaviours have negative consequences for mental health from a young age. Understanding the link between ERS behaviours and depression may have implications for prevention and early points of intervention.

A Qualitative Study Investigating the Transition between Adult Eating Disorder Inpatient Care and Community Services

High relapse rates and readmissions to hospital suggest that the transition of leaving inpatient services and returning to the community can be difficult for adults with eating disorders. This qualitative study aimed to explore service users' experiences of leaving a specialist inpatient eating disorder service and returning to community services, and to identify suggestions for ways this transition can be improved. Individual interviews were conducted with eight service users and analysed thematically. Four main themes were identified: reintegration into the "real world", hospital creates a "safe base", extreme change in levels of support, and learning from admissions. The clinical implications and suggestions for improving this transition are discussed.

The Impact of a Mental Health Diagnosis on Mental Health Professionals' Judgments of Colleagues: An Experimental Study

Stigma surrounding mental health problems can lead to a number of negative consequences, including discrimination and difficulties in disclosing or seeking support. This research aimed to experimentally investigate whether mental health professionals (MHPs) with mental health problems experience stigmatised attitudes from other MHPs. 171 MHPs watched a short video of a fictitious new colleague and then rated their suitability for working in their team. Prior to watching the video, they were randomly allocated to one of four conditions which provided written information about the following: 1) personal background information; 2) the addition of a behavioural description of mental health difficulties; 3a) the further addition of a diagnosis of a historical diagnosis of depression or 3b) the further addition of a diagnosis of a historical diagnosis of borderline personality disorder. The results showed no difference between conditions in the judgments that were made about the colleague. This suggests that MHPs do not show stigmatised attitudes towards other MHPs with mental health difficulties. This may suggest a change in attitudes regarding stigma and mental health and have positive implications for MHPs concerning disclosure of mental health difficulties in the workplace.

Literature Review

The Role of Excessive Reassurance Seeking in Depression in Children and Adolescents: A Meta-Analysis

May 2019

Internal Supervisors: Dr Cara Davis, Dr Catherine Hamilton-Giachritsis and Dr Gemma Taylor

Word Count: 5794

Target Journal: Journal of Abnormal Psychology

(Page left intentionally blank)

The Role of Excessive Reassurance Seeking in Depression in Children and Adolescents: A Meta-Analysis

Depression is the most common mental health problem, estimated to affect 10.8% of people at some point during their lifetime (Lim et al., 2018). Depression is a debilitating problem, whereby people experience symptoms such as pervasive sadness, feelings of low self-worth or guilt, loss of interest or pleasure, poor concentration, feelings of tiredness and disturbed sleep or appetite (World Health Organization, 2017). When exploring the development of depression, existing literature implies that childhood and adolescence is a key period to consider and that developing depression at this time can have negative implications for long-term mental health. Previous research has begun to consider the role of the behavioural process of excessive-reassurance seeking (ERS) in depression in adults. However, the role of ERS in depression has not yet been investigated in childhood and adolescence, despite the significance of this period of development for long-term wellbeing.

Experiencing depression during adolescence has been linked with a number of psychosocial difficulties, including poorer school attendance (1 more day of school missed per month); increased levels of smoking (odds ratio=1.84, $p<0.001$) and bingeing behaviours (odds ratio=2.02, $p<0.001$); and increased rates of suicidal ideation (odds ratio=16.59, $p<0.001$) and suicide attempts (odds ratio=13.9, $p<0.001$) (Glied & Pine, 2002; Weissman et al., 1999). Moreover, experiencing depression during adolescence predicts the likelihood of further episodes of depression in adult life (Harrington, Fudge, Rutter, Pickles, & Hill, 1990; Pine, Cohen, Gurley, Brook, & Ma, 1998). It is therefore crucial to understand the experiences in adolescence that may contribute to the development of depression.

Adolescence is a critical period in terms of social learning and developing relationships with others. At this time, people often experience big changes in their social environment and peer relationships and consequently go through rapid interpersonal development. Thus, there is greater potential for young people to experience difficulties in their interpersonal relationships. Previous research has demonstrated that interpersonal difficulties are associated with depression in both adults and younger people (Hammen, 2009; Petty, Sachs-Ericsson, & Joiner, 2004). Younger people who experience depression have been found to experience conflict or rejection in their relationships, and demonstrate difficulties with problem-solving within an interpersonal context (Rudolph, Flynn, & Abaied, 2008).

The impact of interpersonal factors on depression has been previously explained by the interpersonal theory of depression (Coyne, 1976). This theory suggests that when mildly depressed, individuals may aim to reduce their feelings of guilt and low self-worth by seeking reassurance from close others. While support is initially provided by close others, the sincerity of this is doubted by the depressed individual, meaning they continue to seek additional reassurance. Consequently, close others become annoyed, leading to rejection of the depressed individual. This rejection serves to exacerbate their symptoms, meaning the cycle persists. Additionally, the subsequent breakdown of relationships with close others serves to worsen symptoms, and leads to increased isolation, meaning the individual lacks the social support they need to overcome their symptoms (Joiner & Metalsky, 2001).

The active behavioural component in this cycle that serves as a vulnerability factor to the development of depression has been described as excessive reassurance seeking (ERS). This is defined as a “relatively stable tendency to excessively and persistently seek assurances from others that one is lovable and worthy, regardless of whether such assurance has already been provided” (Joiner, Metalsky, Katz, & Beach, 1999, p.270).

The relationship between ERS and depression in adults has been considered in depth by previous research. This was last summarised by Starr and Davila (2008), who conducted a meta-analysis of the association between ERS and depression. That review found a positive medium relationship between increased ERS and both symptoms of depression and levels of interpersonal rejection, which was understood as support for the interpersonal theory of depression (Starr & Davila, 2008).

Additionally, Starr and Davila (2008) recognised that reassurance-seeking behaviour is likely to change throughout the lifetime: children are more likely to seek support from parents, while college students are more likely to turn to friends or partners and adults are most likely to seek reassurance from their spouses or partners (Furman & Buhrmester, 1992; Starr & Davila, 2008). Reassurance seeking behaviour is also likely to be met with varying reactions from others throughout the lifetime and be better tolerated in childhood when it is more socially acceptable and within developmental norms (Abela, Zuroff, Ho, Adams, & Hankin, 2006).

However, to our understanding, the current literature has not defined the extent to which reassurance seeking is considered “excessive” or how acceptable levels of reassurance seeking may vary as children grow older. Consequently, it has not been possible to fully understand how this may relate to symptoms of depression and whether it is result of low mood or a contributory factor.

During adolescence, young people experience an expansion in their social world, as they spend more time with their peers and these relationships become more significant, with an increased reliance on peers (rather than parents) for social support (Collins & Laursen, 2004). As social systems develop and the views of peers become more influential during adolescence (Prinstein, Borelli, Cheah, Simon, & Aikins, 2005), it seems likely that ERS may have some negative consequences at this stage, as alienating peers or rejection as a result of ERS may be experienced as being particularly upsetting. Given that adolescence has been implicated as a crucial period in the development of depression, it is important to understand the impact of ERS for adolescents. This may help to prevent harmful consequences to their mental health and social world.

At the time of their meta-analysis, Starr and Davila (2008) found that age was not a significant moderator of the relationship between ERS and depression. However, their meta-analysis included few child or adolescent samples and was instead mostly based on studies using college studies. Consequently, it was not possible to consider ERS in young people in detail, or to investigate a developmental perspective of the relationship between ERS and depression, which is a current limitation of the ERS literature. A better understanding of how ERS develops and relates to depression may inform possible points for intervention in younger people, to prevent the development of depression. Increased understanding of ERS as an interpersonal factor may also inform interventions to prevent relationship breakdown and to reduce the maintaining factors of depression.

Additionally, the meta-analysis conducted by Starr and Davila (2008) was predominantly focused on cross-sectional research, as few prospective studies had been conducted at that time. Those prospective studies that were included had relatively short follow-up intervals, meaning it was not possible to test the impact of ERS as a factor that increases the likelihood of developing depression. Therefore, in this study we aimed to:

1) Pool correlation coefficients using meta-analysis to examine the association between ERS and depression in cross-sectional youth samples.
2) Pool correlation coefficients using meta-analysis to examine the prospective association between ERS and depression in longitudinal youth samples.

3) Conduct a narrative review of reported findings relating to the association between ERS and depression.

Method

The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines were followed for this review and protocol details registered on PROSPERO (ID: CRD42019118243).

Search Strategy

Electronic databases (PsychNET, Web of Science and PubMed) were searched individually. The search replicated that conducted by Starr and Davila (2008), but also included terms to identify a child and adolescent population (child*, adol*, teen*, young pe*, youth). Search terms therefore included a combination of reassure* or assur* with seek* or request*; excessive reassurance; interactional theory of depression; and interpersonal theory of depression; combined with the child terms previously outlined (Appendix 1A). Searches were restricted to publications reported in English. The reference lists of included texts were checked for relevant publications. All authors of studies included in the meta-analysis were contacted to request unpublished data. Eight authors (of ten papers included) responded to say they were unaware of any unpublished data that would be appropriate to include. The remaining two authors did not respond.

Study Selection

A PICO structure was utilised (Table 1.1) to determine the search strategy, and inclusion and exclusion criteria developed accordingly. Papers were included in the analysis if they met the following criteria: a) utilised a child and/or adolescent population (18 years old and under); b) utilised measures of ERS and depression, and reported the correlation between them (or other statistics that allowed its calculation); c) reported in English; and d) published in peer-reviewed journals, conference papers or doctorate-level dissertations. Papers were excluded if: a) the sample population was 19 years or older; b) they were theoretical or review articles; or c) studies utilised a qualitative or case study design.

Table 1.1

PICO Structure for Inclusion and Exclusion Criteria

Participants	A child and/or adolescent population was chosen.
Intervention	Levels of ERS: studies were included if they included a measure of ERS.
Comparison	No comparison measure utilised.
Outcome	Quantitative measure of correlation coefficient between ERS and depression: studies were included if they reported the correlation between ERS and depression.

Selection Process

Titles and abstracts were imported to a reference management system and independently screened for duplications and eligibility for inclusion. The remaining full texts were reviewed for inclusion. A second reviewer screened 10% of the papers generated by each search and reviewed 10% of remaining full texts for inclusion (100% inter-rater agreement). This likely reflected clear inclusion criteria.

Data Extraction and Quality Assessment

Data was extracted by the first author using a piloted data extraction form (Appendix 1B). The primary summary measure was the correlation between ERS and depression.

Quality was assessed using the Critical Appraisal Skills Programme (CASP) cohort quality checklist (CASP, 2019) (Appendix 1C) for prospective studies and an adapted version of this checklist for cross-sectional studies (questions about follow-up removed). Study quality was rated as following: low (0–30%); moderate (40–50%); good (60–70%); and excellent (80–100%). A second-rater completed data extraction and quality assessment for 10% of papers. There was 100% agreement regarding data extraction and 82% agreement regarding quality assessment. The discrepancies were discussed with a third and fourth researcher and the agreed criteria was then applied to all other studies.

Data Analysis

All analyses were conducted in RStudio (Appendix 1D). The mean weighted effect estimates were calculated and distributions were inspected for homogeneity.

The primary summary measure included correlational data between measures of excessive-reassurance seeking (ERS) and depression. The standard effect estimates

(EE) of association (measured by Pearson's correlation coefficient, *r*) between ERS and depression were extracted. A random-effects model meta-analysis was conducted to estimate the aggregate association. The EE was interpreted in line with Cohen's (1992) guidelines (0.1=small EE; 0.3=medium EE; 0.5=large EE).

Results

Data Selection

The database searches generated 3077 articles to be screened. Of these, 40 were included for full-text review and 30 were excluded from the analysis (Appendix 1E). The review included 10 articles, incorporating 11 studies (as one article reported two studies) which reported the association between ERS and depressive symptoms (Figure 1.1).

Four sets of potentially overlapping samples were identified. Authors of the papers were contacted to determine whether the samples were independent of each other or which would be most appropriate to include, but were unable to confirm this. This was discussed between the authors of this paper and it was agreed that the most recent study with the largest sample size would be included in the meta-analysis. The author of one additional paper was contacted to request data as the correlation between ERS and depression was not reported. However, this was not provided so it was not possible to include this article.

Data Synthesis

Of the 11 studies (in 10 articles), nine reported cross-sectional correlations and four reported prospective correlations. The characteristics are outlined below.

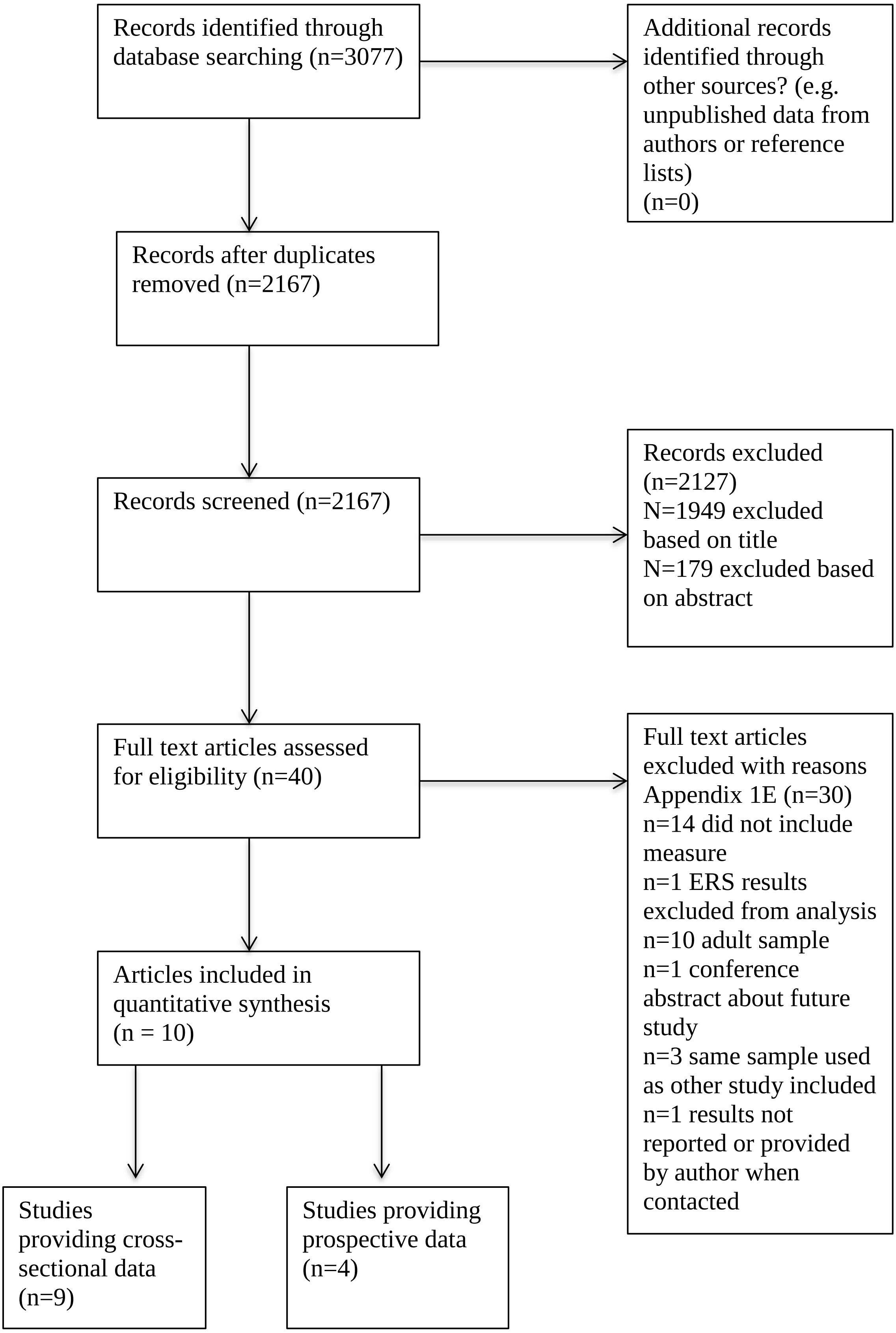


Figure 1.1. PRISMA chart of study selection.

Cross-sectional studies.

Nine data sets reported a cross-sectional correlation between ERS and depressive symptoms (pooled sample=2304, range=68-419). The majority of studies utilised community samples (n=7), which were recruited through schools (n=5), by advertising in the community (n=1) or a combination of these methods (n=1). Two studies were of psychiatric inpatients. Ages ranged between 6–17 years. Samples were 55.9% female; 66.1% Caucasian. All studies were conducted in the United States of America (USA) or Canada (Table 1.2).

Regarding quality, one study was rated as excellent; four studies were rated as good; four were rated as moderate and none were rated as low quality (Table 1.2; Appendix 1F). It is worth noting that most studies were of very good overall quality but that quality was assessed based solely on the measurement of the association between ERS and depression for this study. Consequently, some studies were rated as lower quality as confounding variables were not considered for this relationship if it was not the main focus of the study.

Measures.

In seven studies, levels of ERS were measured using the Reassurance Seeking Scale (adapted for use with children (Joiner & Metalsky, 1995)) and the Reassurance Seeking Subscale of Depression Interpersonal Relationships Inventory was used in another two (Joiner & Metalsky, 2001) (Table 1.2).

Depressive symptoms were measured using: the Children's Depression Inventory (Kovacs, 1992; n=6); the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; n=1); the Short Mood and Feelings Questionnaire (Angold et al., 1995; n=1); and the Schedule for Affective Disorders and Schizophrenia for School-Age Children diagnostic interview (Kaufman et al., 1997; n=1) (Table 1.2).

Prospective studies.

Four data sets reported a prospective correlation between ERS and depression (pooled sample=1062, range=85–67). These were all community studies, conducted in the USA or Canada. Ages ranged between 8–16 years. Overall, samples were 61.2% female; 70.2% Caucasian. All studies were conducted in the United States of America (USA) or Canada (Table 1.3).

Of these studies, one was rated as excellent quality and three were rated as good quality (Table 1.3; Appendix 1F).

Measures.

In two studies, levels of ERS were measured using the Reassurance Seeking Scale (adapted for use with children (Joiner & Metalsky, 1995)) and the Reassurance Seeking Subscale of Depression Interpersonal Relationships Inventory was used in another two (Joiner & Metalsky, 2001) (Table 1.3).

Depressive symptoms were measured using: the Schedule for Affective Disorders and Schizophrenia for School-Age Children diagnostic interview (Kaufman et al., 1997; n=2); the Children's Depression Inventory (Kovacs, 1992; n=1); and the Beck Depression Inventory (Beck et al., 1961; n=1) (Table 1.3).

Table 1.2.

Summary of Studies for Cross-Sectional Analysis (N=9).

Authors	Participant group and demographics	Outcome measures	Key findings	Effect estimate	Quality
Abela et al., 2006 Canada	140 children and adolescents (with one parent who had experienced a past or current episode of depression). 50.7% female. Aged 6–14 years (M=9.8, SD=2.3). 84.3% Caucasian.	RSSC; CDI	Children with higher levels of ERS reported greater elevations in depressive symptoms than children with lower levels of ERS following elevations in life hassles or parental depressive symptoms.	0.31	55.6%
Joiner, 1999 USA	68 youth psychiatric inpatients. 51.5% female. Aged 7–17 years (M=13.34, SD=2.5). 73.7% Caucasian; 17.6% African-American; 8.9% Hispanic.	RSSC; CDI	Depressive symptoms were associated interpersonal problems among youth psychiatric inpatients. Results held regardless of age. ERS was specifically related to depressive symptoms, rather than general emotional distress.	0.42	77.8%
Joiner, Metalsky, Gencoz & Gencoz, 2001 USA	72 youth psychiatric inpatients. 50% female. Aged 7-17 years (M=13.18, SD=2.59). 76.3% Caucasian; 19.4% African-American; 4.2% Hispanic.	RSSC; CDI	Depressed inpatients reported higher levels of ERS than patients with externalizing disorders. Findings converged with adult clinical sample.	0.4	55.6%

Nesi & Prinstein, 2015 USA	619 adolescents from low-middle socio-economic school population. 57.3% female. Aged 12–16 (M= 14.6). 47.9% Caucasian; 21.2% African-American; 23.4% Hispanic; 0.5% Asian; 5.5% other race.	RSSC; SMFQ	Technology-based social comparison and feedback seeking was associated with depressive symptoms, controlling for overall frequencies of technology use, offline ERS and prior depressive symptoms. Popularity and gender appeared to moderate this effect.	0.38	55.6%
Oppenheimer, Technow, Hankin, Young & Abela, 2012 (Study 1) USA	194 6th grade adolescent students. 56% female. Aged 10–13 (M= 11.56). 75.3% African-American. 71% of low socio-economic status.	RSSC; CDI	ERS and rumination were associated with depression in predominantly ethnic minority and low socio-economic status adolescents.	0.26	44.4%
Oppenheimer et al., 2012 (Study 2) USA	402 adolescent students from 3rd, 6th and 9th grades. 55% female. Aged 8-15 years (M=11.56). 63% Caucasian; 8% African-American; 10% Latino; 4% Asian or Pacific Islander; 15% mixed race or other race. 16% of low socio-economic status.	RSSC; CDI	ERS and rumination were associated with depression, after controlling for concurrent anxiety symptoms. ERS did not longitudinally predict depressive symptoms.	0.14	63.6%
Prinstein, Borelli,	598 adolescent students from 6th and	RSSC;	High levels of ERS was associated with	0.25	81.8%

Cheah, Simon & Aikins, 2005 USA	8th grades. 50% female. 87% Caucasian; 2% African-American; 4% Asian-American; 2% Latino-American; 6% mixed ethnic backgrounds. Middle-class socio-economic status.	CDI	increased depressive symptoms and negative consequences for friendship quality in girls.		
Siegel, 2004 USA	85 adolescent students from 9th and 10th grade. Aged 14–17 years (M=15.17; SD=0.79). 64.7% female. 90% Caucasian. Middle-class socio-economic area.	DIRI-RS; BDI	Higher levels of depressive symptoms were related to poorer friendship quality in girls.	0.26	75%
Stroud, Sosoo & Wilson, 2018 USA	126 adolescent female students from6th, 7th and 8th grades. Aged 11 –14 (M=12.39, SD=0.76). 82.6% Caucasian. Mostly middle-upper socio-economic class.	DIRI-RS; K-SADS-PL	ERS mediated link between rumination and interpersonal stress generation. ERS only mediated the link in interpersonal domains of romantic and peer social life, suggesting it is particularly toxic to certain types of relationships.	0.04	75%

RSSC=Reassurance Seeking Scale for Children (Joiner & Metalsky, 1995)
K-SADS-PL=Schedule for Affective Disorders and Schizophrenia for School-Age Children (Kaufman et al., 1997).
CDI=Child Depression Inventory (Kovacs, 1992).
SMFQ=Short Mood and Feelings Questionnaire (Angold et al., 1995)

DIRI-RS=Reassurance Seeking Subscale of Depression Interpersonal Relationships Inventory (Joiner & Metalsky, 2001).
BDI=Beck Depression Inventory

Table 1.3.

Summary of Studies for Prospective Analysis (N=4).

Authors	Participant group and demographics	Outcome measures	Effect estimate	Follow-up	Quality
Hankin, Young, Gallop & Garber, 2018 USA	467 adolescents (community sample, Aged 10–16. (M=13.14, SD=1.62). 57% female. 70% Caucasian; 12% African-American; 9% Asian/Pacific Islander; 9% mixed race or other.	RSSC; K-SADS-PL	0.08	36 months	83.3%
Oppenheimer et al., 2012 (Study 2) USA	402 adolescent students from 3rd, 6th, and 9th grades. 55% female. Aged 8-15 years (M=11.56). 63% Caucasian; 8% African-American; 10% Latino; 4% Asian/Pacific Islander; 15% mixed race or other race. 16% of low socio-economic status.	RSSC; CDI	0.11	3 months	58.3%
Siegel, 2004 USA	85 adolescent students (same sample as cross-sectional study).	DIRI-RS; BDI	0.22	6 months	75%
Stroud et al., 2018 USA	108 adolescent female students (same sample as cross-sectional study. No significant differences in demographics	DIRI-RS; K-SADS-PL	0.02	1 year	75%

reported).

RSSC=Reassurance Seeking Scale for Children (Joiner & Metalsky, 1995)
K-SADS-PL=Schedule for Affective Disorders and Schizophrenia for School-Age Children (Kaufman et al., 1997).
CDI=Child Depression Inventory (Kovacs, 1992).
DIRI-RS=Reassurance Seeking Subscale of Depression Interpersonal Relationships Inventory (Joiner & Metalsky, 2001).
BDI=Beck Depression Inventory

Quantitative Analysis

Cross-sectional studies.

The weighted mean EE (*r*) across all cross-sectional studies for the correlation between ERS and depression was 0.28 (95% confidence interval=0.18–0.38) when using a random effects model to allow for differences between the effect between studies (Riley, Higgins, & Deeks, 2011; Figure 1.2). This was a small effect, according to Cohen’s (1992) standards (0.1–0.3). Thus, higher reported levels of ERS were associated with higher levels of depressive symptoms.

High levels of heterogeneity were found (I^2=84%, τ^2=0.0224, p<0.01), according to Cochrane standards (75–100% represents considerable heterogeneity) (Cochrane Collaboration, 2011). Sub-group analyses were conducted to account for this. These analyses found that when studies where ERS was included as a moderating variable (i.e., did not measure the association between ERS and depression directly) were removed, heterogeneity reduced (I^2=56%, τ^2=0.0095, p=0.06). For the sub-group analysis, the effect estimate for the relationship between ERS and depression in this analysis was 0.27 (95% confidence interval=0.16-0.38). This suggests that the initial association found was reliable despite the variation between studies.

Visual inspection of a funnel plot (Figure 1.3) for these data sets suggested limited publication bias.

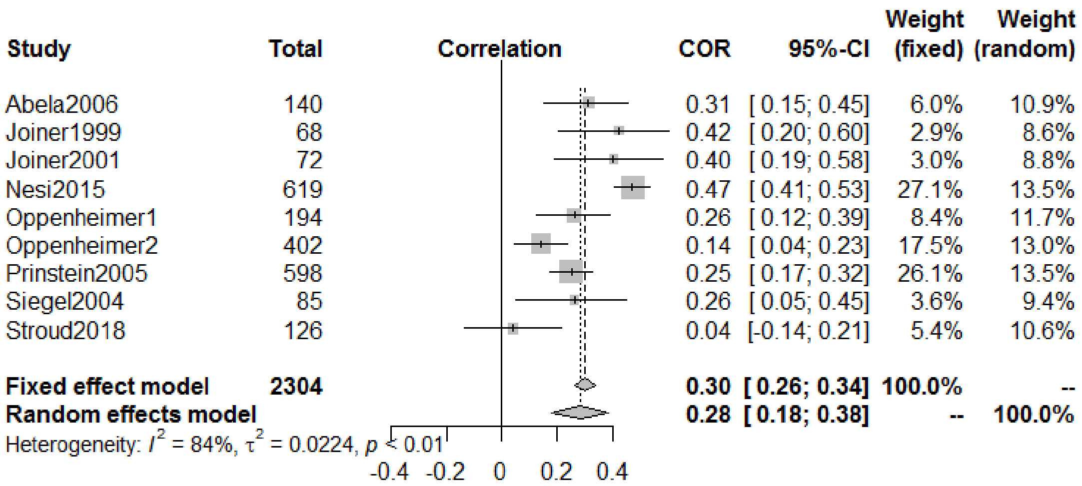


Figure 1.2. Forest plot of cross-sectional data sets.

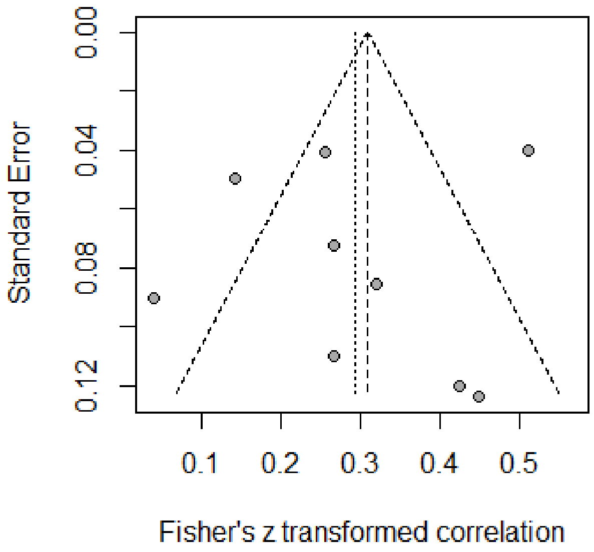


Figure 1.3. Funnel plot of cross-sectional studies.

Descriptive Findings.

Few studies reported on the effect of demographic variables on the relationship between ERS and depression. However, the findings that were reported are summarised below.

Age.

There were variations between the findings reported regarding age. Joiner (1999) found age did not impact on results, in a sample that ranged from participants aged 7–17 years old, suggesting that the association may have similar consequences for younger children and adolescents. However, in contrast, Abela et al. (2006) found that the association between ERS and depression following life hassles was greater for older children (over the age of 9 years old). They also found that younger children reported higher levels of reassurance-seeking.

Gender.

Nesi et al. (2015) found the same correlation between ERS and depression in both genders, suggesting no gender differences in this relationship. Prinstein et al. (2005) also found no differences in levels of reassurance-seeking between genders. However, they found that peer relations were only effected by reassurance-seeking in female participants.

Ethnicity.

Nesi and Prinstein (2015) found that ERS levels were significantly lower among Latino and Hispanic participants, when compared to Caucasian and African-American participants. No other study considered ethnicity.

Prospective studies.

The weighted mean EE (*r*) across prospective data sets (n=4) for the correlation between ERS and depression was 0.11 (95% CI=0.06–0.16) when using a random-effects model to allow for differences between the effect between studies (Riley et al., 2011; Figure 1.4). This demonstrated a positive small effect, according to Cohen's (1992) standards, suggesting that higher reported levels of ERS were associated with increased future depressive symptoms. The range between the confidence intervals was relatively narrow, meaning it is likely that this estimate is precise. However, it should be noted that the lowest boundary of the confidence falls below the range for a small EE, by Cohen's standards (1992).

Heterogeneity was assessed and was not indicated as important (Cochrane Collaboration, 2011) for this analysis (I^2 = 0%, τ^2=0, p<0.65).

A funnel plot for this analysis was visually inspected and suggested some possibility of potential publication bias (Figure 1.5). The absence of heterogeneity in this analysis may also imply publication bias, as it suggests limited variation between the types of studies included. However, no unpublished data was retrieved when requested from study authors, thus it is not possible to confidently conclude this.

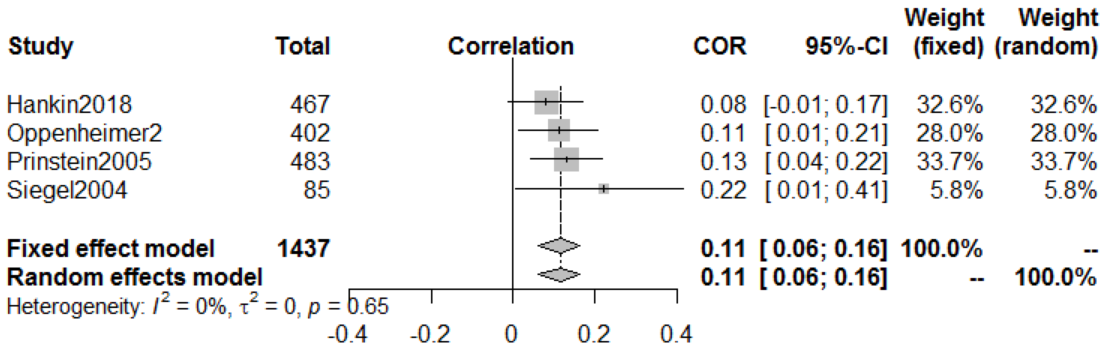


Figure 1.4. Forest plot of prospective studies.

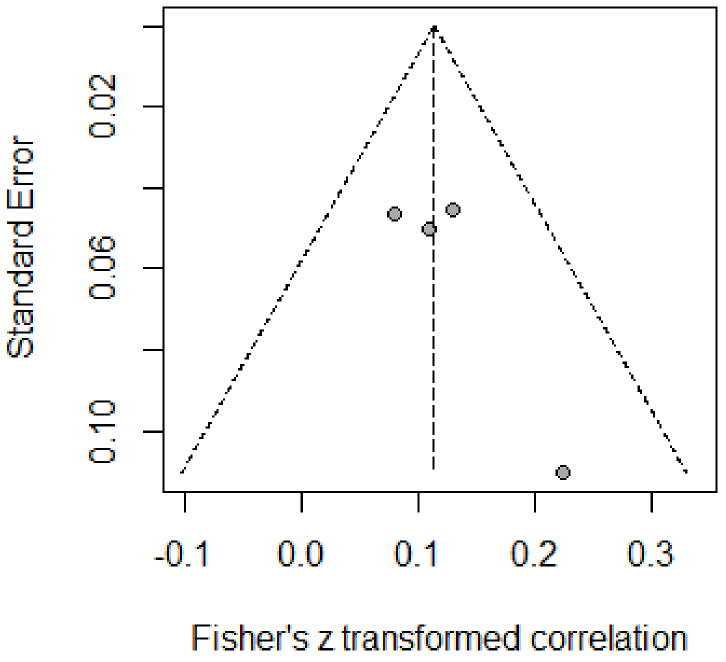


Figure 1.5. Funnel plot for prospective studies.

Discussion

This meta-analysis aimed to provide a quantitative synthesis of the reported association between ERS and depression in young people, both cross-sectionally and longitudinally. We aimed to add to existing literature about the association between ERS and depression, in order to consider support for the interpersonal model of depression (Coyne, 1976; Joiner & Metalsky, 2001) by assessing the application to younger populations. By investigating the prospective relationship between ERS and depression in young people, we hoped to consider the role of ERS as a vulnerability factor in the development of depression (Joiner et al., 1999).

Cross-sectional Studies

Findings from nine studies were combined. The results showed a positive small relationship (0.28) between ERS and depression, when measured cross-sectionally. This is in line with the findings of Starr and Davila (2008), who found a medium positive relationship of a similar size (0.32) between ERS and depression in largely adult populations. It is worth noting there was a considerable level of heterogeneity between studies (Cochrane Collaboration, 2011). However, when this was reduced, a very similar EE was found (0.27), which was also in line with previous findings.

The high levels of heterogeneity may have been due to the differences between types of samples: for example, two studies included clinical samples whereas the rest reported data from community samples, recruited through schools and community advertisement, meaning there would likely be differences between participants' depression severity levels. There was also a wide age range of participants across studies, between 6–17 years of age, which is likely to contribute to heterogeneity, given the considerable interpersonal development that occurs in this period. Additionally, a range of different measures were used to measure levels of ERS and depression.

This meta-analysis therefore adds further support to the interpersonal theory of depression (Coyne, 1976), by showing that young people with higher levels of ERS behaviours also experience increased depressive symptoms. Additionally, three of the studies (Joiner, 1999; Joiner et al., 2001; Oppenheimer et al., 2012) found that ERS was specific to depression as opposed to other mental health problems or general emotional distress in young people. This suggests that similar interpersonal processes occur in childhood, adolescence and adulthood with regard to ERS. This implies that the interpersonal theory of depression can be applied to younger people and that ERS may be one of the processes that influences child and adult experiences of depression. It could be concluded that the relationship between ERS and depressive symptoms originates in childhood and adolescence and extends through to adulthood.

This is in accordance with research that shows the importance of key peer relationships to young people (Collins & Laursen, 2004; Prinstein et al., 2005). Previous research shows that adolescents begin to rely more heavily on their peers for social support and forming their identity, therefore it would be expected that those experiencing low mood may seek reassurance specifically from their peers to enhance their mood and respond to negative beliefs about their self-worth. However, if rejection occurs as a result of this reassurance-seeking behaviour, it would fit with existing literature that higher levels of depression would be experienced as peer opinion has been shown to be important to this age group (Collins & Laursen, 2004).

Prospective Studies

The prospective effect of ERS on depressive symptoms was also considered by this meta-analysis, by combining the results of four studies (n=1062). A small positive relationship was found between ERS and depressive symptoms in young people, up to a period of 3 years. This is the first study to quantitatively summarise the prospective relationship between ERS and depression, therefore it is not possible to compare this finding with an adult population. This finding gives support to Joiner et al.'s (1999) assertion that ERS is likely to contribute to the development of depression. This also demonstrates a prospective relationship over a longer follow-up period than previous summaries of the data (which included follow-up data of up to two years). As might be expected, a smaller association was found longitudinally than cross-sectionally. This suggests that while ERS has a role in the development of depression, the association is not as strong as the correlation found when the individual is already experiencing depressive symptoms. This could be interpreted as evidence showing that reassurance-seeking is a behaviour that occurs alongside low mood, with ERS levels varying as a result. However, it is still likely to have negative interpersonal consequences and may result in higher rates of rejection, as the interpersonal theory of depression proposes (Coyne, 1976).

Age

This review also aimed to contribute to a developmental perspective of the impact of ERS on depression. The analysed data included samples of young people, with participants as young as six years old in some samples. The positive correlation that was found when including these participants implies that ERS is a behaviour that exists even within young children. From this, we could conclude that reassurance-seeking behaviour may begin to have implications for mental health and the development of depressive symptomatology from a very young age.

However, a limited number of the studies controlled for the impact of age, meaning it is difficult at this stage to fully understand at which point the relationship between ERS and depression develops or becomes problematic, and if there is a distinction between the effect in young children and adolescents. As discussed, the studies that considered the impact of age reported varying findings, with one study showing that age was a factor (Abela et al., 2006) whereas another did not (Joiner, 1999). Abela et al.'s findings could be interpreted as showing that the negative implications of ERS on mood and relationships may increase as a function of age, and that reassurance-seeking behaviours are considered more acceptable in childhood.

The difference between these findings may be accounted for as Joiner (1999) utilised a clinical sample of psychiatric inpatients, whereas Abela et al. (2006) utilised a community sample. It may therefore be expected that the younger participants of Joiner's (1999) sample would have higher levels of depressive symptoms than participants from a community sample, and have consequently experienced greater interpersonal difficulties, which may contribute to a stronger association in younger children.

As few studies controlled for age, further research is needed to understand the impact of age, which may contribute to a better understanding of when ERS becomes problematic and less socially acceptable for younger people. It may be helpful to understand at which point ERS leads to rejection from peers, which could result in lower mood, in order to find ways to prevent this and inform appropriate points of intervention. If it is the case that the negative implications of ERS increase as a function of age, this would suggest that psychoeducation or prevention work would be better suited for older children, in cases where they do not naturally reduce this behaviour as they mature. Clinically, it may be useful to monitor ERS behaviours in children who are at risk of developing depression as they age, to ensure this behaviour does not reach levels that become socially unacceptable to others.

Gender

Two studies also reported the impact of gender, again with mixed findings between studies about whether this affected the relationship between ERS and depression. Prinstein et al.'s (2005) finding that peer relations were only effected by reassurance-seeking in female participants suggests that reassurance-seeking may have more negative consequences among female relationships.   Previous research has highlighted differences between gender in interpersonal relationships in adolescents, in that girls form closer relationships with their peers, with greater levels of emotional support than boys (Furman & Buhrmester, 1992) and also report more increases in low mood as a consequence of interpersonal stress than boys (Rudolph et al., 2001). It may therefore be expected that ERS would have greater interpersonal consequences and consequently contribute to increased depressive symptoms in girls than boys, as suggested by Prinstein et al.'s (2005) findings. However, further research is needed to explore this further.

Ethnicity

Most previous research in this area has consisted of samples that were predominantly Caucasian. This meta-analysis was able to include the results of one study utilising a sample which mostly consisted of participants who identified as ethnic minority groups and lower socio-economic status (Oppenheimer et al., 2012). This tentatively suggests that the association between ERS and depression may extend across cultures. Nesi and Prinstein (2015)'s finding that ERS levels were significantly lower among Latino and Hispanic participants suggests it may be interesting to explore the role of culture and ethnicity on the relationship between ERS and depression in more detail.

Clinical Implications

The findings of this research suggest that ERS is a core facet of depression regarding interpersonal relationships in children and young people. This has clinical implications as previous research has not conclusively demonstrated this effect previously. The studies using clinical samples also suggest that ERS is specific to depression, rather than overall emotional difficulties.

Two studies noted clinical implications regarding ERS and depression. Joiner et al. (1999; 2001) highlight that ERS behaviour, and its associated cognitions and assumptions, could be an important target of therapeutic interventions for depression. Additionally, they note the importance of psychoeducation regarding the nature and effects of ERS in reducing and preventing depressive symptoms for people suffering from depression, their close others or people that are vulnerable to developing depression.

This research also highlights the importance of peer experiences in this age group and its potential impact on their mental health. It may therefore be beneficial to focus on interpersonal relationships within a therapeutic context for those struggling with depression, as well as considering how their own experiences and behaviours may impact on their important relationships and interactions with others. It is worth considering that some existing individual interventions for depression in children, such as behavioural activation within a cognitive behavioural therapy (CBT) approach, may focus on increasing social behaviours and interactions with others in order to improve mood. In cases of high levels of ERS, this could potentially have detrimental effects for the individual, if they experience increased rejection when in contact with others. The results of this study therefore suggest that before undertaking this type of intervention within a CBT framework, a thorough individualised formulation would need to be produced, to include the impact of ERS behaviours and the potential maintaining effects that ERS or rejection could have for low mood and confirming existing core beliefs or negative thoughts. The interpersonal processes and the quality of social activities may need to be assessed before or alongside encouraging increased social interaction, to ensure this has positive consequences. The potential implications could then be included in the formulation, and steps may need to be taken before practising these activities, such as role play during therapy or practice and exposure to resisting seeking reassurance from others, to ensure social interactions have positive consequences.

As the research shows a clear association between ERS and depression, this suggests that ERS behaviour could serve as a sign of developing depressive symptoms in younger children and adolescents. Clinically, it may be useful to assess interpersonal behaviours in cases of suspected depression. It may also be helpful to educate important adults in children's lives (e.g. parents, teachers and health professionals) about important interpersonal processes, so they can monitor these behaviours for indications of subtle mood changes, in order to respond quickly. Psychoeducation may also help them to recognise when reassurance-seeking behaviour becomes excessive or outside of social norms, in order to monitor whether this has negative interpersonal implications for their children, and thus reduce the likelihood of developing depression.

As a preventative method, it may also be helpful to teach young adolescents to self-reassure and build self-esteem, so they have less need for ERS behaviours that may put them at risk of rejection and increased levels of depressive symptoms. This may be achieved through parenting programmes or through elements of school education.

Limitations and Suggestions for Further Research

As previously mentioned, the meta-analysis for cross-sectional studies showed high heterogeneity, which questions the validity of combining the aggregate data. This limits the conclusions that can be drawn from this summary. However, when heterogeneity was adjusted for, the EE was very similar (difference of 0.01), which implies that the results held despite the variation between studies.

The studies mostly relied on self-report measures of ERS and depression, recognised previously as limiting the ERS literature as this form of assessment is likely to result in a stronger relationship between ERS and depression (Starr & Davila, 2008). To verify the amount of reassurance-seeking conducted, future research would benefit from incorporating other measures of this behaviour, such as others' ratings. Additionally, further research would benefit from using interview measures to measure levels of depression.

The uneven split of studies utilising community or clinical samples means it is unclear whether a higher association is due to higher clinical levels of depression. Additionally, response bias may be inherent in the predominantly opt-in community samples: those choosing to take part perhaps being less effected by mental health or interpersonal difficulties and more protected from the negative impact of ERS or depressive symptoms. This might have resulted in a lower association. A higher association may be found by using more clinical samples or more inclusive community samples. Alternatively, it is possible that those experiencing higher levels of depressive symptoms were more likely to take part as a way to seek help or understand more about their difficulties.

Furthermore, some studies included the association between ERS and depression as a potentially moderating variable, rather than the primary outcome of the study. Consequently, many did not control for possible confounding factors. To clarify the impact of ERS, further research would benefit from controlling for the effects of factors such as age, gender, and other interpersonal processes. This may help inform possible points of intervention.

Given that previous research has suggested that points of social support change between childhood and adolescence, it may be interesting to investigate whether ERS has different consequences within different relationships, such as when conducted with parents or peers, and who younger people predominantly seek reassurance from (e.g. friends or parents). It may also be interesting to contrast different types of parenting relationships, such as foster parent relationships.

This research focused specifically on the relationship between ERS and depression, therefore further research is needed to consider how this association fits within the bigger picture, including other interpersonal processes, when considering peer relationships and mental health for this age group.

To extend support for the interpersonal theory of depression (Coyne, 1976) in a younger population, it would be helpful to develop more of an understanding of other concepts of this theory as they apply to younger people, such as rejection as a result of ERS. Further models have also extended this theory (Evraire & Dozois, 2011) to include other interpersonal behaviours that impact on ERS and depression with adults, such as negative feedback seeking. Therefore research is needed to establish whether these concepts also extend to younger populations. Few studies considered the prospective relationship between ERS and depression, therefore further research is needed to establish the nature of this relationship, within the context of other interpersonal factors. Additionally, the results of this study suggest that ERS may begin to contribute to depressive symptoms in early life, which then continues in to adulthood. To confirm this, it would be helpful for further longitudinal research to follow a cohort from child to adulthood.

In addition, to enhance support for this theory, further research could investigate whether interventions that aimed to target and reduce reassurance-seeking behaviour were effective in also reducing symptoms of depression in younger people. Alternatively, an experimental approach could be utilised to investigate the impact on mood if reassurance-seeking behaviour was increased i.e. whether participants would experience lower mood if they engaged in higher levels of reassurance seeking. This could be compared across different ages of childhood and adolescence, to understand more about the developmental perspective of this theory.

Conclusion

This study aimed to extend research on the association between ERS and depression by quantitatively summarising this relationship in younger people and investigating ERS behaviour as a vulnerability factor for depression. The results found a positive small association between ERS and depression in younger people, similar to that found in predominantly adult populations, which suggests this is a behavioural process that may originate in younger years. Furthermore, a small prospective association between ERS and depressive symptoms was found. Further research is needed to clarify the role of ERS as a vulnerability factor for the development of depression. This has potential clinical implications for preventing depression, particularly regarding psychoeducation for significant adults in younger people’s lives and potential points of intervention regarding interpersonal relationships.

References

Abela, J. R., Zuroff, D. C., Ho, M.-H. R., Adams, P., & Hankin, B. L. (2006). Excessive reassurance seeking, hassles, and depressive symptoms in children of affectively ill parents: A multiwave longitudinal study. *Journal of Abnormal Child Psychology*, *34*(2), 165-181.

Angold, A., Costello, E., Messer, S., Pickles, A., Winder, F., & Silver, D. (1995). Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. *International Journal of Methods in Psychiatric Research*, *5*, 237-249.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*(6), 561-571.

CASP. (2019). CASP Checklists. Retrieved from https://casp-uk.net/casp-tools-checklists/

Cochrane Collaboration. (2011). *Cochrane handbook for systematic reviews of interventions version 5.1*. Higgins JPT: Green S.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112,* 155-159.

Collins, W. A., & Laursen, B. (2004). Changing relationships, changing youth: Interpersonal contexts of adolescent development. *The Journal of Early Adolescence*, *24*(1), 55-62.

Coyne, J. C. (1976). Toward an interactional description of depression. *Psychiatry, 39*(1), 28-40.

Evraire, L. E., & Dozois, D. J. (2011). An integrative model of excessive reassurance seeking and negative feedback seeking in the development and maintenance of depression. *Clinical Psychology Review*, *31*(8), 1291-1303.

Furman, W., & Buhrmester, D. (1992). Age and sex differences in perceptions of networks of personal relationships. *Child Development*, *63*(1), 103-115.

Glied, S., & Pine, D. S. (2002). Consequences and correlates of adolescent depression. *Archives of Pediatrics & Adolescent Medicine*, *156*(10), 1009-1014.

Hankin, B.L., Young, J.F., Gallop, R., & Garber, J. Cognitive and interpersonal vulnerabilities to adolescent depression: classification of risk profiles for a personalized prevention approach. (2018). *Journal of Abnormal Child Psychology*, *46*, 1521-1533.

Hammen, C. (2009). Adolescent depression: Stressful interpersonal contexts and risk for recurrence. *Current Directions in Psychological Science*, *18*(4), 200-204.

Harrington, R., Fudge, H., Rutter, M., Pickles, A., & Hill, J. (1990). Adult outcomes of childhood and adolescent depression: I. Psychiatric status. *Archives of General Psychiatry, 47*(5), 465-473.

Joiner, T. E. (1999). A test of interpersonal theory of depression in youth psychiatric inpatients. *Journal of Abnormal Child Psychology, 27*(1), 77-85.

Joiner, T. E., & Metalsky, G. I. (1995). A prospective test of an integrative interpersonal theory of depression: A naturalistic study of college roommates. *Journal of Personality and Social Psychology, 69*(4), 778-788.

Joiner, T. E., & Metalsky, G. I. (2001). Excessive reassurance seeking: Delineating a risk factor involved in the development of depressive symptoms. *Psychological Science, 12*(5), 371-378.

Joiner, T. E., Metalsky, G. I., Gencoz, F., & Gencoz, T. (2001). The relative specificity of excessive reassurance-seeking to depressive symptoms and diagnoses among clinical samples of adults and youth. *Journal of Psychopathology and Behavioral Assessment, 23*(1), 35-41.

Joiner, T. E., Metalsky, G. I., Katz, J., & Beach, S. R. (1999). Depression and excessive reassurance-seeking. *Psychological Inquiry, 10*(3), 269-278.

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., . . . Ryan, N. (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(7), 980-988.

Kovacs, M. (1992). *Children's Depression Inventory: Manual.* North Tonowana, NY: Multi-Health Systems.

Lim, G. Y., Tam, W. W., Lu, Y., Ho, C. S., Zhang, M. W., & Ho, R. C. (2018). Prevalence of Depression in the Community from 30 Countries between 1994 and 2014. *Scientific Reports, 8*(1), 2861.

Nesi, J. & Prinstein, M.J. (2015). Using social media for social comparison and feedback-seeking: Gender and popularity moderate associations for depressive symptoms. *Journal of Abnormal Child Psychology, 43*, 1427-1438.

Oppenheimer, C. W., Technow, J. R., Hankin, B. L., Young, J. F., & Abela, J. R. (2012). Rumination and excessive reassurance seeking: Investigation of the vulnerability model and specificity to depression. *International Journal of Cognitive Therapy, 5*(3), 254-267.

Petty, S. C., Sachs-Ericsson, N., & Joiner Jr, T. E. (2004). Interpersonal functioning deficits: Temporary or stable characteristics of depressed individuals? *Journal of Affective Disorders, 81*(2), 115-122.

Pine, D. S., Cohen, P., Gurley, D., Brook, J., & Ma, Y. (1998). The risk for early-adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. *Archives of General Psychiatry, 55*(1), 56-64.

Prinstein, M. J., Borelli, J. L., Cheah, C. S., Simon, V. A., & Aikins, J. W. (2005). Adolescent girls' interpersonal vulnerability to depressive symptoms: A longitudinal examination of reassurance-seeking and peer relationships. *Journal of Abnormal Psychology, 114*(4), 676-688.

Riley, R.D., Higgins, J.P.T. & Deeks, J.J. (2011). Interpretation of random effects meta-analyses. *BMJ, 342,* d549.

Rudolph, K. D., Flynn, M., & Abaied, J. L. (2008). A developmental perspective on interpersonal theories of youth depression. *Handbook of Depression in Children and Adolescents*, 79-102.

Siegel, L. (2004). *Peer group experiences, friendship quality, and depressive symptomatology in adolescence: a longitudinal analysis.* (Unpublished dissertation). Temple University.

Starr, L. R., & Davila, J. (2008). Excessive reassurance seeking, depression, and interpersonal rejection: a meta-analytic review. *Journal of Abnormal Psychology, 117*(4), 762-775.

Stroud, C.B., Sosoo, E.E., & Wilson, S. (2018). Rumination, excessive reassurance seeking, and stress generation among early adolescent girls. *Journal of Early Adolescence, 38*(2), 139-163.

Weissman, M. M., Wolk, S., Goldstein, R. B., Moreau, D., Adams, P., Greenwald, S., . . . Wickramaratne, P. (1999). Depressed adolescents grown up. *Jama, 281*(18), 1707-1713.

World Health Organisation (2017). Depression and Common Mental Disorders: Global Health Estimates. *Geneva: World Health Organization,* 1–24.

(Page left intentionally blank)

Service Improvement Project

A Qualitative Study Investigating the Transition between Adult Eating Disorder Inpatient Care and Community Services

May 2019

Internal Supervisor: Dr James Gregory
External Supervisor: Dr Sanni Norweg

Word Count: 5360
Target Journal: International Journal of Eating Disorders

(Page left intentionally blank)

A Qualitative Study Investigating the Transition between Adult Eating Disorder Inpatient Care and Community Services

Background

Eating disorders (ED) are a significant and distressing issue, with anorexia nervosa (AN) associated with the highest mortality rate of any mental health problem (Treasure, Schmidt, & Hugo, 2005). Consequently, many sufferers require inpatient treatment (APA, 2006; Colton & Pistrang, 2004; Richard, 2005). The transition from inpatient care to other services can be challenging, which is highlighted by statistics showing high rates of relapse and re-admission for service users with EDs and other mental health problems (Lyons et al., 1997; Treasure, Todd & Szmukler, 1995; Vandereycken, 2003). The average reported relapse rate for adults with EDs following hospitalisation is 30% (Olmsted et al., 2010); and research found that 27% of adult AN inpatients were re-admitted to hospital within 3 years after leaving (McCabe, 2008).

Inpatient care can be costly, with recent calculations showing the cost of adult patients admitted to NHS specialised eating disorder services between 2015-2016 was £39,653,000 (NICE, 2017). ED diagnoses have been associated with longer inpatient admissions than other mental health problems (Warnke & Rossler, 2008); the average length of stay for adult inpatients with EDs is reported as 11.8 weeks (Kästner et al., 2018).

Although hospitalisation for service users with EDs is generally effective in reducing immediate physical danger (Colton & Pistrang, 2004; Offord, Turner, & Cooper, 2006), recommendations regarding general mental health have suggested that rehospitalisation should be avoided where possible so service users have time to develop the skills needed for independent living, gain work experience and develop support through maintaining a social life (Thompson, Neighbors, Munday, & Trierweiler, 2003). Given the costs associated with inpatient care, it is important that inpatient admissions are utilised effectively and that further hospitalisation is avoided if possible.

Times of transition, such as leaving hospital, can contribute to difficult experiences. Research indicates that major life transitions can negatively impact on people’s general psychological well-being (Lee & Gramotnev, 2007). Further, literature suggests that other types of transitions for service users with EDs can be problematic, such as between tiers of services and between child and adolescent services to adult services (Treasure et al., 2005). Challenges associated with transitions include the lack of clear procedures for managing transitions between services, navigating and adapting to different treatment approaches and increased personal responsibility, and increased risk (Dimitropoulos et al., 2015; Treasure et al., 2005). It is therefore imperative that significant transitions for this client group are managed well, as poor transfers of care can lead to disengagement or under use of services, resulting in poorer outcomes (Davidson, Cappelli, & Vloet, 2011).

Various factors can complicate the transition of leaving inpatient support and returning to the community. Firstly, previous research has shown that both adult and adolescent inpatient service users can develop an attachment to the inpatient treatment environment, and identify the structure, support and “refuge” found as a positive aspect of hospitalisation (Colton & Pistrang, 2004; Johansson, Skärsäter, & Danielson, 2009; Smith et al., 2016). Consequently, reduction in this support following discharge is likely to be difficult. Research investigating service users’ experiences of inpatient treatment has also highlighted the difference felt between the hospital environment and the “real world”, which again implies that the transition from hospital to community services is likely to be difficult. For example, service users have identified feeling dependent on others or “trapped”, as a result of reduced choice and personal influence (Johansson et al., 2009), whereas other have identified feeling removed and disconnected with “normality” (Smith et al., 2016).

To manage this difficult transition, it has been suggested that discharges from ED inpatient care should be well-planned in order to feel manageable, as part of a step-down plan for service-users towards taking responsibility for their eating and recovery (Olmsted et al., 2010). Previous research has also indicated that lower body mass index (BMI), duration of AN and amenorrhea predicted an increased likelihood of readmission to inpatient care, following transition to day-patient services (Howard, Evans, Quintero-Howard, Bowers, & Andersen, 1999).

The Current Research

While previous research has explored service users’ experiences in inpatient wards and physical risk factors for readmission, little is known about the experience of the transition from inpatient support to the community in patients with EDs.

This need for this service improvement project was identified by the panel of People with Personal Experience (PPE) for a specialist ED service. They raised the transition between inpatient care and community services as an aspect of the service that they felt was important to improve. This notion was shared by staff in the service, who reported anecdotally that many inpatients returned to hospital quickly after being discharged. Staff reported feeling this created an issue in terms of disruption to service users' lives, maintaining progress in the community, and costs to the service. The field supervisor therefore suggested this as an idea for service improvement when approached by the lead researcher.

This research therefore aimed to qualitatively investigate service users' views on the transition from inpatient wards to the community, and how this could be improved, in order to provide recommendations to the service.

This research aims to investigate the following research questions:

1) How is the transition between inpatient care and community services experienced by adult service users with EDs?
2) How could this transition be improved?

Method

Participants

In total, eight adult participants were recruited (7 female; 1 male; aged 21-49, M=32, SD=9.23); at the time of data collection four participants were hospitalised and four were using community services. All participants had a diagnosis of a restrictive ED and had experienced at least two inpatient admissions at a specialist ED unit. The service was a specialist ED team, which consisted of community and inpatient components and was staffed by a multidisciplinary team (including psychological, medical, dietetic, physiotherapy, occupational therapy, art psychotherapy and nursing input). The number of admissions ranged between two and four (M=2.75, SD=0.83).

Participants were recruited by clinicians from the service and the project was advertised by a poster in the service. All had capacity to consent.

Design and Procedure

The research adopted a qualitative design in order to understand participants' experiences and gather detailed information about how the transition could be improved. Data was collected using individual, semi-structured interviews.

The interviews consisted of eight questions (Appendix 2A) about participants' experiences of transitioning from inpatient care and how this could be improved. These questions were developed with the service's People with Personal Experience (PPE) panel and were considered to be understandable and appropriate for the needs of the project.

Interviews were conducted by the lead researcher in a quiet, private room at the service. They lasted approximately 30–60 minutes. Audio was recorded for data analysis purposes.

Qualitative Analytic Plan

Data was analysed using thematic analysis, in line with Braun and Clarke (2006), from a critical realist epistemological position. This flexible approach allowed for unexpected findings about a topic that is not currently well understood (Braun & Clarke, 2006). All interviews were transcribed and analysed by the lead researcher. Following transcription, she re-read the transcripts several times to ensure familiarity with the data, then created initial codes based on the data. Initial codes were developed into potential themes, which were reviewed to ensure they represented overall patterns of the data. Finally, themes were appraised to confirm distinction between themes and definitions of each theme were written.

Researcher Reflexivity

To achieve integrity and quality in the research, the lead author considered her own assumptions and expectations throughout conducting the research and kept a research diary to encourage self-reflection (Ortlipp, 2008). The data was not coded by a second researcher as it has been previously recognised that thematic analysis research to some extent reflects the interpretation of the researcher, and their personal experiences will unavoidably impact on the analysis process (Shaw, 2010; Terry, Hayfield, Clarke, & Braun, 2017). Instead, to assure research quality, supervisory reflective sessions were held between the first and second author to identify possible biases and protect from forming inappropriate conclusions throughout the analysis.

The Researcher

The researcher was a white, middle class female who was training to be a Clinical Psychologist at the time of conducting the research. This project was completed as part of this training.

She did not have personal experience of EDs or identify as having disordered eating behaviour. The researcher had previously conducted a research project with young people with EDs about their use of social media. She did not have an experience of a hospital admission, for either mental or physical health problems.

Ethical Approval

Ethical approval was granted by the University of Bath (reference: 17-174, Appendix 2B) and by the AWP Research & Development (reference: E2017.019, Appendix 2C) ethical approval boards.

Results

The analysis identified four overarching themes: 1) reintegration into the "real world"; 2) hospital as a "safe base" for recovery; 3) extreme change in levels of support; and 4) learning from admissions (Table 2.1).

Table 2.1

Summary of Themes, with Suggestions for Improvements given by Participants

Theme	Suggestions for improvements
Re-integration into the "real world"	Increased support with practical activities (e.g. cooking and meal plans, practising eating in hospital and "real world" settings, social activities, finding local support in the community) Increased occupational therapy (OT) and dietetic input Provision of information about healthy eating and diet, eating disorders and recovery process Provision of information and support for close others Support with finances (e.g. benefits and disability allowances, support with returning to work) Increased home visits from health professionals Longer graduated discharge period and more information about what to expect
Hospital creates a "safe base"	Consistency and continuity of involvement from health professionals, after discharge Suggestions for ways to stay in touch with other inpatients
Extreme change in level of support	Day-patient services Gradual reduction in support after leaving hospital, with more intense support immediately after leaving Regular "check-ins" (e.g. planned phone call from services) from familiar staff, particularly during the first couple of weeks after leaving hospital A phone line that service users can use to reach out after leaving hospital Consistency and continuity of involvement from health professionals, after leaving hospital (to avoid gaps in care)
Learning from admissions	Increased information about what to expect from admissions A "buddy" system with other inpatients, who could help explain the system.

Re-integration into the "Real World"

Participants described significant differences between the hospital environment and their home environment in the community, which was frequently referred to as the "real world". As a result, re-integration into their community environment after leaving hospital was described as difficult in numerous ways. For example, five participants discussed the adjustment from having a strict routine on the ward and the challenges of having less structure in the community or trying to make these routines fit with their "real lives", such as sticking to meal plans around other life commitments.

P4: "You kind of expect yourself to stick to the times that the ward gave you. When realistically that's not always gonna happen. You're gonna have like, situations where your lunch break ran a bit later or something like that."

Additionally, participants discussed feeling that their life had "moved on" following their admission, leaving behind gaps or changes in roles, such as changes to their occupation, re-adjusting to family roles and dynamics and the challenges of re-establishing important social relationships.

P3: "When you go home …you kind of don't feel like you belong there anymore … You kind of feel like a visitor in your home …your family have got on with life without you."

Six participants explained that, before their admission, their ED had been very time-consuming and provided structure and a sense of control, or they had lost important aspects of life as a result of their illness. It was therefore challenging to fill those gaps with healthy activities and alternative coping mechanisms, when trying to re-adjust to life in the community.

P1: "(I was) worrying about coming out and how I would fill my time…before I went in I was doing a ridiculous amount of exercise…and obviously I'd stopped all exercise when I went in there...so to come out and have nothing planned in my day (was difficult)"

Six participants explained that it was easy to fall back into ED habits when faced with stressful life events in the community.

P7: "You just end up falling back into old habits that gave you comfort…in order to kind of, get a sense of.... control".

Additionally, participants discussed the disparity between their physical and psychological recovery, and that maintenance of their progress is somewhat dependent on their approach to recovery or "mindset". Some acknowledged said they thought the physical recovery (e.g. reaching a healthier weight) was more valued by the hospital and so service users may leave hospital when they are physically better but that their psychological recovery may lag behind this.

P2: "Yes, I had regained some weight but my thought patterns hadn't changed".

With this in mind, seven said they valued psychological therapy and thought it was useful to focus on psychological maintenance factors while in hospital. Some particularly referenced wanting to work on improving body acceptance and body image.

P3: "For me body image work would have helped. Definitely."

To cope with leaving hospital, and as a suggestion for improvement, participants described finding it helpful to have support with more practical aspects of life to make the re-integration back to the "real world" easier. Six participants said they would value support with "normal" life activities to help re-integrate into society again.

P5: "Things like (breakfast club) are really helpful…that would help transitioning. That's normal life…And you lose sight of what normal is."

Additionally, many said they would value increased support with managing the practicalities of spending time in hospital, such as implications for working or financial support. Participants also described finding dietetic and (OT) input useful, to learn about diet, healthy eating habits and practising cooking. Three said it would be useful to have more OT input on the ward to consolidate these skills.

P8:"I said that I really want to focus on life skills…there's a lot of focus on while you're in there, that it's just a bit of a transit relating it to the real world".

When considering improvements for leaving hospital, many participants discussed the importance of preparation and "having things in place" before leaving (Table 2.1).

P2:"I want to know like…what sort of meals I need to eat. I want help with meal planning".

P5:"I think because my husband didn't have any help and he didn't know what to do…so he felt powerless."

Graduated discharge (GD) was described as helpful as participants were able to adjust to being at home again, while continuing to feel "held" by hospital and being able to return and reflect on their experience at home. Two participants suggested it would be helpful for graduated discharge to last longer than three weeks and a further two said they would like more information about what to expect from the GD programme.

P2:"I just think it would be useful to have a clearer plan of how um (2) things work in terms of discharge…it's quite hard when you're here as an inpatient...planning your graduated discharge and knowing what to ask for and...what things to get set up for when you leave".

When discharge was experienced as rushed, this resulted in participants feeling disappointed if they had not made tangible progress. As such, it seemed to be helpful to have specific goals to reach during their admission.

Hospital Creates a "Safe Base"

Participants described feeling like the ward was very separate to their lives in the community and a number described it as a "bubble", which was "cut off" from the stress of "real life". This appeared to create a sense of safety, as they felt taken care of and protected from maintaining factors for their ED in the community.

P8: "When I'm in the unit, it can feel like a bit of a bubble…When I'm out in the real world, I have to face up to the real facts."

Participants also discussed having developed strong relationships with other inpatients in hospital, which contributed to this sense of safety as they valued the shared experiences and peer support they experienced. Many also described developing trusting relationships with staff members. Six participants discussed that having constant company (although initially an adjustment for some), meant there was always someone to talk to at difficult moments, which they missed after leaving hospital. For some, this understanding was missing from their "real world" relationships.

P1:"it was amazing to be around people who I could talk to about (my ED) and understood. Because…that's the first time in my life that anyone had actually (1) understood about it maybe".

Consequently, participants appeared to feel contained by being in hospital. Additionally, they described that the structure of the ward and limitations regarding food choice contributed to a sense of abdicating their responsibility for their ED as major decisions were out of their control. To some extent, this seemed to contain their EDs and some described feeling that they had the opportunity to explore or re-visit their identity away from their ED.

P6:"Being in the ward it's like, your ED goes into day care…And it's only you in there….it makes you feel like a human again...just being able to...be you for a while…The food and that side of things… was out of my control, therefore not my fault."

Extreme Change in Level of Support

Six participants described finding it difficult to leave hospital because they went from having constant support available, from people with understanding of EDs, to much more limited support in the community.

P3:"It's a massive step to go from having somebody available to talk to you...at any point… to essentially having your once a week appointment...I don't know whether it *would be (2) possible for some sort of like, check in from the ward…for the first week or so."*

Five described feeling isolated after leaving the ward and somewhat abandoned by hospital staff and left to cope on their own.

P4:"It's almost kind of like you've been given all of this help and then you're just kind of like thrown out of there…And it's just kind of like "do it by yourself" …So I think it is quite a shocking feeling…And really overwhelming."

This was in spite of an awareness of the process and limited resources and many recognised that the staff do what they can to help.

P5:"Your bed's hardly cold before the next one goes in".

This sense of rejection or abandonment appeared more difficult when there was a lack of consistency or gaps in care. It also seemed particularly challenging for those living further away, who therefore had to travel or had less access to community care. Many said they hoped to find similar support in their local area but found this difficult.

A number of suggestions for improvements were given regarding this issue (Table 2.1). Five participants said they thought a day-patient service would be beneficial as it would reduce the jump in the level of support available between the hospital environment and the community.

P6: "I thought you'd go from in the ward, to day therapy …that would make the transition really…much better…it would bridge the gap in that you're not seven days completely left to your own devices."

Six described finding it difficult to reach out to hospital staff or loved ones at home when they were struggling, therefore said it would be helpful for staff to reach out to them instead (i.e. a "check in" system) or to know when they could expect to have contact with someone, which would help them feel held in mind.

P4: "When you go home you just think right, that's it. I'm all by myself now. And just having that like, 20 minute phone call, kind of makes you realise that you weren't forgotten…Like, they still care"

Learning from Admissions

Participants explained that over time, their experience of being in hospital then leaving hospital changed, as they learned more about what to expect, how to cope and how to "make the most" of the admission. First admissions were described as being scary and overwhelming as they did not know what to expect.

P2: "I didn't really know what to expect of the unit. It was just so overwhelming...and the environment frightened me…Whereas for this admission we took maybe six weeks to plan it…I asked loads of questions about it and I was given loads of information…and I had time on the ward as well to see what it would be like. So…I knew what to expect."

There was a sense that people were often admitted more while in crisis in early admissions or because they felt stuck for other options, whereas later admissions were associated with increased planning and choice.

P1: "It was much more of like a crisis situation the first time…And then the second time, it was much more a planned admission. I much more like, wanted to go in, it was more of my decision".

Participants described taking more control over their experience and recovery as their admissions went on, developing more ideas about their care, having clearer ideas about what they wanted to achieve through the admission and wanting more involvement in making decisions. They also described a sense of learning from the experience and having an increased desire for recovery, as opposed to wanting the safety of the ward.

P6: "My expectations of myself had dropped… I was going into the ward to kind of get a kick-start on the road to recovery but not going into the ward to get fixed so my mind-set was different".

P4: "I think a lot of the time it is down to like the individual. And like, how they've used their admission. Because only you can, like, carry on with the work that you've learned if you really want to do it"

Discussion

This research aimed to qualitatively explore the experience of transitioning from adult inpatient services to the community for participants with EDs. It is the first study to investigate adult service users with EDs' experience of leaving inpatient care. Additionally, this research hoped to identify suggestions for ways this transition can be improved. Four overarching themes were identified: reintegration into the "real world"; hospital as a "safe base" for recovery; extreme change in levels of support; and learning from admissions.

The findings showed that transitioning to the community is associated with numerous challenges. This included changes to daily routines, roles and identities. Additionally, participants discussed challenges with facing triggering life stressors, alongside readjusting to gaps in their life that were previously taken up through ED behaviours. In line with previous findings, the results implied that prior to admissions, the ED was experienced as providing a sense of comfort and control in difficult times (Fox, Larkin, & Leung, 2011), in that participants described it as a routine and structure that could be relied on.

This may in part contribute to the high rates of relapse and readmission in service users with AN and highlights the importance of service users finding other ways to cope with emotions and developing or re-establishing valued and meaningful activities. Additionally, this shows the necessity of appropriate planning throughout the transition period to overcome these challenges and prevent future admissions, which was recognised as important by participants. This supports previous research showing that planning is key for successful transitions (Offord et al., 2006). This research added to previous literature by identifying suggestions where preparation is key, and also by finding that this includes useful information and preparation for loved ones who support the individual with the eating disorder in the community.

In support of previous research, the hospital environment was described as very distinct to the "real world" (Smith et al., 2016), and participants reported feeling cut-off from "normality". A common suggestion for improvements regarding this was to have support with "normal" activities, such as social activities or eating in public places, in order to more successfully re-adjust to the community. Whilst these activities are often included in inpatient work, this highlights the importance of having sufficient time to practise and consolidate these skills whilst in hospital, while inpatients have lots of support available to help them reflect and prepare.

This distinction between the community and hospital appeared to create a sense of safety for participants, who felt protected and contained by the inpatient environment. Consequently, this appeared to be challenging to leave, particularly during earlier admissions. This is in support of previous research showing that patients can become attached to the inpatient environment and find the structure and support found in hospital to be beneficial (Johansson et al., 2009; Smith et al., 2016).

The support found from others in hospital appeared to contribute to this and a number of participants described a strong sense of isolation and abandonment after leaving hospital, and a desire for continued connections and feeling held in mind by hospital staff. This perhaps highlights that service users may not perceive the relationships in their community environment as being supportive in the same way, and highlights the value found from shared experiences. Consequently, leaving the environment where they are surrounded by others with similar experiences may feel daunting. Preparation work may need to include psychoeducation for their close others, or to consider ways to maximise their current support system. Previous research has found that supportive relationships are key to recovery from EDs (Arthur-Cameselle & Quatromoni, 2014), which supports that connection and understanding from others is important.

The results also showed that participants valued the shared experiences and relationships they formed with other inpatients. Some said they would like to continue this connection in the community. Interestingly, Arthur-Cameselle and Quatromoni (2014) also found that spending time with others with EDs could hinder recovery from EDs, which suggests these relationships may be unhelpful in the long-term. Instead, perhaps this highlights the need for understanding and support from the relationships with close others in the community, to reduce a sense of isolation, rather than, or alongside, continued contact with other patients.

The results suggested that being hospitalised for the first time can be overwhelming and frightening, and that people are unsure of what to expect. It seemed that for service users who had multiple admissions, learning and an attitude of “making the most” of their admission was developed over time. They highlighted the importance of having a particular psychological “mindset” for recovery. The findings also showed a disparity between physical and psychological recovery, which suggests service users may sometimes leave hospital before they are psychologically ready to maintain progress in the community. This highlights a difficult issue in ED treatment, as evidence recognises that psychological change takes time (e.g. cognitive behavioural therapy for ED recommends 40 sessions (NICE, 2017)), which may not be achievable or cost-effective during inpatient treatment.

The results found that participants experienced an extreme change in the support that was available to them and found it difficult to reach out to find support in the community. This emphasises the need for a gradual return to the community, while continuing to feel supported and connected to the inpatient environment. This provides strong support for day-patient services and graduated discharge, which were both considered by participants to be beneficial and necessary for a successful transition. Previous research has found that day-patient service programs have financial and clinical benefits, such as: encouraging a sense of independence and enabling service users to continue with their family, social and occupational roles in the community; facilitating the generalisation of learning to their home environment; and addressing community situations that may act as maintenance factors (Zipfel et al., 2002). The current research demonstrates that alongside financial and clinical benefits, day-patient or gradual discharge programs would also be a preferential option and well-received by service users.

Clinical Implications

The results implied that to some extent, the hospital environment creates a sense of safety that is hard to leave, meaning that the return to the community can be experienced as overwhelming and rejecting. This suggests that to foster a successful transition, efforts need to be made to create this sense of safety in the community instead, and to focus on building up areas of service users' lives and social support that they may feel they are lacking. This could also involve consideration of service users' identities outside of their ED and devoting time to increasing their sense of self-efficacy and confidence in their ability to cope on their own after leaving hospital.

The sense of abandonment that was described implies it may be useful to discuss and manage their discharge early on in their admission, and clarify aims and objectives of the admission, the role of the inpatient team and the transition to the community team. This may also include validating and normalising the difficult emotions that are experienced when returning to the community. Most participants said they would appreciate a planned telephone “check-in” for the first couple of weeks after leaving, which may reduce their sense of isolation and feeling forgotten.

Additionally, this shows the importance of having consistency in their care where possible and ensuring that service users do not fall through gaps after leaving hospital in order to reduce the potential for them feeling isolated and therefore maintain their progress.

The findings also showed that it was difficult for service users to re-adjust to different structures and routines in the community. This has implications for reasonable adjustments that are necessary in the community, such as when returning to work or other occupational roles so that they can continue with routines that are key to recovery, such as making sure they do not miss meals.

Further, the desire for support in the community with “normal” activities, such as social activities and eating in public places, suggests that increased support outside of therapy would be helpful in order to consolidate life skills. This also shows the importance of key workers in supporting these roles.

The results also show that it is important for service users to know what to expect when entering and leaving the ward, and for them to be equipped with the necessary information.

Feedback to Service

The results and suggestions for improvement were fed back to the service at a multi-disciplinary team meeting. The results were received positively and staff reported that some suggestions would be feasible e.g. increasing the frequency of phone calls to service users in the first couple of weeks after leaving hospital. Staff also commented they were eager to re-introduce day-patient services and felt the results could be used as support for gaining funding. They considered whether quotations could be used as evidence that participants of this study were supportive of day-patient services.

Limitations

The sample was limited in that it only included one male participant, meaning the findings may not be representative of both genders. However, statistics suggest approximately 10% of people with EDs are male in clinical samples (Sweeting et al., 2015), meaning this sample is approximately representative of this group. Additionally, all participants had a restrictive ED, therefore findings may not generalise to those with other types of EDs. An opt-in sample was utilised, which may have biased the findings, as those that chose to take part may have had particularly strong views. It is important to note that the data collection and analysis was conducted by one researcher, and so, as with all qualitative research, the results are likely to be affected by the researchers' interpretations and experiences. However, precautions were taken to lessen the impact of this, as discussed.

It is also important to note that due to the qualitative nature of this research, the results of this study represent the experiences of these participants and may not translate directly to other services or service users. When making recommendations and adjustments to services, it is therefore important that isolated quotations are not taken out of context and are considered within the wider framework.

Further Research

The suggestions for improvements generated by this research could provide the basis for hypotheses for further service improvement projects, in order to evaluate whether these suggestions lead to better outcomes. It may be helpful for the service to conduct service audits in order to monitor the effectiveness of the suggestions given. For example, many service users stated they thought the transition could be improved by having an increased number of "check-in" telephone calls immediately after discharge. It may therefore be beneficial to evaluate whether satisfaction rates about the transition improved after introducing increased telephone calls to the service, and whether this reduced re-admission rates.

This research focused on participants who had at least two hospital admissions, therefore it was not possible to capture the experience of people who do not return to hospital following an inpatient stay. Further research would benefit from exploring what the experience of transition is like for this population and by investigating protective factors that prevent a return to hospital.

This research also found that the support found in hospital was important to participants and appeared to make transitioning to the community difficult. It may be useful to understand what kind of environment service users are returning to and what their relationships in the community are like, in order to work towards creating a similar sense of safety in the community.

Finally, participants spoke about the importance of a psychological mindset towards recovery. Further research is needed to investigate how this type of approach can be fostered in the inpatient environment, so that the potential for recovery can be maximised during their admission.

(Page left intentionally blank)

References

APA. (2006). *Practice Guidelines for the Treatment of Patients with Eating Disorders.* Washington, DS: American Psychiatric Association.

Arthur-Cameselle, J. N., & Quatromoni, P. A. (2014). A qualitative analysis of female collegiate athletes' eating disorder recovery experiences. *The Sport Psychologist, 28*(4), 334-346.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.

Colton, A., & Pistrang, N. (2004). Adolescents' experiences of inpatient treatment for anorexia nervosa. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association, 12*(5), 307-316.

Davidson, S.I., Cappelli, M., & Vloet, M.A. (2011). *We've got growing up to do: Transitioning youth from child and adolescent mental health services to adult mental health servives.* Ontario, Canada: Ontario Centre of Excellence for Child and Youth Mental Health.

Dimitropoulos, G., Toulany, A., Herschman, J., Kovacs, A., Steinegger, C., Bardsley, J., . . . Anderson, J. (2015). A qualitative study on the experiences of young adults with eating disorders transferring from pediatric to adult care. *Eating Disorders, 23*(2), 144-162.

Fox, A. P., Larkin, M., & Leung, N. (2011). The personal meaning of eating disorder symptoms: An interpretative phenomenological analysis. *Journal of Health Psychology, 16*(1), 116-125.

Howard, W. T., Evans, K. K., Quintero-Howard, C. V., Bowers, W. A., & Andersen, A. E. (1999). Predictors of success or failure of transition to day hospital treatment for inpatients with anorexia nervosa. *American Journal of Psychiatry, 156*(11), 1697-1702.

Johansson, I. M., Skärsäter, I., & Danielson, E. (2009). The meaning of care on a locked acute psychiatric ward: Patients' experiences. *Nordic Journal of Psychiatry, 63*(6), 501-507.

Kästner, D., Löwe, B., Weigel, A., Osen, B., Voderholzer, U., & Gumz, A. (2018). Factors influencing the length of hospital stay of patients with anorexia nervosa–results of a prospective multi-center study. *BMC Health Services Research, 18*(22), doi.org/10.1186/s12913-017-2800-4.

.

Lee, C., & Gramotnev, H. (2007). Life transitions and mental health in a national cohort of young Australian women. *Developmental Psychology, 43*(4), 877-888.

Lyons, J. S., O'Mahoney, M. T., Miller, S. I., Neme, J., Kabat, J., & Miller, F. (1997). Predicting readmission to the psychiatric hospital in a managed care environment: Implications for quality indicators. *American Journal of Psychiatry, 154*(3), 337-340.

McCabe, E. B. (2008). *Predictors of Readmission in Hospitalized Anorexia Nervosa Patients.* (Doctoral dissertation). University of Pittsburgh.

National Institute for Health and Care Excellence (NICE) (2017). Resource impact report: Eating disorders: recognition and treatment (NG69). Retrived from https://www.nice.org.uk/guidance/ng69/resources/resource-impact-report-pdf-4479687469.

Offord, A., Turner, H., & Cooper, M. (2006). Adolescent inpatient treatment for anorexia nervosa: A qualitative study exploring young adults' retrospective views of treatment and discharge. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association*, *14*(6), 377-387.

Olmsted, M. P., McFarlane, T. L., Carter, J. C., Trottier, K., Woodside, D. B., & Dimitropoulos, G. (2010). Inpatient and day hospital treatment for anorexia nervosa. *The Treatment of Eating Disorders: A Clinical Handbook*, 198-211.

Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report*, *13*(4), 695-705.

Richard, M. (2005). Care provision for patients with eating disorders in Europe: what patients get what treatment where? *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association*, *13*(3), 159-168.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, *7*(3), 233-243.

Smith, V., Chouliara, Z., Morris, P. G., Collin, P., Power, K., Yellowlees, A., . . . Cook, M. (2016). The experience of specialist inpatient treatment for anorexia nervosa: A qualitative study from adult patients’ perspectives. *Journal of Health Psychology*, *21*(1), 16-27.

Sweeting, H., Walker, L., MacLean, A., Patterson, C., Räisänen, U., & Hunt, K. (2015). Prevalence of eating disorders in males: A review of rates reported in academic research and UK mass media. *International Journal of Men's Health, 14*(2).

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. *The SAGE Handbook of Qualitative Research in Psychology, 2*, 17-37.

Thompson, E. E., Neighbors, H. W., Munday, C., & Trierweiler, S. (2003). Length of stay, referral to aftercare, and rehospitalization among psychiatric inpatients. *Psychiatric Services, 54*(9), 1271-1276.

Treasure, J., Schmidt, U., & Hugo, P. (2005). Mind the gap: Service transition and interface problems for patients with eating disorders. *The British Journal of Psychiatry, 187*(5), 398-400.

Treasure, J., Todd, G., & Szmukler, G. (1995). The inpatient treatment of anorexia nervosa. In G. Szmukler, C. Dare & J. Treasure (Eds.). *Handbook of eating disorders: Theory, treatment and research,* 275–293. New York: John Wiley & Sons.

Vandereycken, W. (2003). The place of inpatient care in the treatment of anorexia nervosa: Questions to be answered. *International Journal of Eating Disorders, 34*(4), 409-422.

Warnke, I., & Rossler, W. (2008). Length of stay by ICD-based diagnostic groups as basis for the remuneration of psychiatric inpatient care in Switzerland? *Swiss Medical Weekly, 138*(35), 520-527.

Zipfel, S., Reas, D. L., Thornton, C., Olmsted, M. P., Williamson, D. A., Gerlinghoff, M., . . . Beumont, P. J. (2002). Day hospitalization programs for eating disorders: A systematic review of the literature. *International Journal of Eating Disorders, 31*(2), 105-117.

(Page left intentionally blank)

Main Research Project

The Impact of a Mental Health Diagnosis on Mental Health Professionals' Judgments of Colleagues: An Experimental Study

May 2019

Internal Supervisors: Lorna Hogg and Dr Cathy Randle-Phillips
External Supervisor: Dr Falguni Nathwani

Word Count: 5500
Target Journal: Stigma and Health

(Page left intentionally blank)

The Impact of a Mental Health Diagnosis on Mental Health Professionals' Judgments of Colleagues: An Experimental Study

Mental health problems are recognised as a stigmatised issue by the World Health Association and the World Psychiatric Association. They are associated with suffering, disability and poverty (Corrigan & Watson, 2006). For people with mental health problems, stigma can act as a barrier to seeking help, participating fully with mental health services and reintegration into society (Corrigan, 2004). Research has suggested that mental health professionals (MHPs) have an increased risk of developing mental health difficulties (Kleepsies et al., 2011), but, unfortunately, are not immune to developing their own stigmatised attitudes towards others with mental health problems. This study aims to investigate whether such stigmatising attitudes extend to other MHP colleagues, who suffer from mental health problems.

Stigma and Disclosure

Stigma has been defined as the social construction that results in people being devalued due to a distinguishing characteristic or mark (Biernat & Dovidio, 2000). It can be categorised into two types: public and self-stigma. Public stigma refers to negative attitudes held by the general population, about people with distinguishing, devalued characteristics, which results in discrimination. If these public attitudes are internalised and endorsed by people who then identify as part of the "devalued group", they can develop self-stigma (Corrigan & Rao, 2012). This can result in a number of negative consequences, such as low self-esteem, poor self-efficacy, self-discrimination, decreased use of healthcare services, and diminished health outcomes and quality of life (Corrigan & Roa, 2012; Sirey, et al., 2001a; b).

Personal attitudes and stigma towards mental health conditions can be explained by modified labelling theory (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989), which suggests that, as a result of their own social and cultural context, people develop beliefs about how others with mental health problems are treated. This impacts on their beliefs about how they would be treated if they develop mental health problems (i.e. through internalising public attitudes and developing self-stigma). If they have a stronger belief that they will be discriminated against, this theory suggests they will engage in more defensive behaviours in order to protect against subsequent rejection, such as withdrawing from others, concealing their difficulties or educating others (Rüsch, Angermeyer & Corrigan, 2005). Consequently, they are likely to feel more threatened by interacting with others, or disclosing their mental health issues.

Subsequent research has indicated that this process may be moderated by the specific diagnostic category of the mental health problem (Kroska & Harkness, 2008) i.e. the extent to which it is concealable or not.

The concealable nature of mental health difficulties can create a dilemma as people have to decide whether to disclose their mental health problems to others (Pachankis, 2007). Making this decision can be stressful, and requires careful consideration of the costs, benefits and risks (Korsbek, 2013; Whittle, 2017). Through disclosing, people face making themselves vulnerable to the impact of stigma or discrimination, whereas a decision not to disclose can block access to valuable support.

Disadvantages of disclosure include the stigma and discrimination that may be faced (Corrigan, 2004; Whittle, 2017), the possibility of coercive treatment (Corrigan & Matthews, 2003), reduced academic performance (Quinn, Kahng & Crocker, 2004), worries about burdening others and the possibility of consequent dismissal by peers (Whittle, 2017). However, there are a number of advantages to disclosure including: gaining support and positive feedback from others; reduction of anxiety about being "found out"; normalisation and support through contact with others who are similarly stigmatised; and the opportunity for social connection, increased self-acceptance and increased congruence between private and public identities (Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018; Pachankis, 2007; Whittle, 2017). The process of disclosure may also allow for emotions to be cognitively processed (Ignatius & Kokkonen, 2007) and reduce distress, in particular stigma stress and other negative emotions surrounding disclosure (Grice, Alcock, & Scior, 2018a).

Mental Health Professionals with Mental Health Problems

Existing research suggests that many mental health professionals (MHPs) experience mental health difficulties at some point in their lives, at least at the same rate as the rest of the population (Edwards & Crisp, 2016). Recent statistics showed that 67% of clinical psychologists or clinical psychologists in training experience significant mental health problems at some point during their lifetime (Grice, Alcock, & Scior, 2018b).

Some literature implies that working in this area puts people at high risk of developing mental health problems, such as depression, anxiety, substance abuse and suicidality (Kleepsies et al. 2011; Piloski & O'Sullican, 1989; White et al., 2006). This may in part be due to the stressful nature of the role, highlighted by high rates of burnout (Morse, Salyers, Rollins, Monro-DeVita & Pfahler, 2012). Additionally, the work can expose people to issues that make them vulnerable to mental health difficulties, such as isolation, vicarious traumatisation, compassion fatigue and a lessened sense of personal accomplishment in their careers (Emerson & Markos, 1996; Katsavdakis, Gabbard, & Athey, 2004; Kleespies et al., 2011). Existing literature about "wounded healers" would also suggest that some people may be drawn to the profession as a result of their own experiences of mental health difficulties (Barnett, 2007; Sussman, 2007). Thus, the evidence would suggest that there are likely to be high rates of mental health problems within MHPs which may create problems if they are likely to face stigma in the workplace or have difficulty disclosing their issues if needed.

Stigmatised Attitudes among MHPs

Previous research has implied the existence of stigmatised attitudes among MHPs towards people with mental health problems, including schizophrenia (Rao et al., 2009), substance misuse, personality disorder (Thornicroft, 2006), learning disability and chronic fatigue (Rao et al., 2009). Research suggests that MHPs are also aware of existing stigmas; they are more likely to believe that individuals with severe mental health difficulties would experience stigmatisation and discrimination from others (Jorm et al., 1999; Reavley, Mackinnon, Morgan, & Jorm, 2014) and are more pessimistic about the possibility of recovery (Jorm et al., 1999). This may therefore make disclosure decisions within the workplace more complex for MHPs who themselves have mental health difficulties.

Recent research has highlighted that specific mental health diagnoses are associated with higher levels of stigmatised attitudes in MHPs towards clients. For example, Lam, Salkovskis, & Hogg (2016) investigated whether MHPs attitudes towards a client presenting with a panic disorder were affected by being told they also had a comorbid diagnostic label of borderline personality disorder (BPD). They found that participants who were explicitly told the client had a BPD diagnosis were more pessimistic about their treatment than those who only received general background information or descriptive information about behaviour associated with BPD. Similarly, other research has demonstrated that differential stigma is attached to different diagnoses (Sheehan, Nieweglowski & Corrigan, 2016; Wood, Birtel, Alsawy, Pile & Morrison, 2014). However, research has not investigated whether stigmatised attitudes held by MHPs extend to other MHPs with mental health problems and so this is the focus for this study.

Disclosure within the Workplace

A review of disclosure within the workplace has suggested that people worry about their mental health problems being disclosed within this context (Jones, 2011). Further, this review suggested that disclosure within the workplace impacts on relationships in different ways: disclosing resulted in increased support from supervisors, but caused some relationships with co-workers to become more “strained”. In addition, some workers reported that they believed they did not receive job offers as a result of their disclosure.

Through their profession, it is possible that MHPs will have raised awareness of existing stigma towards people with mental health problems, including stigmatised attitudes of other MHPs, and the potential negative consequences of stigma. This may add to the dilemma of whether to disclose within a mental health workplace. For example, Grice et al. (2018b) found that Clinical Psychologists with mental health problems were more likely to disclose their difficulties to their family or friends than colleagues or supervisors. Further research has shown that MHPs are reluctant to disclose their own experiences of mental health problems to their colleagues (Gras et al., 2014) or seek formal treatment (Abbey et al., 2011). When investigating attitudes towards seeking help within MHPs, Edwards and Crisp (2016) found that while 89% of MHP participants stated they would seek help if they were distressed or experiencing mental health difficulties, 57% also acknowledged that there had been times in their career when they would have benefited from seeking help but chose not to do so. The barriers to seeking help included: fear about their colleagues finding out, the potential for negative consequences relating to professional regulations, a perception that they would have difficulty in taking time off work to attend to their mental health and wanting to solve the problem on their own. It has also been suggested that it may be more difficult for mental health professionals to disclose their own mental health problems due to assumptions that they should be able to “fix” their own problems (Schulze, 2007; Sussman, 1992), or feel more inclined to attempt to treat themselves (White et al., 2006). This may be heightened by a fear that disclosure will result in others questioning their competency or ability to do the job (Sherman, 1996). It is therefore important to understand whether stigmatised attitudes exist within MHPs towards other MHPs with mental health problems, as this may impact on whether they feel able to disclose or seek support.

To summarise, it is likely that high rates of MHPs will experience mental health problems during their lifetime. Research has highlighted that disclosure within the workplace in general can be difficult, and that some MHPs would be reluctant to disclose their mental health problems to their colleagues. Additionally, stigmatised attitudes towards clients have been found within mental health professionals. However, research has not considered whether these stigmatised attitudes extend towards other MHPs with mental health problems.

This research therefore aimed to develop and trial a method of measuring attitudes towards MHPs with mental problems, from other MHPs. Through doing this, we aimed to investigate how potential new colleagues with mental health problems are judged by other MHPs. The research also aimed to investigate whether judgements are differentially affected by specific diagnostic labels.

It was hypothesised that information about historical mental health difficulties would result in more negative judgements being made about a fictitious new colleague. It was also hypothesised that more severe mental health diagnoses would result in more negative judgments being made about the MHP, than a less severe mental health diagnosis or a behavioural description of mental health difficulties.

Method

Participants

The sample consisted of 171 mental health professionals. Participation was voluntary and informed consent was taken. Participants were recruited at conferences and continued professional development events through a UK University (36.3%), and online, through advertisement on social media and through NHS settings (63.7%), via an online survey, run by Qualtrics. The research was advertised as investigating perceived important personal qualities in new colleagues. The true purpose of the study was withheld in order to reduce demand characteristics.

Design

The study aimed to investigate whether being given information that a new colleague had historical mental health difficulties would affect the judgements participants made about them. To test this, a cross-sectional between-groups experimental design was adopted (see Table 3.1 for condition descriptions). The independent variable was the condition (background information given; four levels) and the dependent variable was the total JONCS score.

Table 3.1

Description of Experimental Conditions

Condition	Description
1	Background information about the potential new colleague
2	Background information about the subject, plus a behavioural description of historical difficulties with mental health
3a	Background information about the subject, plus a behavioural description of historical difficulties with mental health and a historical diagnosis of depression
3b	Background information about the subject, plus a behavioural description of historical difficulties with mental health and a historical diagnosis of borderline personality disorder (BPD).

Hypotheses.

The null hypothesis was that knowledge of a historical mental health problem would not affect the way an MHP was judged by other MHPS. The primary hypothesis was that receiving information that a potential new colleague had a historical mental health problem would lead other MHPs to make more negative judgements about them, than receiving no information about a historical mental health problem.

1) Further hypotheses to be tested were: Receiving information that a potential new colleague had a historical mental health problem diagnosis would lead MHPs to judge them more negatively than if they received information including a purely behavioural description suggestive of emotional difficulties.
2) Receiving information that a potential new colleague had a more severe historical mental health diagnosis would lead MHPs to judge them more negatively than if they received information they had a less severe historical mental health diagnosis.

Procedure

The design and procedure of Lam et al. (2016) was utilised as precedence for the methodology of the current study.

Participants recruited in person were provided with the information sheet (Appendix 3A) at least 48 hours in advance of taking part. Participants recruited in person mostly took part in group settings and were seated so they could not see others' responses or information. Informed consent was obtained (Appendix 3B). Participants were randomly allocated to one of four conditions (Table 3.2) with different background priming information (Appendices 3C–3F) to read before watching a short video of a fictitious new colleague. In the video, the colleague introduced themselves and gave some background information about their personal circumstances and previous experience (Appendix 3G). After watching the video, participants completed the measures listed in Table 3.3. Debriefing information was provided after participation, in which participants were informed of the true hypotheses of the study (Appendix 3L).

Measures

The questionnaires outlined in Table 3.2 were completed by all participants (in order listed).

Table 3.2

Measure Completed by all Participants

Measure	Details
Judgement of New Colleague Scale (JONCS)	A questionnaire was developed for the purpose of the study (Appendix 3H), which aimed to assess the judgements made about the fictitious colleague, relating to their suitability for joining and working with their team. This questionnaire consisted of 15 test items and 10 additional decoy items, which were included to reduce demand characteristics (excluded from the analysis). The JONCS initially included 20 test items plus the additional decoy items, but 5 test items were removed following analysis of its psychometric properties, as they did not show good test-retest reliability. A visual analogue scale was used; participants were asked to make a mark on a line, to rate their judgement, ranging from “not at all” to “very much so”. 8 items were inversely rated to avoid response biases. A score between 0-100 was assigned for each item based on this mark, where a higher score represented a more positive judgement. An average score of the 15 test items was calculated, to give a final score between 0-100, to represent

	overall judgement. A higher JONCS scores represented a more positive overall judgement.
Demographics Questionnaire	Demographic characteristics were measured using a questionnaire developed for the study (Appendix 3I).
Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007).	A self-report 14-item measure with 5 response categories, which aims to assess feeling and functioning aspects of mental wellbeing (Appendix 3J). This was included in order to measure whether personal wellbeing impacted on the judgements participants made about the potential new colleague. Cronbach's alpha=0.91; Test-retest reliability=0.83 (Tennant et al., 2007).
The Self-Stigma of Mental Illness Scale – Short Form (SSMI-SF) (Corrigan et al., 2012).	A self-report 20-item measure which examines participants' awareness of negative stereotypes associated with mental health problems, and the extent to which they agree with, and apply these stereotypes to themselves (Appendix 3K). This was included in order to measure whether levels of self-stigma impacted on the judgements participants made about the potential new colleague. Cronbach's alpha: awareness scale=0.87; agreement scale=0.79; application scale=0.69; harm scale=0.76 (Corrigan et al., 2012).

Ethics

The project was approved by the University of Bath Ethics Panel (reference: 18-134, Appendix 3M) and NHS Health Research Authority (project ID: 249949; Appendix 3N).

Data Analytic Strategy

As the JONCS was developed for the purpose of the study, we examined its psychometric properties, including test-retest reliability and factor analysis.

To test the primary hypothesis, a one-way ANOVA was conducted. To test the role of wellbeing and self-stigma, one-way ANCOVAs were conducted, including these factors as covariate variables. We planned to conduct post-hoc tests if the ANOVA showed significant results. A multiple regression analysis was planned to investigate the effect of demographic factors.

Data was excluded if the JONCS was not completed (n=7) and if participants stated they were working in roles that were not at either professional level or in training for a professional role (e.g. support workers; n=5). Missing data and outliers were removed from all continuous variables.

Power considerations.

According to G*power calculations, to achieve power of 0.8 with alpha of 0.05 and a moderate effect size (0.25), a sample size of 180 (45 in each group) was required.

Results

Sample

Demographic characteristics of participants are outlined in Table 3.3 below.

Table 3.3

Demographic Characteristics of Sample

Demographic Characteristic	N (%)	Range	Mean (SD)
Age	167	19 – 61	35.55 (10.28)
Missing data	4		
Gender			
Female	150 (88.2)		
Male	20 (11.8)		
Missing data	1		
Ethnic Origin			
White British	144 (84.7)		
White Other	13 (7.6)		
Other (White Irish; Mixed – White & Asian; Indian; Bangladeshi; Black African; Chinese; Dutch; Latina).	13 (7.6)		
Missing data	1 (0.6)		
Professional Role			
Mental Health Nurse	54 31.6)		
Clinical Psychologist	43 (25.1)		
Trainee Clinical Psychologist	33 (19.3)		
Student Mental Health Nurse	9 (5.3)		
Occupational Therapist	9 (5.3)		
Counsellor	6 (3.5)		
CBT therapist	6 (3.5)		
Psychiatrist	5 (2.9)		
Other (Psychotherapists and Trainee Psychiatrists)	4 (2.4)		
Missing data	2 (1.2)		
Level of qualification			
Qualified	118 (69)		
Currently in training	51 (29.8)		
Number of years qualified		0 – 36	6.11 (8.66)

Missing data	2 (1.2)
Experience of personal mental health problems	
Yes	100 (58.5)
No	69 (40.4)
Missing data	2 (1.2)
Primary diagnosis of personal mental health problem (self-identified)	
Depression	36 (36)
Generalised Anxiety Disorder	25 (25)
Social Anxiety	7 (7)
Obsessive-Compulsive Disorder	6 (6)
Other (Post-Traumatic Stress Disorder; Health Anxiety; Panic Disorder; Schizophrenia/Psychosis; Anorexia Nervosa; Other Eating Disorder; Personality Disorder; Complex Grief Reaction; Burnout; Specific Phobia)	18 (18)
Missing Data	10 (10)

Psychometric Properties of the Judgement of New Colleague Scale (JONCS)

Face validity.

The questionnaire was developed by the lead and second author. Face validity was ascertained through consultation with the third and fourth authors and through a research consultation panel with two other MHPs.

Test-retest reliability.

14 MHPs completed the questionnaire at two time points, 48 hours apart. Correlations between the test and retest scores (using Pearson's correlation coefficient, *r*) indicated good reliability (0.71-0.96) for 15 items (Table 3.4). Decoy items and a further five items with *r* value<0.7 were excluded from the questionnaire for the final analysis, as they did not show good test-retest reliability, leaving 15 items.

Table 3.4

*JONCS Questionnaire Items, with Test-retest Reliability Correlation Scores (*indicates items removed)*

	Item	*r* value	Description
1.	This person seems knowledgeable	0.90	
2.	This person could be relied on to attend team meetings	0.71	
3.*	This person seems sociable	0.73	(Decoy item)
4.*	This person would be able to keep a good work/life balance	0.34	
5.*	This person seems warm and empathic	0.47	
6.*	This person is able to communicate well	0.58	
7.*	This person seems untrustworthy	0.64	
8.*	This person would like sports	0.77	(Decoy item)
9.*	This person would struggle with the demands of the job	0.56	
10.*	This person has an adventurous personality	0.88	(Decoy item)
11.	This person would be disruptive to the team	0.83	
12.	I would be able to approach this person with a problem	0.78	
13.*	This person seems fun and easy going	0.89	(Decoy item)
14.	This person appears judgemental	0.86	
15.	This person appears to be safe	0.94	
16.	This person would keep to their word	0.91	
17.	This person would be able to cope with difficult situations	0.79	
18.*	This person seems relaxed	0.47	(Decoy item)
19.*	This person is dressed inappropriately	0.65	(Decoy item)
20.*	This person seems competitive	0.31	(Decoy item)
21.	This person seems competent	0.94	
22.	This person would require their own professional help	0.96	
23.*	This person would have strong religious beliefs	0.95	(Decoy item)
24.*	This person has good family values	0.70	(Decoy item)
25.	I would expect this person to be self-reflective	0.72	
26.	This person would struggle to build relationships with clients	0.87	
27.	This person would be a danger to others	0.93	

28.	This person would require the same amount of supervision as others	0.72	
29.	This person seems committed to improving quality	0.71	
30.*	This person would have a lot of friends	0.94	(Decoy item)

Factor analysis.

The JONCS was initially developed based on four potential sub-scales of items (effectiveness, reliability, resilience and personal qualities). As this was the first time using the measure, an exploratory factor analysis was conducted on the initial 20 test items (decoy items removed), using varimax rotation (n=171). The scree plot for this analysis (Figure 3.1) indicated that the items grouped into two subscales. However, inspection of the subscale items did not show a clear division between the subscales in terms of content i.e. there was conceptual overlap between the subscales so they did not represent separate concepts regarding judgements made. A further exploratory factor analysis was conducted on the 15-items with good test-retest reliability, which also indicated that these items grouped into two subscales but again, these subscales were not conceptually distinct in terms of content. It was therefore decided that scores of the 15 items with good test-retest reliability would be combined to calculate an overall judgement score, which would be used as the dependent variable for the main analysis.

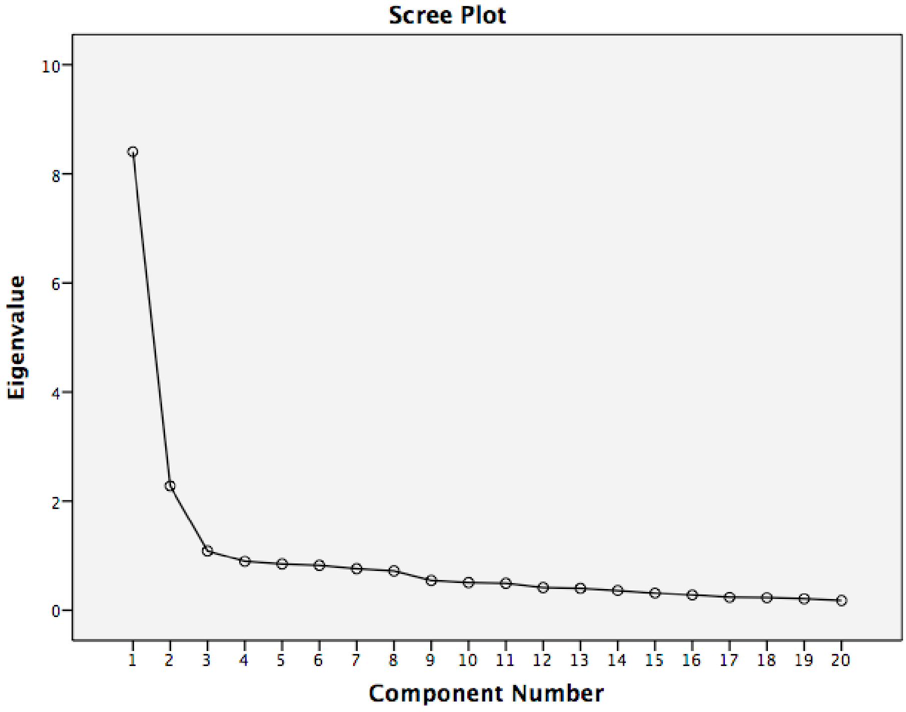


Figure 3.1. Scree plot for factor analysis of JONCS (20-items).

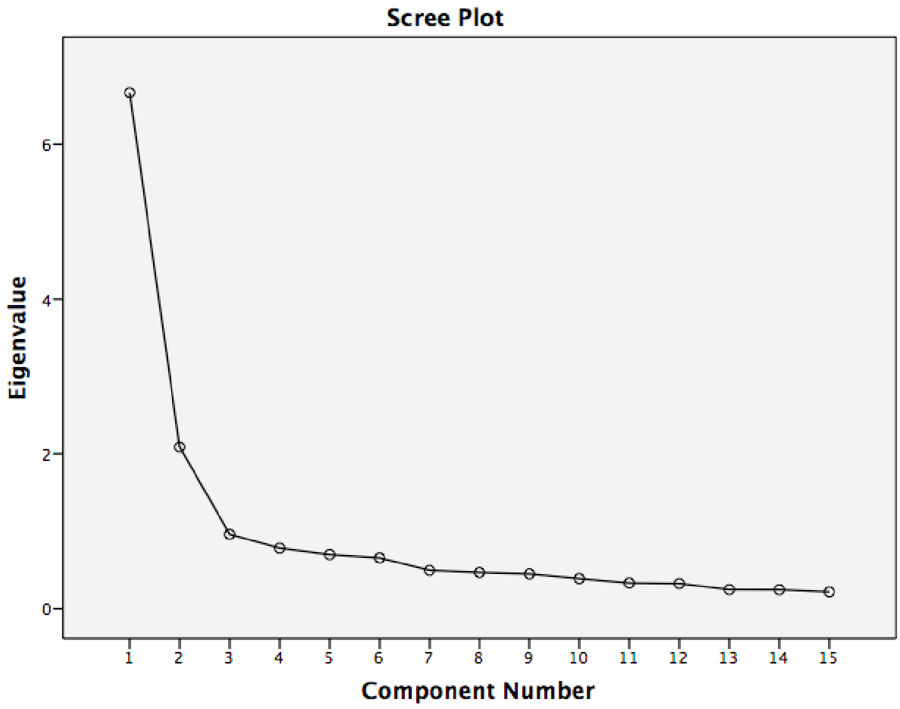


Figure 3.2. Scree plot for factor analysis of JONCS (15-items).

Internal consistency.

A reliability analysis was conducted on the 15 items included in the JONCS. Cronbach's alpha showed the questionnaire reached excellent levels of reliability, α=0.90 (George & Mallery, 2003).

Primary Analysis: Impact of Condition on Judgement Scores.

The primary purpose of this study was to investigate whether being given background priming information that a new colleague had a historical mental health problem would affect MHPs judgements about them. This was analysed using an unadjusted one-way ANOVA. Analysis showed that the scores were normally distributed between conditions and no outliers were identified. There was an uneven split between conditions, due to drop-out before completion through online participation (Table 3.5).

The results showed there was no statistically significant difference between group mean JONCS scores (Figure 3.3) (F(3,171)=1.006, p=0.392) (Table 3.5). As the results did not indicate statistically significant difference, post-hoc tests were not conducted.

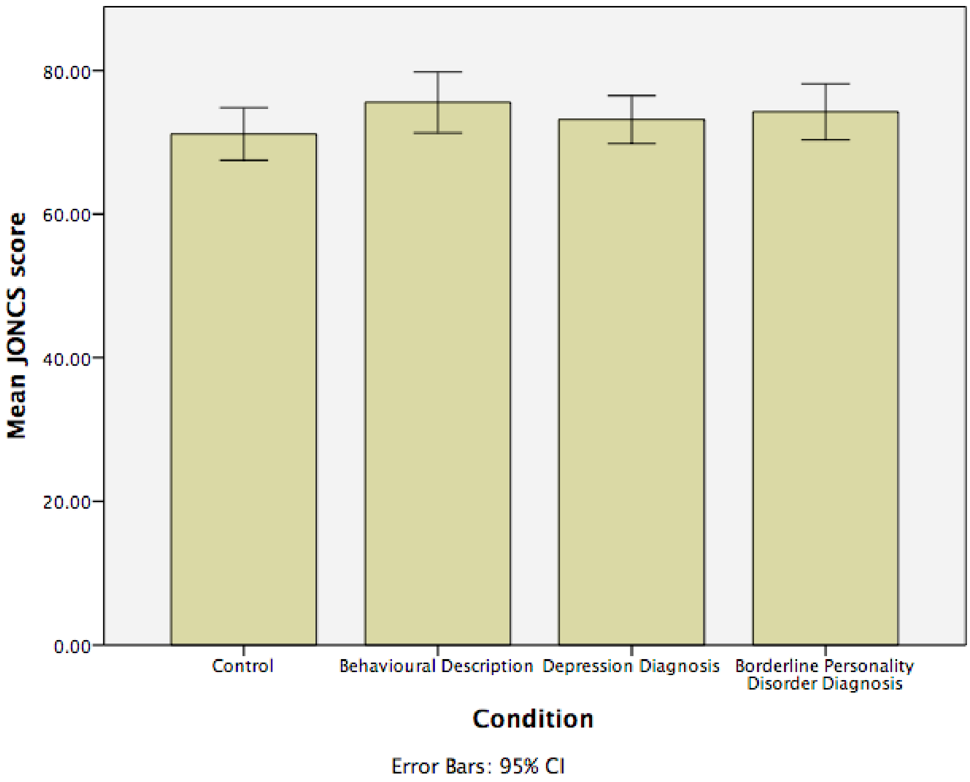


Figure 3.3. Graphical representation of mean JONCS scores, between conditions.

Table 3.5

Descriptive Statistics for JONCS scores, between Conditions

Condition	N	Mean	Standard Deviation
1 – Control	47	71.16	12.49
2 – Behavioural Description	42	75.55	13.61
3a – Depression	41	73.16	10.53
3b – Borderline Personality Disorder	41	74.22	12.38

To adjust for the potential impact of mental well-being, a one-way ANCOVA was conducted, with WEMWBS score as a covariate variable. This adjusted model did not indicate a statistically significant difference between means (F(3,168)=0.789, p=0.502).

To adjust for the potential impact of personal levels of self-stigma, a one-way ANCOVA was conducted, with SSMI-SF as a covariate variable. This adjusted model did not indicate a statistically significant difference between means (F(3,164)=0.751, p=0.523).

Secondary analyses were planned to investigate the impact of demographic characteristics on the results. However, as no difference between mean scores was found, these were not conducted.

Discussion

This study investigated whether MHPs with experiences of mental health difficulties would be likely to face stigmatising attitudes from other MHPs in the workplace. We investigated this using an experimental design, which assessed whether having information that a fictitious MHP had historical mental health difficulties would impact the judgements that were made about them by other MHPs.

The results did not support the hypothesis that receiving this information would result in less favourable judgements being made, both using an unadjusted model and when the reported personal wellbeing and levels of self-stigma of the participant were adjusted for. Additionally, the information given about the type of historical mental health difficulties did not affect the judgements made (i.e. there was no difference dependent on the type of mental health diagnosis that was given (depression or BPD), or whether mental health difficulties were described in terms of behavioural characteristics, rather than given a specific diagnosis).

Previous literature has suggested that people, including MHPs, have concerns about disclosing their mental health difficulties in the workplace for fear of stigma and discrimination (Edwards & Crisp, 2016; Gras, 2014). For example, Grice et al. (2018b) found that trainee clinical psychologists were less likely to disclose mental health problems to colleagues or supervisors than family or friends.

The results of this study tentatively suggest that MHPs within the UK may have more concerns about the consequences of disclosing their personal mental health problems than are necessary. This has interesting implications for disclosure decision-making regarding mental health problems. Previous literature has indicated that deciding whether to disclose or not can be stressful (Korsbek, 2013; Whittle, 2017). When considered within the context of modified labelling theory (Link et al., 1989), it might be expected that MHPs would develop strong beliefs that they will be discriminated against as a result of public attitudes and consequently feel threatened by disclosing their mental health issues. Whilst previous research conducted with general population samples and also MHPs would suggest that such reticence to disclose may be justified, this is not supported by the results of this study. MHPs were not found to demonstrate more negative attitudes towards colleagues with a past history of mental health difficulties or previous diagnosis, nor did the specific diagnosis (depression or BPD) affect MHPs' judgements.

There are a number of possible reasons that this study did not find similar results to previous studies. These include the possibility that attitudes have changed over time or that MHPs are more understanding towards other MHPs with mental health problems, due to social groupings. It may also be that some aspects of the design of this study influenced the outcome.

In recent years, efforts have been made to reduce the stigma regarding mental health problems (Rüsch et al. (2005), including public campaigns such as Time to Change (Time to Change, 2019), which have brought this issue into greater public awareness. Additionally, the value of including those with personal experience within mental health services has been recognised and in some services actively encouraged. Guidelines recommend the promotion of service user involvement, and increasingly partnership working in service developments (Health and Social Care Advisory Service, 2005; Neech, Scott, Priest, Bradley & Tweed, 2018). Additionally, some therapeutic approaches promote the value of therapists having personal experience of the issues they are working on with services users, including eating disorders and substance misuse (Costin & Johnson, 2002; Priester, Azen, Speight & Vera, 2007). Further to this, within the context and training of their work, MHPs are likely to have raised awareness of the stigma and discrimination that others with mental health difficulties may face (supported by previous research (Jorm et al., 1999; Reavley, Mackinnon, Morgan & Jorm, 2014)), which may enhance their understanding towards others with these difficulties. The results of this study may therefore represent a shift in stigmatising attitudes (or absence of stigma), particularly from MHPs, who are likely to have increased understanding of the impact of stigma towards those with mental health problems. For example, Henderson et al. (2016) found there was an improvement in overall attitudes towards people with mental health problems following the Time to Change Programme.

Interestingly, the demographic analyses showed that 58.5% of participants reported that they had experienced their own mental health difficulties. This is in line with Grice et al.'s (2018b) findings that 67% of trainee clinical psychologists reported personal experiences of mental health problems. This implies that this finding can be applied across different professionals within mental health work. Additionally, it might suggest, as supported by previous literature, that working as an MHP may put people at risk of developing mental health problems (Kleepsies et al. 2011; Piloski & O'Sullican, 1989; White et al., 2006) or that people may be drawn to the profession as a result of their own experiences (Barnett, 2007; Sussman, 2007). It is possible that the high prevalence of personal experience may result in MHPs being more understanding towards others with mental health difficulties, particularly if they have had their own experiences of stigma. However, the results showed no difference in judgements made when levels of self-stigma were adjusted for as a covariate.

There is also some discrepancy between our results and the findings of Lam et al. (2016), which showed that MHPs reacted with more negative ratings towards a service user when given the information that they had a diagnosis of BPD alongside panic disorder, as opposed to only panic disorder. It is possible that different processes occur when making judgements about service users, compared to MHPs. This may be dependent on the social group that they are in. Social identity theory would suggest that more favourable judgements are likely to be made about others who share a similar identity and are therefore perceived as being part of the "in-group" as opposed to the "out-group" (Tajfel & Turner, 1979). It may therefore be that more favourable judgements are made by MHPs about other MHPs, because they are perceived as being part of their "in-group", if they have a prominent professional identity. If negative judgments are made about an "in-group" that MHPs identify with strongly, this could also be experienced as threatening to their personal self-esteem, therefore they may avoid them for this reason. Additionally, it has been suggested that in order for stigma to have negative consequences, the stigmatising group has to be in a more powerful position, meaning that MHPs may not show stigma towards other MHPs, if they consider that they are from an equal position of power. It is also possible that what people are being judged on will affect the outcome: the Lam et al. (2016) study asked about suitability for therapy whilst this study asked about suitability for joining a mental health team. It may be that judgments are made via more complex processes than purely based on diagnosis. However, we can only tentatively comment on these ideas based on the results of this study, and further research would be needed to investigate this further.

The absence of the finding could be explained by a number of alternative reasons as a result of the design of the study. Firstly, the JONCS measure was developed and piloted for the purpose of the study. As this was the first use of this questionnaire, it is possible that it was not measuring what we thought or that a more sophisticated measure needs to be developed in order to measure stigmatised attitudes, which may be more subtle or based on factors other than first impressions. Further analysis into the construct and criterion validity of the measure would be needed to increase confidence that the results were not due to the unsuitability of the measure to find an effect and ensure differences between scores were a result of the information received by participants. Further research may be beneficial to measure different types of reactions to new colleagues or to measure attitudes that are developed once somebody is already working alongside other MHPs.

Additionally, given that research shows MHPs are likely to have awareness of existing stigma, it is possible that the research was vulnerable to social desirability bias. It is also possible that as a result of their training, MHPs would be more skilled at reflecting on their own biases, meaning they may have re-evaluated responses that initially reflected negative judgements. Consequently, it is possible if an effect exists, it would be a smaller effect as participants may not want to be seen as showing stigmatising attitudes. Therefore, a larger sample would be needed to find a smaller effect.

It is also possible that the study may have been vulnerable to selection bias – although we did not advertise the true aims of the study, people who had experiences of facing stigmatising attitudes may be more likely to take interest in a study about how colleagues are judged.

Limitations

A number of limitations should be noted. Firstly, the sample predominantly consisted of a white British female demographic. This may limit the generalisability of the study to other populations. It is possible that people from different backgrounds or cultures may have different experiences or relationships with stigma, due to the intersection of other types of discrimination (Jackson-Best & Edwards, 2018). Additionally, the study aimed to recruit a range of MHPs but the final sample consisted predominantly of clinical psychologists and mental health nurses. As a result, there was limited opportunity to compare responses between different professions.

A further limitation is that the sample size was slightly below what was needed to detect a moderate effect, therefore a larger sample may have found different results. Additionally, the WEMWBS measure was used to assess general wellbeing, rather than taking a specific measure of current experiences of mental health problems.

Consequently, it is not possible to specify whether this was measuring participants' acute mental state or longer-term mental health difficulties.

As previously mentioned, the JONCS measure was developed for the purpose of the study, therefore the study is limited as the results found may be due to limitations of this measure. Factor analysis of this measure showed that test items did not group as initially expected when the measure was developed and the construct and criterion validity was not investigated. As such, the results of this study should be interpreted with caution.

Furthermore, as the factor analysis suggested it was inappropriate to use subscales regarding judgements made, the JONCS was scored by calculating an average score for all test items. However, this means that more extreme scores for specific items may have skewed the scores. It may have been more appropriate to include a total score of all test items, to avoid this. Alternatively, using an average score also means it was not possible to identify differences between specific test items, meaning complexities in the data may have been lost in the analysis.

Further, the JONCS relied on assessment of explicit stigmatised attitudes, which may have been problematic. Explicit measures have been shown to be limited in accurately measuring socially unacceptable biases, and research suggests their outcomes do not necessarily match measures of implicit attitudes regarding the same subjects (Stier & Hinshaw, 2007).

Additionally, the study did not check whether participants' were aware of the true aims of the study. If they had awareness, this may have influenced their responses, as discussed. Further, it may have been prudent to include a measure of social desirability bias or to include a measure of whether participants would want to be seen as viewing the colleague in a positive manner (Nederhof, 1985).

Further research

This study was a preliminary attempt to investigate whether MHPs hold stigmatising views towards MHPs with mental health difficulties. This research did not find that MHPs with mental health problems would be judged negatively by others, when joining a new team. This is in contradiction to some of the concerns that MHPs have about disclosure that have been highlighted previously. Further qualitative research may be helpful to investigate what the experience of disclosing mental health difficulties within the workplace is like for MHPs. This may also add to current understanding about the decision-making process regarding disclosure for MHPs. It may also inform ways that supervisors or other colleagues can helpfully respond to disclosure, to reduce the stress around this issue.

It would also be interesting to investigate whether different attitudes or expectations are held regarding service users or MHPs with mental health problems and how this affects how others respond to them. Previous literature has identified that labelling can be suggestive of separation between “us” and “them” (Rüsch et al., 2005) therefore different processes may occur depending on perceived social groupings.

Further, it may be interesting to investigate whether there are differences in responses towards colleagues with physical health problems or mental health problems. It may be valuable to ascertain whether varying attitudes are held by different groups of people, such as whether different responses are found between MHPs and the general public.

This research measured attitudes after participants had seen a video of a new colleague. This design may have given people more opportunity to feel personally connected with the subject, which may override less favourable judgements. Further research could test whether receiving information about mental health difficulties in different formats, e.g. as written background information or alongside a photograph of a new colleague, would result in similar responses.

As mentioned, the study is likely to be susceptible to social desirability bias. To account for this in further research, forced choice methods could be used, in line with suggestions for managing social desirability (Nederhof, 1985). For example, by investigating whether there is a difference in response to potential new team members when deciding between a new colleague with or without mental health difficulties. Further research may also benefit from using other implicit measures of stigmatising attitudes, which assume implicit attitudes are beyond participants’ conscious awareness and are more likely to represent true discriminatory behaviour (Stier & Hinshaw, 2007). For example, previous studies have used the Implicit Association Test (e.g. Greenwald & Banaji, 1995) or have measured psychophysiological differences (e.g. Graves, Cassisi & Penn, 2005) in responses to mental health problems. To build on the current research, psychophysiological differences (e.g. heart rate or brow muscle tension) could be measured between participants in different conditions, when making judgements about the fictitious colleague.

The background information people received also indicated that the mental health difficulties experienced were historical, and some time ago. Previous research has suggested that greater stigma is associated with current mental health problems than historical (Bushnell et al., 2005), therefore it may be interesting for further research to investigate whether the length of time since a mental health problem was experienced makes a difference to how people are judged.

Finally, it would be helpful to have more of an understanding about the factors, personal characteristics and processes that prevent stigmatising attitudes, so this understanding can be shared to lessen and overcome the impact of stigma in other areas. This could inform training on a wider level or public anti-stigma campaigns.

Conclusion

This study aimed to investigate whether MHPs hold stigmatised attitudes towards other MHPs with mental health problems. The results showed the judgements made about a fictitious MHP were not affected by information that they had a historical mental health problem. This is promising in terms of understanding stigma in the workplace for MHPs regarding their personal mental health, particularly as the results showed that a high proportion of participants had experiences of mental health problems.

References

Abbey, S., Charbonneau, M., Baici, W., Layla Dabby, M.D., Gautam, M. & Pare, M. (2011). Stigma and discrimination. *Canadian Journal of Psychiatry, 56*(10), S1.

Barnett, M. (2007). What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors. *Psychodynamic Practice, 13*(3), 257–274.

Biernat, M. & Dovidio, J.F. (2000). *Stigma and stereotypes.* In: The Social Psychology of Stigma, 88–125, Guildford Press: New York.

Bushnell, J., McLeod, D., Dowell, A., Salmond, C., Ramage, S., Collings, S., …MaGPIe (Mental Health and General Practice Investigation) Research Group. (2005). Do patients want to disclose psychological problems to GPs? *Family Practise, 22*, 631-637.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614–625.

Corrigan, P.W. & Matthews, A.K. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health, 12,* 235–248.

Corrigan, P.W., Michaels, P.J., Vega, E., Gause, M., Watson, A.C. & Rüsch, N. (2013). Self-stigma of mental illness scale – short form: Reliability and validity. *Psychiatry Research, 199*(1), 65–69.

Corrigan, P.W. & Roa, D. (2012). On the self-stigma of mental illness: Stages, disclosure and strategies for change. *Canadian Journal of Psychiatry, 57*(8), 464–469.

Corrigan, P.W. & Watson, A.C. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology, 25*(8), 875–884.

Costin, C. & Johnson, C.L. (2002). Been there, done that: Clinician's use of personal recovery in the treatment of eating disorders. *Eating Disorders, 10,* 293–303.

Edwards, J.L. & Crisp, D.A. (2016). Seeking help for psychological distress: Barriers for health professionals. *Australian Journal of Psychology,* 69(3), 218–225.

Emerson, S. & Markos, P.A. (1996). Stigma and symptoms of the impaired counselor. *Journal of Humanistic Education and Development, 34*(3), 108–117.

George, D., & Mallery, P. (2003). SPSS for Windows Step by Step: A Simple Guide and Reference. 11.0 update (4th ed.). Boston: Allyn & Bacon.

Gras, L.M., Swart, M., Sloof, C.J., van Weeghel, J., Knegtering, H. & Castelein, S. (2015). Differential stigmatising attitudes of healthcare professionals towards psychiatry and patients with mental health problems: Something to worry about? A pilot study. *Social Psychiatry and Psychiatric Epidemiology, 50*(2), 299–306.

Graves, R. E., Cassisi, J. E., & Penn, D. L. (2005). Psychophysiological evaluation of stigma towards schizophrenia. *Schizophrenia Research*, *76*(2-3), 317-327.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: attitudes, self-esteem, and stereotypes. *Psychological Review*, *102*(1), 4.

Grice, T., Alcock, K. & Scior, K. (2018a). Factors associated with mental health disclosure outside of the workplace: A systematic literature review. *Stigma and Health, 3*(2), 116-130.

Grice, T., Alcock, K., & Scior, K. (2018b). Mental health disclosure amongst clinical psychologists in training: Perfectionism and pragmatism. *Clinical Psychology & Psychotherapy*, *25*(5), 721-729.

Health and Social Care Advisory Service. (2005). *Making a real difference: Strengthening service user and carer involvement in NIMHE: Final report.* London, UK: HASCAS.

Henderson, C., Robinson, E., Evans-Lacko, S., Corker, E., Rebollo-Mesa, I., Rose, D. & Thornicroft, G. (2016). Public knowledge, attitudes, social distance and reported contacted regarding people with mental illness 2009–2015. *Acta Psychiatric Scandinavica*, *134*(suppl 446), 22-33.

Ignatius, E. & Kokkonen, M. (2007). Factors contributing to verbal self-disclosure. *Nordic Psychology*, *59*(4), 362–391.

Jackon-Best, F. & Edwards, N. (2018). Stigma and intersectionality: A systematic review of systematic reviews across HIV/AIDS, mental illness and physical disability. *BMC Public Health, 18*(919), doi.org/10.1186/s12889-018-5861-3.

Jones, A.M. (2011). Disclosure of mental illness in the workplace: A literature review. *American Journal of Psychiatric Rehabilitation, 14*, 212–229.

Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australina public and health professionals. *Australian and New Zealand Journal of Psychiatry, 33*(1), 77–83.

Katsavdakis, K.A., Gabbard, G.O. & Athey, G.I. Jr. (2004). Profiles of impaired health professionals. *Bulletin of Menninger Clinic*, *68*(1), 60–72.

Kleespies, P.M., Van Orden, K.A., Bongar, B., Bridgeman, D., Bufka, L.F., Galper, D.I. & Yufit, R.I. (2011). Psychological suicide: incidence, impact, and suggestions for prevention, intervention and postvention. *Professional Psychology: Research and Practice, 42*(3), 244-251.

Korsbek, L. (2013). Disclosure: What is the point and for whom? *Journal of Mental Health, 22*(3), 283-290.

Kroska, A. & Harkness, S.K. (2008). Exploring the role of diagnosis in the modified labeling theory of mental illness. *Social Psychology Quarterly, 71*(2), 193-208.

Lam, D.C., Salkovskis, P.M. & Hogg, L.I. (2016). “Judging a book by its cover”: An experimental study of the negative impact of a diagnosis of borderline personality disorder on clinicians’ judgement of uncomplicated panic disorder. *The British Journal of Clinical Psychology, 55*(3), 253–268.

Link, B,G., Cullen, F.T., Struening, E., Shrout, P.E. & Dohrenwend, B.P. (1989). A modified labelling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*(3), 400–423.

Morse, G., Salyers, M.P., Rollins, A.L., Monro-DeVita, M. & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 341–352.

Nederhof, A.J. (1985). Methods of coping with social desirability bias: A review. *European Journal of Social Psychology, 15*(3).

Neech, S.G.B., Scott, H., Priest, H.M., Bradley, E.J. & Tweed, A.E. (2018). Experiences of user involvement in mental health settings: User motivations and benefits. *Journal of Psychiatric and Mental Health Nursing, 25*(5-6), 327-337.

Pachankis, J.E. (2007). The psychological implications of concealing a stigma: A cognitive-affective behavioural model. *Psychological Bulletin, 133*(2), 328-345.

Pilowski, L. & O’Sullivan, G. (1989). Mental illness in doctors. *British Medical Journal, 298*(6669), 269.

Priester, P.E., Azen, R., Speight, S. & Vera, E.M. (2007). The impact of counsellor recovery status similarity on perceptions of attractiveness with members of alcoholics anonymous. *Rehabilitation Counseling Bulletin, 51*(1), 14–20.

Quinn, D.M., Kahng, S.K. & Crocker, J. (2004). Discreditable: Stigma effects of revealing a mental illness history on test performance. *Personality and Social Psychology Bulletin, 30*(7), 803–815.

Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A. & Luty, J. (2009). A study of stigmatised attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing, 16,* 279–284.

Reavley, N.J., Mackinnon, A.J., Morgan, A.J. & Jorm, A.F. (2014). Stigmatising attitudes towards people with mental disorders: A comparison of Australian health professionals with the general community. *Australian and New Zealand Journal of Psychiatry, 48*(5), 433–441.

Rüsch, N., Angermeyer, M.C. & Corrigan, P.W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*(8), 529-539.

Schulze, B. (2007). Stigma and mental health professionals. A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19*(2), 137–155.

Sheehan, L., Nieweglowski, K., & Corrigan, P. (2016). The stigma of personality disorders. *Current Psychiatry Reports*, *18*(1), 11.

Sherman, M.D. (1996). Distress and professional impairment due to mental health problems among psychotherapists. *Clinical Psychology Review, 16*(4), 299-315.

Sirey, J.A., Bruce, M.L., Alexopoulos, G.S. et al. (2001a). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry, 158*(3), 479–481.

Sirey, J.A., Bruce, M.L., Alexopoulos, G.S. et al. (2001b). Stigma as a barrier to recovery perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherences. *Psychiatric Services, 52*(12), 1615–1620.

Stier, A. & Hinshaw, S.P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist, 42*(2), 106-117.

Sussman, M.B. (2007). *A curious calling.* New York: Jason Aronson.

Tajfel, H., & Turner, J.C. (1979). An Integrative Theory of Intergroup Conflict. In *Organizational Identity*. Oxford University Press: New York.

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J. & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes, 5*(63), doi.org/10.1186/1477-7525-5-63.

Thornicroft, G. (2006). *Shunned: Discrimination against people with Mental Illness* (Vol. 339): Oxford: Oxford University Press.

Time to Change, (2019). Let's end mental health discrimination. Retrieved from https://www.time-to-change.org.uk/.

Wood, L., Birtel, M., Alsawy, S., Pyle, M., & Morrison, A. (2014). Public perceptions of stigma towards people with schizophrenia, depression, and anxiety. *Psychiatry Research*, *220*(1-2), 604-608.

White, A., Shiralkar, P., Hassan, T., Galbraith, N. & Callagan, R. (2006). Barriers to mental healthcare for psychiatrists. *Psychiatric Bulletin, 30*(10), 382–384.

Whittle, C. (2017). *Discussing disclosure: a mixed method exploration of disclosing mental health problems.* (Unpublished dissertation). Department of Psychology: University of Bath.

(Page left intentionally blank)

Executive Summary of Main Research Project

Experiencing mental health problems is a stigmatising issue, which has been associated with suffering, disability and poverty. This stigma can effect the perception people have about how they themselves will be treated if they have mental health problems and can act as a barrier to seeking help, participating fully with mental health services and integrating with society. Research has suggested that mental health professionals (MHPs) have an increased risk of developing mental health difficulties due to the demands of the job and material they are exposed to. Previous literature suggests that disclosure within the workplace in general can be difficult, and that some MHPs would be reluctant to disclose their mental health problems to their colleagues. Additionally, research also suggests MHPS are not immune to developing their own stigmatised attitudes towards others with mental health problems. Little is known about whether such stigmatising attitudes extend to other MHP colleagues, who suffer from mental health problems. It is likely that if this is the case, it will have important implications for MHPs readiness to disclose in the workplace and their overall wellbeing.

This research therefore aimed to investigate whether MHPs hold stigmatised attitudes towards other MHPs with mental health problems, by investigating how potential new MHPs with mental health problems are judged by other MHPs. It also aimed to investigate whether specific diagnostic labels impact the judgements that are made. It was hypothesised that information about historical mental health difficulties would result in more negative judgements being made about a fictitious new colleague.

A sample of 171 mental health professionals were recruited through training events, NHS workplaces and online, via social media advertisement. The research was advertised as investigating perceived important personal qualities in new colleagues, to reduce demand characteristics. A cross-sectional experimental design was adopted. Participants were randomly allocated to one of four conditions with different background information to read about a fictitious prospective colleague. The conditions were as follows: 1) background information only (control); 2) behavioural description of mental health difficulties; 3a) historical depression diagnosis; 3b) historical borderline personality disorder diagnosis. They were then shown a short video clip in which the fictitious colleague introduced themself. After watching the video, participants completed measures to assess their perception of the colleague, demographic information, their general psychological wellbeing and own levels of self-stigma.

The measure used to assess participants' perception of the colleague was developed for the purpose of the study (Judgment of New Colleague Scale, JONCS). 15 items were found to have good test-retest reliability. Five items with *r*-value<0.7 were excluded from the analysis. Factor analysis showed that items did not reliably group into subscales therefore an average score of the remaining 15 items was used for the analysis.

The results showed that the judgments made about a fictitious MHP were not effected by information that they had a historical mental health problem. Additionally, the results showed a high proportion of MHPs (59%) reported experiencing personal mental health difficulties.

The results tentatively suggest that MHPs are more concerned about the consequences of disclosing their own experiences of mental health difficulties than may be necessary, based on the reality of what disclosure may be like within the current climate. This is promising in terms of understanding stigma in the workplace for MHPs regarding their personal mental health. It is possible that there has been a shift in stigmatizing attitudes towards people with mental health problems, possibly as a result of recent anti-stigma campaigns and increased involvement of people with personal experience in mental health services. It is also possible that different processes occur regarding stigma when making judgments about others who share a similar identity to ourselves, or depending on the purpose of the judgment.

It is possible that no effect was found as a result of the measure that was used, as this was the first use of this measure; or due to effects of social desirability bias, which may mean a larger sample would be required to detect an effect.

This research contributes to our understanding of stigma and disclosure regarding mental health problems. Further research is needed to understand the experience of disclosing mental health difficulties for MHPs and to understand the processes that prevent stigmatizing attitudes, which may help to lessen the impact of stigma in other areas.

Connecting Narrative

In this connecting narrative, I will reflect on my experiences of conducting the research aspect of the course, including reflections on the separate components: the literature review, service improvement project, main research project and case studies.

Despite having completed research previously, I was apprehensive about the research element of training. In particular, I found developing the projects to be the most difficult part of the research experience and the end of the first year was probably when I felt most stressed and overwhelmed during the training experience. I reflected that in my previous experience, I had usually worked on projects that were already in development by the time I started working with them, so to start from scratch, in areas of my own choosing, felt very daunting. I hadn't come on to training with particular research questions in mind so it was hard to know where to start. The research conference helped for inspiration and I had a lot of interesting conversations with potential supervisors which helped with the thinking process, but it took a lot of work to turn these ideas into well thought out projects, with specific research questions.

My final projects have ended up in a variety of areas, which has helped me to develop a range of different research skills. I think one of the difficulties of the research element of the course is trying to manage the different projects alongside each other and needing to continually switch focus in order to keep everything moving forward. This has left me with the constant feeling that I must be forgetting something. I noticed fairly early on that I worked best when trying to focus on only a couple of projects at a time, but this was difficult to stick to when there are external pressures or factors that feel out of your control. I developed a rather optimistic GANT chart with my personal tutor in the first year which has gone through many changes since then. It has been really hard at times to believe that it would all come together but I have been surprised with how much can be done within the time frame and am proud of the end result.

Literature Review

I had previously completed a systematic review as part of an MSc programme and enjoyed the structure and focus of it so I was looking forward to this project. I found the process of pinning down a specific idea really challenging. It seemed like everything I looked into had either been done already, or there was not enough research in the area to constitute or justify a systematic review. This process took much longer than I expected, despite thinking I had started with plenty of time, and I remember panicking that it would be an impossible task.

I landed on my final idea through a conversation about excessive reassurance seeking. This was a concept that I was beginning to hear a lot about on the course, mostly with regards to anxiety and obsessive-compulsive disorder. I was interested in whether this idea had been applied to other mental health difficulties and after research, learned about the interpersonal theory of depression (Coyne, 1976). This theory considers the role of excessive-reassurance seeking (ERS) in the development and maintenance of depression and posits that this behaviour can result in rejection from close others, which serves to maintain negative beliefs about the self, and maintains depressive symptoms. This was a theory that I was not familiar with previously, but that really made sense to me as I learned more about it. I found I could easily imagine the ramifications of excessive-reassurance seeking in relation to interpersonal relationships and how this could maintain low mood.

My preliminary scoping showed that a meta-analysis had been done on this topic previously, but ten years earlier, and I initially thought about replicating this to update the evidence. I was also interested in the developmental aspects of ERS behaviour and depression and hoped to cover both. Through conversations with my supervisors, we considered the scope of the project and decided that focusing on ERS behaviours and depression in young people would be adding more to the existing literature and have a clearer research focus.

As a meta-analysis had been conducted previously, it seemed most appropriate to take this approach in order to be able to make comparisons and consider the findings within the context of existing literature. I had not used this approach before and was apprehensive about this, but I am pleased to have learned the skills for this and would be more inclined to embrace using this methodology in the future. I think this project in particular has helped me to be thorough when conducting research, particularly when searching for all possible research to include e.g. by contacting study authors and keeping track of why studies were excluded. This has also demonstrated to me the importance of having a clear rationale for inclusion and exclusion criteria and holding a specific question in mind. Additionally, although conducting quality assessments sometimes seemed like a laborious process as I found I went back over them and made amendments several times as I read new papers, this helped me to consider the papers more critically and I think this has helped me to become a more analytic reader of research in general. I am pleased to have conducted this research and will be interested to continue to find out more about this topic.

Service Improvement Project

My service improvement project (SIP) has been the project I enjoyed the most. I think this has been because the research question and results seem so directly applicable to clinical practise, and so this in some ways feels like it has been the most immediately "useful" piece of work. For me, the project meant returning to an area of interest, as I had previous experience of completing qualitative research with people who had experiences of eating disorders.

I initially prepared a different project for my SIP, which went through the Project Approval Session process. I was told in this session that this idea was more suited to a consultancy project. Although it was good to have an idea for a consultancy project early on, this was frustrating at the time as we had had very limited teaching on the difference between a SIP and a consultancy project, so I was unsure what the difference was at this stage. However, I have enjoyed both projects, which are in very different areas, and so I am glad I was able to use both ideas.

The idea for my final SIP came together quickly after this setback and it seemed like the service had a clear need and motivation for the project. This meant that the design and purpose of the research was much clearer from the start and I felt excited about the potential for meeting a pressing need. When preparing the project, I took potential interview questions to the service's user involvement committee. It was really valuable to get their feedback on how to word the questions and to confirm that the questions we planned to ask seemed relevant. Recruitment was initially slow but I had a lot of support from my external supervisor, which definitely helped with the experience of conducting the research. I really appreciated the involvement of each participant and noticed that some were keen to contribute their ideas about how the transition process could be improved. This seemed important to reflect on when analysing the data and considering possible biases for the research, as some had strong ideas and had clearly had emotional experiences of leaving inpatient care. It was therefore helpful to reflect in supervision whether I was more drawn to points they had brought up when developing themes.

I noticed value from transcribing the interviews myself, as well as conducting them, in terms of really immersing myself in the data and having a second chance to hear the interviews, in order to notice things I may have initially missed and re-evaluate potential assumptions. I had previously conducted qualitative research but ended up completing the analysis in a short time frame as this was my dissertation for a Master's degree, and the ethical approval came through very late. In this instance, I found it difficult to clarify themes and to step outside of the detail to have an overview, due to the limited time frame. With this in mind, I was careful to give myself enough time when analysing the data for this piece of research and found it helpful to take breaks, especially when reviewing the similarities or overlap between themes.

Regarding the analysis, my internal supervisor and I considered carefully whether it would be helpful to have a second person to code some of the interviews. After reading around this and watching a lecture by Braun and Clarke, we agreed instead to have supervisory reflective sessions, to account for the fact that qualitative research is unavoidably effected by individual assumptions and perspectives to some extent. These sessions were really useful for reflecting on why I had come to particular conclusions and for staying alert to potential biases. I was also grateful for input from Dr Felicity Cowdrey, who agreed to look over the research from the perspective of someone currently working in an eating disorder setting. This helped me to reflect on the themes further and to think about how to write the research up in a way that made clinical sense within this setting.

I am looking forward to hearing how the results of this project are taken forward by the service and will be interested to learn more about improving transitions between services in general in the future.

Main Research Project

My initial interest in this project stemmed from an interest in the literature surrounding disclosure of mental health difficulties. This seems like an exciting research area at the moment and I felt it was really important to understand this issue, particularly within the current climate where disclosure is perhaps encouraged societally and with increasing involvement of people with personal experience in mental health services. I was particularly interested in this from an identity perspective and if there are particular challenges of holding dual identities of being someone who provides mental health care and experiences their own mental health difficulties. After previous personal experiences and learning about how high the rates of mental health problems are within mental health professionals, I was interested in what it would be like to disclose in a mental health context and was drawn to the project for this reason. It has also been interesting to think about this issue while recognising the stresses that we are going through as part of the training experiences and recognising the impact this can have.

When I was developing research ideas, it seemed there may be scope for a qualitative piece of research around what disclosure is like for mental health professionals and whether different processes occur when compared with others who do not work in mental health. However, although there was existing evidence that mental health professionals report concerns about disclosing within the workplace, I did not find research regarding potential attitudes towards disclosure from others from mental health professionals. The final project therefore seemed to be a sensible next step to further the existing evidence by investigating how mental health professionals with mental health problems are perceived by others.

As I was developing the project, I noticed it felt uncomfortable to assert the hypothesis that mental health professionals might hold stigmatising attitudes towards others. This made me reflect on my position as a mental health professional and how I would hope others with mental health problems would be treated. I also considered how this could create barriers to conducting research in areas that feel difficult to talk about.

We thought carefully about who to approach regarding recruitment for this project and initially planned to recruit through NHS settings as a contingency plan. After consideration, we decided to start the application process earlier than planned to broaden the options for recruitment. Despite this, there was a lot of back and forth and mixed messages throughout the process which was extremely frustrating amongst all the other research commitments. Once it came through, I found that it was difficult to recruit through NHS bases, given the numerable time pressures that staff are already under. This meant that many approached through these avenues completed the study online and in their own time, which I am grateful for. This process also raised some issues about how to run the study as some managers were uncomfortable with me running the study in small groups or one-to-one due to the sensitive nature of some of the demographic information. I also contacted lots of local charity bases but found that most either did not reply or said they would struggle to find the time. It felt quite difficult to pursue this, particularly as this raised awareness of how stretched so many services are. I found the process of recruiting online to be interesting in terms of considering which channels to focus on and found that professional groups on social media were the most fruitful and some were generous in sharing the advert further. I considered whether this would effect the responses that people gave and was surprised that this did not appear to have an effect, after inspecting the results.

I found it interesting to interpret the results supporting the null hypothesis and this made me think carefully about the ways in which the design may have created limitations for the study. It was particularly interesting to consider this in comparison to another study of a similar design. However, I was pleased that this result seemed initially promising in terms of stigma and I would like to continue to research this area in the future.

Case Studies

My first case study was a single-case experiment design piece of work, which I think helped to structure my thinking in writing up the case studies from the start. I completed this piece of work in the context of an Improving Access to Psychological Therapy (IAPT) service, and found this an easier way to include measures in each session as this was already included in the structure of the service. I have noticed throughout the rest of my placements that it has sometimes felt like a struggle in different contexts or under different supervisors to include outcome measures to supplement the assessment and outcome of therapy, or that different services have not necessarily had “go to” outcome measures. I have also reflected that it has sometimes been difficult to choose relevant outcome measures from the first session, which has sometimes made writing up a case study tricky. I have found that the initial referral did not always fit with what seemed most helpful after the first session, or that the focus of therapy would evolve into something different. This experience has helped me to think carefully about choosing outcome measures that accurately reflect the therapy experience and progress.

Despite this, I have found writing case studies to be a really useful exercise in reflecting on a piece of work and to think about how well the case and outcome fit with the existing evidence. I have noticed that the cases I have written up have often been with people that I have left placements with strong feelings about or feeling particularly invested in their wellbeing. This has made me think about how having the extra thinking space and probably an additional expectation will undoubtedly change the work and the relationship with the client. With this in mind, I have always felt very grateful to client’s for agreeing to have their experiences written up and have tried to hold this in mind and be careful when anonymising details and writing up difficult experiences thoughtfully. I was surprised at how willing people were to give consent to have their work written up and also that people did not ask to see the work.

I found that writing a systemic case study on my learning disabilities placement was initially challenging and with the shift in approach, it took me a while to structure and to think about how to write this up concisely. I think working with this case has been invaluable in helping me to formalise some systemic concepts in my mind and recognising when specific techniques would be most useful, as these had perhaps seemed more abstract.

Conclusion

In conclusion, I feel I have learned a lot through the experience of conducting research in different areas and have gained a variety of skills that I hope to take forward in my future career. I have noticed that I am particularly interested in how people relate to others when experiencing mental health problems and how systemic factors can be key when understanding their experiences. This has seemed to be a theme throughout my research.

(*Page left intentionally blank)*

Acknowledgements

Firstly, I would like to thank my research supervisors, whose insight and experience has been invaluable. I would like to thank Lorna Hogg, for the stimulating conversations that helped me to shape up my MRP and for your support and patience with this process; and Dr Falguni Nathwani and Dr Cathy Randle-Phillips for helping me to complete and make sense of this project. Thank you to Dr Cara Davis and Dr Catherine Hamilton-Giachritsis for your support with my literature review and for encouraging me when it was most challenging; and to Dr Gemma Taylor for your statistical expertise. I would especially like to thank Dr James Gregory for your enthusiasm, encouragement and support with my SIP. Thank you also to Dr Sanni Norweg for your help with recruitment and to Dr Felicity Cowdrey for your thoughts about the clinical relevance of the project.

I would like to thank my clinical tutors, Dr Megan Wilkinson-Tough and Dr Cathy Randle-Phillips. Thank you to Megan for helping me to navigate the first challenges of training, and for inspiring me to think about what kind of clinical psychologist I want to be. Thank you to Cathy for supporting me through the later challenges and for helping me to stay positive and believe it would all come together.

I would particularly like to thank my parents for your endless and unconditional support and for modelling and teaching me the values and empathy that have helped me to find my place in this profession.

It has been a lovely benefit of training to have moved closer and be able to spend more time with my grandparents - thank you for your boundless positivity and support.

I would also like to acknowledge my friends, who I have seen much less of than I would have liked while I have been busy writing these portfolios! Thank you for your patience and I am looking forward to seeing much more of you soon. Thank you particularly to Dannie and Debbie for helping me to believe in myself in the difficult times.

I would like to especially thank Dan, for being such a reassuring and grounding presence and for helping me to keep perspective and have fun when things have been challenging.

And finally, I would like to thank the wonderful, strong, and hugely compassionate women who I have been so lucky to have as part of my cohort. Thank you for being such a source of inspiration and support and for being great company

throughout. I hope I have made some lifelong friends and that we continue to lift each other up.

Dedicated to my Grandad, Colin Freshney.

Appendices

Appendix 1A: Search Strategy

(Child* OR adol* OR teen* OR young pe* OR youth*) AND ((Reassur* OR assur*) AND (seek* OR request*))

OR (Child* OR adol* OR teen* OR young pe* OR youth*) AND ("excessive reassurance")

OR (Child* OR adol* OR teen* OR young pe* OR youth*) AND ("interactional theory of depression")

OR (Child* OR adol* OR teen* OR young pe* OR youth*) AND ("interpersonal theory of depression")

Appendix 1B: Data Extraction Form

THE COCHRANE
COLLABORATION®

1. Data collection form

Intervention review – RCTs and non-RCTs

This form can be used as a guide for developing your own data extraction form. Sections can be expanded and added, and irrelevant sections can be removed. It is difficult to design a single form that meets the needs of all reviews, so it is important to consider carefully the information you need to collect, and design your form accordingly. Information included on this form should be comprehensive, and may be used in the text of your review, 'Characteristics of included studies' table, risk of bias assessment, and statistical analysis.

Notes on using a data extraction form:

- Be consistent in the order and style you use to describe the information for each included study.
- Record any missing information as unclear or not described, to make it clear that the information was not found in the study report(s), not that you forgot to extract it.
- Include any instructions and decision rules on the data collection form, or in an accompanying document. It is important to practice using the form and give training to any other authors using the form.
- You will need to protect the document in order to use the form fields (Tools / Protect document)

Review title or ID

Study ID *(surname of first author and year first full report of study was published e.g. Smith 2001)*

Report IDs of other reports of this study *(e.g. duplicate publications, follow-up studies)*

Notes:

1. General Information

1. **Date form completed** *(dd/mm/yyyy)*	
2. **Name/ID of person extracting data**	
3. **Report title** *(title of paper/ abstract/ report that data are extracted from)*	
4. **Report ID** *(if there are multiple reports of this study)*	
5. **Reference details**	
6. **Report author contact details**	

7. **Publication type** *(e.g. full report, abstract, letter)*	
8. **Study funding source** *(including role of funders)*	
Possible conflicts of interest *(for study authors)*	
9. **Notes:**	

2. Eligibility

Study Characteristics	**Review Inclusion Criteria** *(Insert inclusion criteria for each characteristic as defined in the Protocol)*	**Yes/ No / Unclear**	**Location in text** *(pg & ¶/fig/table)*
10. **Type of study**	Randomised trial	...	
	Non-randomised trial	...	
	Controlled before-after study - Contemporaneous data collection - At least 2 intervention and 2 control clusters	...	
	Interrupted time series OR Repeated measures study - At least 3 timepoints before and 3 after the intervention - Clearly defined intervention point	... ...	
	Other design (specify):	...	
11. **Participants**		...	
12. **Types of intervention**		...	
13. **Types of outcome measures**		...	
14. **Decision:**	...		
15. **Reason for exclusion**			
16. **Notes:**			

DO NOT PROCEED IF STUDY EXCLUDED FROM REVIEW

3. Population and setting

	Description *Include comparative information for each group (i.e. intervention and controls) if available*	**Location in text** *(pg & ¶/fig/table)*
17. **Population description** *(from which study participants are drawn)*		
18. **Setting** *(including location and social context)*		

	Description *Include comparative information for each group (i.e. intervention and controls) if available*	**Location in text** *(pg & ¶/fig/table)*
19. **Inclusion criteria**		
20. **Exclusion criteria**		
21. **Method/s of recruitment of participants**		
22. **Notes:**		

4. Methods

	Descriptions as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
23. **Aim of study**		
24. **Design** *(e.g. parallel, crossover, non-RCT)*		
25. **Unit of allocation** *(by individuals, cluster/ groups or body parts)*		
26. **Start date**		
27. **End date**		
28. **Duration of participation** *(from recruitment to last follow-up)*		
29. **Notes:**		

5. Risk of Bias assessment

See Chapter 8 of the Cochrane Handbook. Additional domains may be required for non-randomised studies.

Domain	**Risk of bias** *Low/ High/Unclear*	**Support for judgement**	**Location in text** *(pg & ¶/fig/table)*
30. **Random sequence generation** *(selection bias)*	…		
31. **Allocation concealment** *(selection bias)*	…		
32. **Blinding of participants and personnel** *(performance bias)*	…	**Outcome group:**	
(if required)	…	**Outcome group:**	
33. **Blinding of outcome assessment** *(detection bias)*	…	**Outcome group: All/**	
(if required)	…	**Outcome group:**	

Domain	Risk of bias *Low/ High/Unclear*	Support for judgement	Location in text *(pg & ¶/fig/table)*
34. **Incomplete outcome data** *(attrition bias)*	…		
35. **Selective outcome reporting?** *(reporting bias)*	…		
36. **Other bias**	…		
37. **Notes:**			

6. Participants

Provide overall data and, if available, comparative data for each intervention or comparison group.

	Description as stated in report/paper	Location in text (pg & ¶/fig/table)
38. **Total no. randomised** *(or total pop. at start of study for NRCTs)*		
39. **Clusters** *(if applicable, no., type, no. people per cluster)*		
40. **Baseline imbalances**		
41. **Withdrawals and exclusions** *(if not provided below by outcome)*		
42. **Age**		
43. **Sex**		
44. **Race/Ethnicity**		
45. **Severity of illness**		
46. **Co-morbidities**		
47. **Other treatment received** *(additional to study intervention)*		
48. **Other relevant sociodemographics**		
49. **Subgroups measured**		
50. **Subgroups reported**		
51. **Notes:**		

7. Intervention groups

Copy and paste table for each intervention and comparison group

1.1.1. Intervention Group 1

	Description as stated in report/paper	Location in text *(pg & ¶/fig/table)*
52. **Group name**		
53. **No. randomised to group** *(specify whether no. people or clusters)*		

	Description as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
54. **Description** *(include sufficient detail for replication, e.g. content, dose, components; if it is a natural experiment, describe the pre-intervention)*		
55. **Duration of treatment period**		
56. **Timing** *(e.g. frequency, duration of each episode)*		
57. **Delivery** *(e.g. mechanism, medium, intensity, fidelity)*		
58. **Providers** *(e.g. no., profession, training, ethnicity etc. if relevant)*		
59. **Co-interventions**		
60. **Economic variables** *(i.e. intervention cost, changes in other costs as result of intervention)*		
61. **Resource requirements to replicate intervention** *(e.g. staff numbers, cold chain, equipment)*		
62. **Notes**		

8. Outcomes

Copy and paste table for each outcome.

1.1.2. Outcome 1

	Description as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
63. **Outcome name**		
64. **Time points measured** *(specify whether from start or end of intervention)*		
65. **Time points reported**		
66. **Outcome definition** *(with diagnostic criteria if relevant and note whether the outcome is desirable or undesirable if this is not obvious)*		
67. **Person measuring/ reporting**		
68. **Unit of measurement** *(if relevant)*		

	Description as stated in report/paper		**Location in text** *(pg & ¶/fig/table)*
69. **Scales: upper and lower limits** *(indicate whether high or low score is good)*			
70. **Is outcome/tool validated?**	… *Yes/No/Unclear*		
71. **Imputation of missing data** *(e.g. assumptions made for ITT analysis)*			
72. **Assumed risk estimate** *(e.g. baseline or population risk noted in Background)*			
73. **Notes:**			

9. Results

Copy and paste the appropriate table for each outcome, including additional tables for each time point and subgroup as required.

1.1.3. For randomised or non-randomised trial - Dichotomous outcome

	Description as stated in report/paper				**Location in text** *(pg & ¶/fig/table)*
74. **Comparison**					
75. **Outcome**					
76. **Subgroup**					
77. **Time point** *(specify whether from start or end of intervention)*					
78. **Results** *Note whether:* **…** *post-intervention OR* **…** *change from baseline* *And whether* **…** *Adjusted OR* **…***Unadjusted*	**Intervention**		**Comparison**		
	No. events	No. participants	No. events	No. participants	
79. **Baseline data**	**Intervention**		**Comparison**		
	No. events	No. participants	No. events	No. participants	
80. **No. missing participants and reasons**					
81. **No. participants moved from other group and reasons**					
82. **Any other results reported**					
83. **Unit of analysis** *(e.g. by individuals, health professional, practice, hospital, community)*					

	Description as stated in report/paper		**Location in text** *(pg & ¶/fig/table)*
84. **Statistical methods used and appropriateness of these methods** *(e.g. adjustment for correlation)*			
85. **Reanalysis required?** *(if yes, specify why, e.g. correlation adjustment)*	… *Yes/No/Unclear*		
86. **Reanalysis possible?**	… *Yes/No/Unclear*		
87. **Reanalysed results**			
88. **Notes:**			

1.1.4. For randomised or non-randomised trial - Continuous outcome

	Description as stated in report/paper						**Location in text** *(pg & ¶/fig/table)*
89. **Comparison**							
90. **Outcome**							
91. **Subgroup**							
92. **Time point** *(specify whether from start or end of intervention)*							
93. **Post-intervention or change from baseline?**							
94. **Results** *Note whether:* **…** *post-intervention OR* **…** *change from baseline* *And whether* **…** *Adjusted OR* **…***Unadjusted*	**Intervention**			**Comparison**			
	Mean	SD (or other variance)	No. participants	Mean	SD (or other variance)	No. participants	
95. **Baseline data**	**Intervention**			**Comparison**			
	Mean	SD (or other variance)	No. participants	Mean	SD (or other variance)	No. participants	
96. **No. missing participants and reasons**							
97. **No. participants moved from other group and reasons**							
98. **Any other results reported**							

	Description as stated in report/paper		**Location in text** *(pg & ¶/fig/table)*
99. **Unit of analysis** *(e.g. by individuals, health professional, practice, hospital, community)*			
100. **Statistical methods used and appropriateness of these methods** *(e.g. adjustment for correlation)*			
101. **Reanalysis required?** *(if yes, specify why)*	… *Yes/No/Unclear*		
102. **Reanalysis possible?**	… *Yes/No/Unclear*		
103. **Reanalysed results**			
104. **Notes:**			

1.1.5. For randomised or non-randomised trial - Other outcome

	Description as stated in report/paper				**Location in text** *(pg & ¶/fig/table)*
105. **Comparison**					
106. **Outcome**					
107. **Subgroup**					
108. **Time point** *(specify whether from start or end of intervention)*					
109. **Type of outcome**					
110. **Results**	Intervention result	SD (or other variance)	Control result	SD (or other variance)	
	Overall results		SE (or other variance)		
111. **No. participant**	Intervention		Control		
112. **No. missing participants and reasons**					
113. **No. participants moved from other group and reasons**					
114. **Any other results reported**					
115. **Unit of analysis** *(e.g. by individuals, health professional, practice, hospital, community)*					

	Description as stated in report/paper		**Location in text** *(pg & ¶/fig/table)*
116. **Statistical methods used and appropriateness of these methods**			
117. **Reanalysis required?** *(if yes, specify why)*	…		
118. **Reanalysis possible?**	…		
119. **Reanalysed results**			
120. **Notes:**			

For controlled before-after study

	Description as stated in report/paper				**Location in text** *(pg & ¶/fig/table)*
121. **Comparison**					
122. **Outcome**					
123. **Subgroup**					
124. **Timepoint** *(specify whether from start or end of intervention)*					
125. **Post-intervention or change from baseline?**					
126. **Results**	Intervention result	SD (or other variance)	Control result	SD (or other variance)	
	Overall results		SE (or other variance)		
127. **No. participants**	Intervention		Control		
128. **No. missing participants and reasons**					
129. **No. participants moved from other group and reasons**					
130. **Any other results reported**					
131. **Unit of analysis** *(individuals, cluster/ groups or body parts)*					
132. **Statistical methods used and appropriateness of these methods**					

	Description as stated in report/paper		**Location in text** *(pg & ¶/fig/table)*
133. **Reanalysis required?** *(specify)*	… *Yes/No/Unclear*		
134. **Reanalysis possible?**	… *Yes/No/Unclear*		
135. **Reanalysed results**			
136. **Notes:**			

1.1.6. For interrupted time series or repeated measures study

	Description as stated in report/paper				**Location in text** *(pg & ¶/fig/table)*
137. **Comparison**					
138. **Outcome**					
139. **Subgroup**					
140. **Length of timepoints measured** *(e.g. days, months)*					
Total period measured					
141. **No. participants measured**					
142. **No. missing participants and reasons**					
143. **No. timepoints measured**	144. **Pre-intervention**		145. **Post-intervention**		
146. **Mean value** *(with variance measure)*					
147. **Difference in means (post – pre)**					
148. **Percent relative change**					
149. **Result reported by authors** *(with variance measure)*					
150. **Unit of analysis** *(individuals or cluster/ groups)*					
151. **Statistical methods used and appropriateness of these methods**					
152. **Reanalysis required?** *(specify)*	… *Yes/No/Unclear*				
153. **Reanalysis possible?**	… *Yes/No/Unclear*				
154. **Individual timepoint results**					
155. **Read from figure?**	… *Yes/No/Unclear*				
156. **Reanalysed results**	**Change in level**	**SE**	**Change in slope**		**SE**

	Description as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*

157. **Notes:**

10. Applicability

158. **Have important populations been excluded from the study?** *(consider disadvantaged populations, and possible differences in the intervention effect)*	... *Yes/No/Unclear*	
159. **Is the intervention likely to be aimed at disadvantaged groups?** *(e.g. lower socioeconomic groups)*	... *Yes/No/Unclear*	
160. **Does the study directly address the review question?** *(any issues of partial or indirect applicability)*	... *Yes/No/Unclear*	
161. **Notes:**		

11. Other information

	Description as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
162. **Key conclusions of study authors**		
163. **References to other relevant studies**		
164. **Correspondence required for further study information** *(what and from whom)*		
165. **Further study information requested** *(from whom, what and when)*		
166. **Correspondence received** *(from whom, what and when)*		
167. **Notes:**		

Appendix 1C: CASP Cohort Checklist

CASP
Critical Appraisal
Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle
Way Oxford OX2 7LG

CASP Checklist: 12 questions to help you make sense of a Cohort Study

How to use this appraisal tool: Three broad issues need to be considered when appraising a cohort study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 12 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Cohort Study) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

CASP
Critical Appraisal
Skills Programme

Paper for appraisal and reference:...

Section A: Are the results of the study valid?

1. Did the study address a clearly focused issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: A question can be 'focused' in terms of
- the population studied
- the risk factors studied
- is it clear whether the study tried to detect a beneficial or harmful effect
- the outcomes considered

Comments:

2. Was the cohort recruited in an acceptable way?

Yes ☐
Can't Tell ☐
No ☐

HINT: Look for selection bias which might compromise the generalisability of the findings:
- was the cohort representative of a defined population
- was there something special about the cohort
- was everybody included who should have been

Comments:

Is it worth continuing?

CASP
Critical Appraisal
Skills Programme

3. Was the exposure accurately measured to minimise bias?

Yes ☐
Can't Tell ☐
No ☐

HINT: Look for measurement or classification bias:

- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- were all the subjects classified into exposure groups using the same procedure

Comments:

4. Was the outcome accurately measured to minimise bias?

Yes ☐
Can't Tell ☐
No ☐

HINT: Look for measurement or classification bias:

- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- has a reliable system been established for detecting all the cases (for measuring disease occurrence)
- were the measurement methods similar in the different groups
- were the subjects and/or the outcome assessor blinded to exposure (does this matter)

Comments:

5. (a) Have the authors identified all important confounding factors?

Yes ☐
Can't Tell ☐
No ☐

HINT:
- list the ones you think might be important, and ones the author missed

Comments:

5. (b) Have they taken account of the confounding factors in the design and/or analysis?

Yes ☐
Can't Tell ☐
No ☐

HINT:
- look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

Comments:

6. (a) Was the follow up of subjects complete enough?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- the good or bad effects should have had long enough to reveal themselves
- the persons that are lost to follow-up may have different outcomes than those available for assessment
- in an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort

6. (b) Was the follow up of subjects long enough?

Yes ☐
Can't Tell ☐
No ☐

Comments:

Section B: What are the results?

7. What are the results of this study?

HINT: Consider
- what are the bottom line results
- have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference
- how strong is the association between exposure and outcome (RR)
- what is the absolute risk reduction (ARR)

Comments:

8. How precise are the results?

HINT:
- look for the range of the confidence intervals, if given

Comments:

9. Do you believe the results?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- big effect is hard to ignore
- can it be due to bias, chance or confounding
- are the design and methods of this study sufficiently flawed to make the results unreliable
- Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)

Comments:

Section C: Will the results help locally?

10. Can the results be applied to the local population?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- a cohort study was the appropriate method to answer this question
- the subjects covered in this study could be sufficiently different from your population to cause concern
- your local setting is likely to differ much from that of the study
- you can quantify the local benefits and harms

Comments:

11. Do the results of this study fit with other available evidence?

Yes ☐
Can't Tell ☐
No ☐

Comments:

12. What are the implications of this study for practice?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making • for certain questions, observational studies provide the only evidence • recommendations from observational studies are always stronger when supported by other evidence

Comments:

Appendix 1D: RStudio Script used for Quantitative Analysis

Script for Cross-Sectional Studies Analysis:

1. Install.packages(“meta”)
2. library(meta)
3. m<-metacor(r, n, study, data = correl_metaCS)
4. summary(m)
5. forest(m)
6. funnel(m)

Data from file correl_metaCS:

	Study	N	R
1	Abela2006	140	0.31
2	Joiner1999	68	0.42
3	Joiner2001	72	0.40
4	Nesi2015	619	0.47
5	Oppenheimer1	194	0.26
6	Oppenheimer2	402	0.14
7	Prinstein2005	598	0.25
8	Siegel2004	85	0.26
9	Stroud2018	126	0.04

Script for Longitudinal Studies Analysis:

1. Install.packages(“meta”)
2. library(meta)
3. m<-metacor(r, n, study, data = correl_metaLT)
4. summary(m)
5. forest(m)
6. funnel(m)

Data from file correl_metaLT

	Study	N	R
1	Hankin2018	467	0.08
2	Oppenheimer2	402	0.11
3	Prinstein2005	483	0.13
4	Siegel2004	85	0.22

Appendix 1E: Studies Excluded after Full-Text Screening

Table 1.4

Studies Excluded after Full-Text Screening

Study Reference	Reason for Exclusion
Abela, J., Adams, P., & Hankin, B. (2004). Contagious depression: Does excessive reassurance seeking moderate the relationship between parental and child depressive symptoms? *International Journal of Psychology, 39*(5–6, S), 199.	Conference presentation – abstract only
Abela, J. R. Z., & Taylor, G. (2003). Specific vulnerability to depressive mood reactions in schoolchildren: the moderating role of self-esteem. *Journal of Clinical Child and Adolescent Psychology*, *32*(3), 408-418.	No measure of ERS
Abela, J.R.Z, Skitch, S.A., Auerbach, R.P., & Adams, P. (2005). The impact of parental borderline personality disorder on vulnerability to depression in children of affectively ill parents. *Journal of Personality Disorders, 19*(1), 68–83.	Same sample as Abela et al., 2006
Abela, J.R.Z, Hankin, B.L., Haigh, E.A.P., Adams, P., Vinokuroff, T. & Trayhern, L. (2005). Interpersonal vulnerability to depression in high-risk children: the role of insecure attachment and reassurance seeking. *Journal of Child Clinical Child and Adolescent Psychology, 34*(1), 182–192.	Same sample as Abela et al., 2006
Abela, J. R., Morrison, E., & Starrs, C. (2007). Excessive reassurance seeking, self–esteem, and depressive symptoms in children of affectively ill parents: An experience sampling analysis. *Journal of Social and Clinical Psychology*, *26*(7), 849-869.	Same sample as Abela et al., 2006
Brière, F. N., Archambault, K., & Janosz, M. (2013). Reciprocal prospective associations between depressive symptoms and perceived relationship with parents in early adolescence. *The Canadian Journal of Psychiatry*, *58*(3), 169-176.	No measure of ERS
Cambron, M.J., Acitelli, L.K. (2010). Examining the link between friendship contingent self-esteem and the self-propagating cycle of depression. *Journal of Social and Clinical Psychology*, *29*(6) 701–726.	Adult sample
Grant, D. M., Beck, J. G., Farrow, S. M., & Davila, J. (2007). Do interpersonal features of social anxiety influence the development of depressive symptoms? *Cognition and Emotion*, *21*(3), 646–663.	No measure of ERS

Haeffel, G. J., & Mathew, A. R. (2010). Inside thoughts and outside influences: Cognitive vulnerability moderates the effect of decreases in perceived social support on depressive symptoms. *Journal of Social and Clinical Psychology, 29*(3), 281–300.	Adult sample
Haeffel, G. J., Voelz, Z. R., & Joiner Jr., T. E. (2007). Vulnerability to depressive symptoms: Clarifying the role of excessive reassurance seeking and perceived social support in an interpersonal model of depression. *Cognition and Emotion*, *21*(3), 681–688.	Adult sample
Hankin, B. L., Stone, L., & Wright, P. A. (2010). Corumination, interpersonal stress generation, and internalizing symptoms: Accumulating effects and transactional influences in a multiwave study of adolescents. *Development and Psychopathology, 22*(1), 217–235.	No measure of ERS
Hankin, B.L. & Abela, J.R.Z. (2011). Nonsuicidal self-injury in adolescence: prospective rates and risk factors in a 2.5-year longitudinal study. *Psychiatry Research, 186*, 65–70.	Correlation between ERS and depression not reported.
Hermanto, N., Zuroff, D. C., Kelly, A. C., & Leybman, M. J. (2017). Receiving support, giving support, and self-reassurance: A daily diary test of social mentality theory. *Personality and Individual Differences, 107*, 37–42.	No measure of ERS
Hudson, C. C., Shamblaw, A. L., Wilson, G. A., Roes, M. M., Sabbagh, M. A., & Harkness, K. L. (2018). Theory of mind, excessive reassurance-seeking, and stress generation in depression: a social-cognitive interpersonal integration. *Journal of Social and Clinical Psychology, 37*(9), 725–750.	Adult sample
Jacobson, J. A. (2007). The relationship among causal uncertainty, reassurance seeking, and dysphoria. *Journal of Social and Clinical Psychology*, *26*(8), 922–939.	Adult sample
Joiner, T. E., Brown, D. L., Felthous, A. R., Barratt, E. P., & Brown, L. A. (1998). A severe test of interpersonal theory of depression among criminal defendents. *Social Behavior and Personality*. New Zealand: Society for Personality Research.	Adult sample
Joiner, T. E. & Metalsky, G. I. (2001). Excessive reassurance seeking: Delineating a risk factor involved in the development of depressive symptoms. *Psychological Science, 12*(5), 371-378.	Adult sample
Joiner, T. E., & Schmidt, N. B. (1998). Excessive reassurance-	Adult sample

seeking predicts depressive but not anxious reactions to acute stress. *Journal of Abnormal Psychology, 107*(3), 533.	
Joiner, T. E., & Barnett, J. (1994). A test of interpersonal theory of depression in children and adolescents using a projective technique. *Journal of Abnormal Child Psychology, 22*(5), 595-609.	No measure of ERS
Joiner, T. E., Katz, J., & Lew, A. S. (1997). Self-verification and depression among youth psychiatric inpatients. *Journal of Abnormal Psychology, 106*(4), 608.	No measure of ERS
Lee, A., & Hankin, B. L. (2009). Insecure Attachment, Dysfunctional Attitudes, and Low Self-Esteem Predicting Prospective Symptoms of Depression and Anxiety During Adolescence. *Journal of Clinical Child and Adolescent Psychology, 38*(2), 219 – 231.	No measure of ERS
Lemay Jr., E. P., & Cannon, K. T. (2012). Dysphoric reassurance seeking breeds contempt: experimental evidence. *Journal of Social and Clinical Psychology, 31*(10), 1023–1050.	Adult sample
Nesi, J., Miller, A. B., & Prinstein, M. J. (2017). Adolescents' depressive symptoms and subsequent technology-based interpersonal behaviors: A multi-wave study. *Journal of Applied Developmental Psychology, 51*, 12–19.	No measure of ERS
Rood, L., Roelofs, J., Bogels, S. M., & Meesters, C. (2012). Stress-Reactive Rumination, Negative Cognitive Style, and Stressors in Relationship to Depressive Symptoms in Non-Clinical Youth. *Journal of Youth and Adolescence, 41*(4), 414–425.	No measure of ERS
Schwartz-Mette, R. A., & Rose, A. J. (2016). Depressive Symptoms and Conversational Self-Focus in Adolescents' Friendships. *Journal of Abnormal Child Psychology, 44*(1), 87–100.	No measure of ERS
Schwartz-Mette, R.A., & Smith, R.L. (2016). When does co-rumination facilitate depression contagion in adolescent friendships? Investigating intrapersonal and interpersonal factors. *Journal of Clinical Child & Adolescent Psychology, 00*, 1-13. DOI: 10.1080/15374416.2016.1197837.	No measure of individual ERS
Serwik, A.K. (2011). The effects of negative social processes on depression and friendship quality in adolescent females. *Unpublished thesis, University of Maine.*	Dropped ERS measure from analysis due to variability in results.

Shih, J. H., Abela, J. R. Z., & Starrs, C. (2009). Cognitive and interpersonal predictors of stress generation in children of affectively ill parents. *Journal of Abnormal Child Psychology*, *37*(2), 195.	No measure of ERS
St John, N.H. (2002). Quantity and quality of social coping behavior: effects of mood, interpersonal representations, and self-worth vulnerability. *Unpublished dissertation, University of Denver.*	Adult sample
Turner, B. J., Wakefield, M. A., Gratz, K. L., & Chapman, A. L. (2017). Characterizing Interpersonal Difficulties Among Young Adults Who Engage in Nonsuicidal Self-Injury Using a Daily Diary. *Behavior Therapy*, *48*(3), 366–379.	No measure of depression

Appendix 1E: Quality Ratings

Table 1.5

Quality Ratings, Assessed using CASP Cohort Checklist

Study	Score (total)*	%	CASP Item											
			1	2	3	4	5	6	7	8	9	10	11**	12
Abela et al., 2006	5 (9)	55.6%	Yes	Yes	No	No	Yes	No	N/A	N/A	Yes	No	N/A	Yes
Hankin 2018	10 (11)	90.9%	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Joiner 1999	7 (9)	77.8%	Yes	Yes	No	Yes	Yes	Yes	N/A	N/A	Yes	No	N/A	Yes
Joiner 2001	5 (9)	55.6%	Yes	Yes	No	Yes	No	No	N/A	N/A	Yes	No	N/A	Yes
Nesi 2015	5 (9)	55.6%	Yes	Yes	No	No	Yes	No	N/A	N/A	Yes	Yes	N/A	Yes
Oppenheimer et al., 2012 (1)	4 (9)	44.4%	Yes	Yes	No	No	No	No	N/A	N/A	Yes	No	N/A	Yes
Oppenheimer et al., 2012 (2)	7 (11)	63.6%	Yes	Yes	No	No	No	No	Yes	Yes	Yes	Yes	N/A	No
Prinstein 2005	9 (11)	81.8%	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Siegel 2004	8 (11)	72.7%	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Stroud 2018	6 (9)	66.7%	Yes	Yes	No	Yes	Yes	No	N/A	N/A	Yes	No	N/A	No

*"Yes" scores 1 point; "No" scores 0 points. **Item excluded from final score.

Appendix 1G: Submission Guidelines for Journal of Abnormal Psychology

1.2. Submission

To submit to the Editorial Office of Angus MacDonald, III, please submit manuscripts electronically through the Manuscript Submission Portal in Microsoft Word or Open Office format.

Angus MacDonald, III, PhD
Editor, *Journal of Abnormal Psychology*
Department of Psychology
University of Minnesota
75 E River Rd
Minneapolis, MN 55455

General correspondence may be directed to the Editor's Office.

Journal of Abnormal Psychology is now using a software system to screen submitted content for similarity with other published content. The system compares the initial version of each submitted manuscript against a database of 40+ million scholarly documents, as well as content appearing on the open web. This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

1.3. Masked Reviews

Masked reviews are optional and must be specifically requested in the cover letter accompanying the submission. For masked reviews, the manuscript must include a separate title page with the authors' names and affiliations, and these ought not to appear anywhere else in the manuscript.

Footnotes that identify the authors must be typed on a separate page.

Make every effort to see that the manuscript itself contains no clues to authors' identities.

1.4. Types of Articles

1.4.1. Brief Report

The manuscript should not exceed 5,000 words when including the abstract, body of the text, tables, table captions, figure captions, footnotes, author notes, appendices, and references in a word count.

Note that supplementary materials and figures are not included in the word count.

Brief reports can have a maximum of two figures (there is no table limit).

1.4.2. Regular Article

The manuscript should not exceed 9,000 words when including the abstract, body of the text, tables, table captions, figure captions, footnotes, author notes, appendices, and references in a word count.

Note that supplementary materials and figures are not included in the word count.

1.4.3. Extended Article

Extended articles are published within regular issues of the journal (they are not free-standing). This article type is reserved for manuscripts that require extended exposition beyond the length of a regular article (e.g., reporting results of multiple experiments, multifaceted longitudinal studies, cross-disciplinary investigations, or studies that are extraordinarily complex in terms of methodology or analysis).

Extended article submissions are expected to be precleared by contacting the editorial office to determine the appropriateness for this format. When seeking preclearance, please provide a description of your manuscript and its significance.

Other submissions that exceed 9,000 words will be returned for shortening.

1.4.4. Commentary

Commentaries on articles previously published in Journal of Abnormal Psychology are also considered for publication. Commentaries should contain original data relevant to the topic at hand. They are subject to the same process of peer review and the same editorial criteria and standards as any other manuscript. If a commentary is deemed acceptable for publication, authors of the original submission are given the opportunity to reply to the commentary. Commentaries may be no more than half the length of the original article, and replies may be no more than half the length of the commentary. A commentary and reply will be published together. Except under rare circumstances, there will be only one round of comment and reply.

1.4.5.Cover Letters

All cover letters must contain the following:

- a statement that the material is original — if findings from the dataset have been previously published or are in other submitted articles, please include the following information:
  a. Is the present study a new analysis of previously analyzed data? If yes, please describe differences in analytic approach.
  b. Are some of the data used in the present study being analyzed for the first time? If yes, please identify data (constructs) that were not included in previously published or submitted manuscripts.
  c. Are there published or submitted papers from this data set that address related questions? If yes, please provide the citations, and describe the degree of overlap and the unique contributions of your submitted manuscript.
- if the manuscript has been pre-posted online prior to peer review, this fact should be stated in the acknowledgements and the URL for the posting should be included in the acknowledgements as well.
- the full postal and email address of the corresponding author;
- the complete telephone and fax numbers of the same;
- the proposed category under which the manuscript was submitted;
- a statement that the authors complied with APA ethical standards in the treatment of their participants and that the work was approved by the relevant Institutional Review Board(s);
- whether or not the manuscript has been or is posted on a web site;
- that APA style (Publication Manual, 6th edition) has been followed;
- the disclosure of any conflicts of interest with regard to the submitted work;
- a request for masked review, if desired, along with a statement ensuring that the manuscript was prepared in accordance with the guidelines above.

Authors should also specify the overall word length of the manuscript (including all aspects of the manuscript, except figures) and indicate the number of tables, figures, and supplemental materials that are included.

1.5. Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

1.5.1.Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

1.5.2.Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

1.5.3.Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

1.6. Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

1.7. Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

1.8. Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

1.9. General Scientific Summaries (GSS)

Please provide a General Scientific Summary of the paper on the manuscript file below the abstract.

This should be a brief (2-3 sentences) statement that, in nontechnical language, explains the contributions of the paper.

This is not a simplified version of the abstract, which highlights the details of your study and its findings for other specialists who know the history of the research, will be able to comprehend a description of methodology, and can determine the significance of your results amidst more technical language.

Rather, assume that the reader is an intelligent, interested individual who might know something about abnormal psychology, but may not know technical terms or abbreviations such as ERP, SEM, endophenotype, error-related negativity, or mediation.

Examples are included below:

"This study suggests that some approaches to subtyping eating disorders in adolescence, specifically those that include _____, _____, and _____, may be more useful than _____in predicting outcomes in young adulthood."

"Decreased motivation to seek out rewarding experiences is a key symptom in depression. This study supports the notion that for depressed individuals, this decrease in motivation is more likely due to lower anticipation that an activity will be pleasurable than by the ability to actually experience pleasure during the activity itself."

1.10. References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
  Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566
- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
  Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

1.11. Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

1.12. Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

1.13. Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

In light of changing patterns of scientific knowledge dissemination, APA requires authors to provide information on prior dissemination of the data and narrative interpretations of the data/research appearing in the manuscript (e.g., if some or all were presented at a conference or meeting, posted on a listserv, shared on a website, including academic social networks like ResearchGate, etc.). This information (2–4 sentences) must be provided as part of the Author Note.

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

1.14. Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

Please include in the Author Note information regarding your research ethics committee approval (i.e., institution granting approval, study name, or study #).

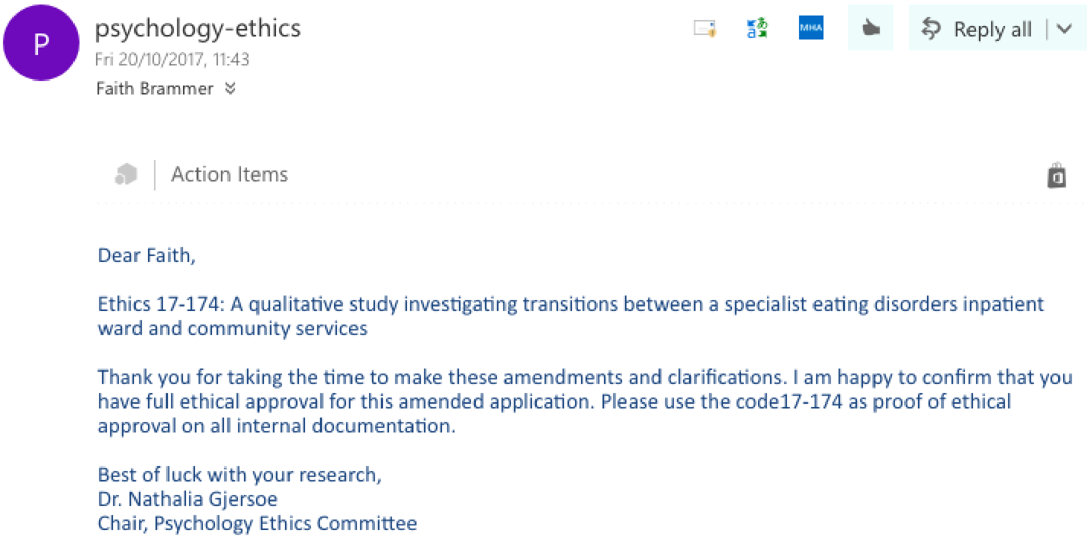
- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conductelectronically on itsr website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Appendix 2A: SIP Interview Questions

1. Describe your experience of leaving the inpatient ward, and returning to the community?
2. What (if any) worries did you have about leaving the inpatient ward?
3. Please describe your experiences of leaving the inpatient ward in relation to these worries. What were the main challenges of leaving the inpatient ward and returning to the community?
4. How did you cope with these challenges?
5. Is there anything that was helpful during this process/did anything make this transition easier?
6. What do you think led to a later re-admission to the inpatient ward? How did your experience during each admission differ?
7. What could the service have done differently, to make the transition experience easier?
8. Is there anything that could have happened in the community that could have prevented a later re-admission (e.g. other services that could have met your needs in the community)?

Appendix 2B: Confirmation of Ethical Approval, University of Bath



Dear Faith,

Ethics 17-174: A qualitative study investigating transitions between a specialist eating disorders inpatient ward and community services

Thank you for taking the time to make these amendments and clarifications. I am happy to confirm that you have full ethical approval for this amended application. Please use the code17-174 as proof of ethical approval on all internal documentation.

Best of luck with your research,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

Appendix 2C: Confirmation of Ethical Approval, Avon and Wiltshire Research & Development

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Avon and Wiltshire Mental Health Partnership AWP Trust
AWP Quality Academy
Fromeside- East Wing
Manor Road
Fishponds
BS16 2EW

0117 378 4217

Date: 5th October 2017

Dear Faith,

A Qualitative study investigating transitions between a specialist eating disorders inpatient ward and community services

AWP Reference: E2017.019

This letter is to confirm that your evaluation is now approved and also provides you with our reference number.

If you do need any further support or information, please contact us using the contact details above, quoting our reference number for your study.

The importance of disseminating all evaluation work cannot be over emphasised. It is only by sharing our learning that we can improve services across AWP. For this reason, the findings of all evaluation work should be reported to the Evaluation team via email. The team will champion the results of service evaluations, and work with evaluators to ensure those results are disseminated and acted upon, and that the results of evaluations are reflected in future service delivery. The team will also work with evaluators to produce publications for the public domain.

Please also remember that all service evaluation work must be represented as such in future publications or presentations.

I very much look forward to receiving the results of your evaluation in due course.

Yours sincerely,

Bryony McCann
Project Support Officer, Research and Development

Appendix 2D: Submission Instructions for International Journal of Eating Disorders

2. AUTHOR GUIDELINES

GUIDELINE SECTIONS

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium. If there is a related paper under consideration at another journal, a copy of that paper should be submitted with the primary manuscript as supporting information.

International Journal of Eating Disorders will consider submissions that have previously been made available online, either on a preprint server like arXiv, bioRxiv, or PeerJ PrePrints, or on the authors' own website. However, any such submissions must not have been published in a scientific journal, book or other venue that could be considered formal publication. Authors must inform the editorial office at submission if their paper has been made available as a preprint.

- Authors of accepted papers that were made available as preprints must be able to assign copyright to *International Journal of Eating Disorders*, or agree to the terms of the Wiley Open Access agreement and pay the associated fee
- Given that the measurable impact of the article is diminished when citations are split between the preprint and the published article, authors are required to:
  - Update the entry on the preprint server so that it links to and cites the DOI for the published version
  - Cite only the published article themselves

Authors should follow the guidelines carefully; failure to do so will delay the processing of the manuscript. **Once the submission has been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at mc.manuscriptcentral.com/ijed**. Authors unfamiliar with ScholarOne can find details on how to use the system here: **www.wileyauthors.com/scholarone**.

The submission system will prompt the author to use an ORCID iD (a unique author identifier) to help distinguish their work from that of other researchers. Details can be found **elsewhere** in these guidelines.

By submitting a manuscript to or reviewing for this publication, an individual's name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **authorservices.wiley.com/statements/data-protection-policy**.

For help with submissions, authors should contact the Editorial Office: **ijed@wiley.com**. When necessary, the Editorial Office staff may refer questions to the Editor-in-Chief or Associate Editors.

Return to Guideline Sections

2. AIMS AND SCOPE

The *International Journal of Eating Disorders*—A leading peer-reviewed journal in the fields of psychology, psychiatry, public health, and nutrition & dietetics.

Mission: With a mission to advance the scientific knowledge needed for understanding, treating, and preventing eating disorders, the *International Journal of Eating Disorders* publishes rigorously evaluated, high-quality contributions to an international readership of health professionals, clinicians, and scientists. The journal also draws the interest of patient groups and advocates focused on eating disorders, and many of the articles draw attention from mainstream media outlets.

Scope: Articles featured in the journal describe state-of-the-art scientific research on theory, methodology, etiology, clinical practice, and policy related to eating disorders, as well as contributions that facilitate scholarly critique and discussion of science and practice in the field. Theoretical and empirical work on obesity or healthy eating falls within the journal's scope inasmuch as it facilitates the advancement of efforts to describe and understand, prevent, or treat eating disorders. The *International Journal of Eating Disorders* welcomes submissions from all regions of the world and representing all levels of inquiry (including basic science, clinical trials, implementation research, and dissemination studies), and across a full range of scientific methods, disciplines, and approaches.

A complete **overview** of the journal is given elsewhere on the journal's homepage.

Return to Guideline Sections

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

The *International Journal of Eating Disorders* publishes the following contribution types:

1. Original Articles
2. Brief Reports
3. Clinical Case Reports
4. Reviews
5. An Idea Worth Researching
6. Commentaries

When uploading their manuscript, authors will be asked to complete a checklist indicating that they have followed the Author Guidelines pertaining to the appropriate article type. All word limits relate to the body of the text (i.e., not including abstract, references, tables and figures) and represent maximum lengths. Authors are encouraged to keep their manuscript as short as possible while communicating clearly.

1) Original Articles

These contributions report substantive research that is novel, definitive, or complex enough to require a longer communication. Only a subset of research papers is expected to warrant full-length format.

- Word Limit: 4,500 (excluding abstract, references, tables or figures)
- Abstract: 250 words.
- References: 60 are recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 8 essential tables/figures, overall.

When preparing their manuscript, authors should follow the IMRaD guidelines (***I***ntroduction, ***M***ethods, ***R***esults, ***a***nd ***D***iscussion), which are recommended by the International Committee of Medical Journal Editors (ICMJE) (**J. Pharmacol. Pharmacother. 2010, 1, 42–58**). When preparing the Methods section, authors should refer to the **Editorial Policy on Sample Size and Statistics**.

2) Brief Reports

This contribution type is intended for manuscripts describing studies with straightforward research designs, pilot or "proof of concept" studies, and replications.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: 200 words.
- References: 20 are recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

As for **Original Articles**, when preparing their manuscript, authors should follow the IMRaD guidelines and comply with the **Editorial Policy on Sample Size and Statistics**.

3) Clinical Case Reports.

Clinical Case Reports detail key elements of cases where there is novelty in the presentation, pathology or treatment, and where that novelty will inform clinicians and researchers about rare presentations or novel ideas. This category will often be appropriate to rare biological or psychological presentations. Reports of rigorously conducted studies employing single-case experimental designs are especially welcome.

Every effort should be taken to ensure the anonymity of the patient concerned, and any clinicians not involved as authors. If there is any potentially identifiable information, then it is the responsibility of the authors to obtain approval from the local Institutional Review Board (IRB) (or equivalent) for the case to be reported, and a copy of that approval should be made available to the Editor on request.

To assist authors in preparing their Case Report, Associate Editor Glenn Waller has prepared a set of **helpful hints and tips for authors**, available for download in PDF format here: **IJED Case Report Guidelines**.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: 200 words.
- References: 20.
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

4) Reviews

These articles critically review the status of a given research area and propose new directions for research and/or practice. Both systematic and meta-analytic review papers are welcomed if they review a literature that is advanced and/or developed to the point of warranting a review and synthesis of existing studies. Reviews of topics with a limited number of studies are unlikely to be deemed as substantive enough for a Review paper. The journal does not accept papers that merely describe or compile a list of previous studies without a critical synthesis of the literature that moves the field the forward.

- Word Limit: 7,500 (excluding abstract, references, tables or figures).
- Abstract: 250 words.
- References: 100.
- Figures/Tables: no maximum, but should be appropriate to the material covered.

All Review articles must follow the PRISMA Guidelines (**www.prisma-statement.org**), summarized in a 2009 *J. Clin. Epidemiol.* article by Moher et al. entitled *“Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement”* (DOI: **10.1016/j.jclinepi.2009.06.005**), freely available for download in both English and Spanish.

Authors who choose this contribution type must complete the Review Checklist upon submission of the manuscript, an example of which can be found **here**). This example is for informational purposes only. During the submission process, authors will be prompted to complete the Review Checklist directly in ScholarOne. The rationale for any unchecked items on the Review Checklist must be explicitly described in the accompanying Cover Letter.

5) An Idea Worth Researching

This is a contribution type where authors propose an idea that may not yet have adequate empirical support or be ready for full empirical testing, but holds great promise for advancing research of eating disorders. Authors are encouraged to write a piece that is bold, forward looking, and suggestive of new and exciting avenues for research and/or practice in the field.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: 200 words.
- References: 20 recommended (more permitted, for cause).
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

6) Commentaries

Commentaries are solicited by the Editors when multiple perspectives on or critical appraisal of an article would assist in placing that article in context. Unsolicited commentaries are not considered for publication.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: 200 words.
- References: 5, using the footnote format rather than the journal's standard format.
- Figures/Tables: none.

Return to Guideline Sections

4. PREPARING THE SUBMISSION

Parts of the Manuscript

The submission should be uploaded in separate files: 1) **manuscript file**; 2) **figures**; 3) **Supporting Information file(s)**.

1. Manuscript File

The text file should contain all of the manuscript text, including the tables and figure legends. The text should be presented in the following order, with items i-v appearing on the **Title Page**:

1. Title
2. A short running title of less than 40 characters
3. The full names of all authors
4. The authors' institutional affiliations where the work was conducted, with a footnote for an author's present address if different to where the work was carried out
5. Word counts (abstract and main text, excl. tables and references)
6. Acknowledgements
7. Abstract and Keywords
8. Main text
9. References
10. Tables (each table complete with title and footnotes)
11. Figure legends

Title Page

On the title page, authors should list the **title**, the short running title, the full names of all **authors**, and their affiliations. Authors should also state the **number of words** contained in the abstract and the number of words of the manuscript (excluding tables and references).

Title

The title should be short and informative, containing major keywords related to the content. The title should not contain abbreviations (see **Wiley's best practice SEO tips**).

Authorship

For details on eligibility for author listing, please refer to the journal's **Authorship policy** outlined in Section 5 of these Author Guidelines.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. See the journal's policy on **Conflict of Interest** outlined in Section 5 of these Author Guidelines. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

The word maximum and abstract format varies by contribution type (see above). When an abstract is required, the abstract should be typed as a single paragraph. The journal requires **structured abstracts** with three exceptions: the journal will continue to use unstructured abstracts for Clinical Case Reports, Commentaries and "An Idea Worth Researching".

Structured abstracts should be organized as follows: **Objective**: briefly indicate the primary purpose of the article, or major question addressed in the study. **Method**: indicate the sources of data, give brief overview of methodology, or, if review article, how the literature was searched and articles selected for discussion. For research based articles, this section should briefly note study design, how participants were selected, and major study measures. **Results**: summarize the key findings. **Discussion**: indicate main clinical, theoretical, or research applications/implications.

Keywords

Please provide five to seven keywords. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **www.nlm.nih.gov/mesh**.

Main Text

- Authors should refrain from using terms that are stigmatizing or terms that are ambiguous. For further explanation and examples, see the 2016 IJED article by Weissman et al. entitled "*Speaking of that: Terms to avoid or reconsider in the eating disorders field*" (DOI: 10.1002/eat.22528.)
- The text should be divided as outlined in Section 3 "Manuscript Categories and Requirements".
- Manuscripts reporting original research should follow the **IMRaD guidelines** (***I***ntroduction, (***M***ethods, ***R***esults, ***a***nd ***D***iscussion), which are recommended by the International Committee of Medical Journal Editors (ICMJE) (J. Pharmacol. Pharmacother. 2010, 1, 42–58).
- To facilitate evaluation by the Editors and Reviewers, each manuscript page should be numbered; the text should be double-spaced; and line numbers should be applied (restarting from 1 on each page). Instructions on how to implement this feature in Microsoft Word are given here.
- The journal uses US spelling. Authors may submit using any form of English as the spelling of accepted papers is converted to US English during the production process.
- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.
- It is the primary responsibility of the authors to proofread thoroughly and ensure correct spelling and punctuation, completeness and accuracy of references, clarity of expression, thoughtful construction of sentences, and legible appearance prior to the manuscript's submission.
- Authors for whom English is not their first language are encouraged to seek assistance from a native or fluent English speaker to proof read the manuscript prior to submission. Wiley offers a paid service that provides expert help in English language editing—further details are given below.
- Articles reporting data taken from or deposited elsewhere should refer to the journal policy on Data Storage and Documentation in Section 5 (below).

References

References in all manuscripts should follow the style of the American Psychological Association (6th edition), except in regards to spelling. The APA website includes **a range of resources for authors learning to write in APA style**, including **An overview of the Publication Manual of the American Psychological Association, Sixth Edition**; includes **free tutorials on APA Style basics** and an **APA Style Blog**. Please note APA referencing style requires that a Digital Object Identifier (DOI) be provided for all references where available.

Tables

Each table must be numbered in order of appearance in the text with Arabic numerals and be cited at an appropriate point in the text. Tables should be self-contained and complement, not duplicate, information contained in the text. They should be editable (i.e., created in Microsoft Word or similar), not pasted as images. Legends should be concise but comprehensive—the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as standard deviation (SD) or standard error of the mean (SEM) should be identified in the headings. The journal's **Editorial Policy on Sample Size and Statistics** is given in Section 5.

Figure Legends/Captions

Each figure caption should have a brief title that describes the entire figure without citing specific panels, followed by a description of each panel. Captions should be concise but comprehensive—the figure and its caption must be understandable without reference to the text. Be sure to explain abbreviations in figures even if they have already been explained in-text. Axes for figures must be labeled with appropriate units of measurement and description. Include definitions of any symbols used and units of measurement.

2. Figures

Although authors are encouraged to send the highest quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. **Click here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Helvetica typeface is preferred for lettering within figures. All letters, numbers and symbols must be at least 2 mm in height. Courier typeface should be used for sequence figures. Figures should be numbered consecutively with Arabic numerals, and they should be numbered in the order in which they appear in the text.

Figures should be submitted as electronic images to fit either one (55 mm, 2 3/16”, 13 picas), two (115 mm, 4 1/2”, 27 picas), or three (175 mm, 6 7/8”, 41 picas) columns. The length of an illustration cannot exceed 227 mm (9”). Journal quality reproduction requires grey scale and color files at resolutions of 300 dpi. Bitmapped line art should be submitted at resolutions of 600–1200 dpi.

Figures submitted in color will be reproduced in color online free of charge. Authors wishing to have figures printed in color in hard copies of the journal will be charged a fee by the Publisher; further details are given **elsewhere** in these Author Guidelines. Authors should note however, that it is preferable that line figures (e.g., graphs) are supplied in black and white so that they are legible if printed by a reader in black and white.

3. Supporting Information Files(s)

Supporting Information is information that is supplementary and not essential to the article, but provides greater depth and background. Examples of such information include more detailed descriptions of therapeutic protocols, results related to exploratory or post-hoc analyses, and elements otherwise not suitable for inclusion in the main article, such as video clips, large sections of tabular data, program code, or large graphical files. It is *not* appropriate to include, in the Supporting Information, text that would normally go into a discussion section; all discussion-related material should be presented in the main article.

Because the Supporting Information is separate from the paper and supplementary in nature, the main article should be able to be read as a stand-alone document by readers. Reference to the Supporting Information should be made in the text of the main article to provide context for the reader and highlight where and how the supplemental material contributes to the article.

Should authors wish to provide supplementary file(s) along with their article, these materials *must* be included upon submission to the journal. If such materials are added to the submission as a result of peer review, i.e., during a revision, then the authors should bring this to the attention of the editor in their response letter. If accepted for publication, Supporting Information is hosted online together with the article and appears without editing or typesetting.

Wiley's FAQs on Supporting Information are available on the Wiley Author Services site: **www.wileyauthors.com**.

Note: Authors are encouraged to utilize publicly available data repository for data, scripts, or other artefacts used to generate the analyses presented in the paper; in such cases, authors should include a reference to the location of the material within their paper.

General Style Points

The following points provide general advice on formatting and style.

- **Terminology**: Terms such as "anorexics" or "bulimics" as personal pronouns, referring to groups of individuals by their common diagnosis, should be avoided. Terms like "individuals with anorexia nervosa", "people with bulimia nervosa", or "participants with eating disorders" should be used instead. Note, "participants" should be used in place of "subjects".
- **Abbreviations**: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement**: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at www.bipm.fr for more information about SI units.
- **Numbers** under 10 should be spelt out, except for: measurements with a unit (8 mmol/L); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **The word "data"** is plural; therefore, text should follow accordingly (for example, "The data show…the data are … the data were…").
- **Sex/Gender & Age**: When referring to sex/gender, "males" and "females" should be used only in cases where the study samples include both children (below age 18) and adults and only if word limit precludes using terms such as "male participants/female participants," "female patients/male patients"; when the participants comprise adults only, the terms "men" and "women" should be used. In articles that refer to children, "boys" and "girls" should be used.
- **Trade Names**: Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.
- **Statistics**: Authors should adhere to the journal's policy on Sample Size and Statistics when reporting studies. For information on how to present p values and other standard measurements see IJED Statistical Formatting Requirements.

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here**. In particular, authors may benefit from referring to Wiley's best practice tips on **Writing for Search Engine Optimization**.

Editing, Translation, and Formatting Support: **Wiley Editing Services** can greatly improve the chances of a manuscript being accepted. Offering expert help in English language editing, translation, manuscript formatting, and figure preparation, Wiley Editing Services ensures that the manuscript is ready for submission.

Return to Guideline Sections

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Editorial Review and Acceptance

Rigorous evaluation of submitted material by expert reviewers is essential to ensuring that the journal achieves its mission. To facilitate timely feedback to authors and to avoid burdening expert reviewers unduly, the journal utilizes a two-tiered review process for all contributions (whether invited or unsolicited). The first tier involves an initial editorial preview to be implemented within days of receipt of a submission. If the manuscript is considered to have potential for publication in the journal, the second tier involves peer review, typically by two to three experts. The Editor-in-Chief, at times, may delegate final decision making authority to one of the Associate Editors.

Editorial Pre-Screen. The Editor-in-Chief will pre-screen all submissions to determine the suitability based on fit with the journal's scope and scholarly merit. Manuscripts deemed to fall outside of the journal's scope or to be of limited merit (e.g., because of substantial methodological flaws or insufficiently novel contribution to the field) will not be sent out for peer review. Pre-screening of articles does not involve detailed evaluation. Authors receiving a negative decision at this stage may appeal by sending a concise rationale to the Editor-in-Chief.

Appeal of Rejection Decision. Requests for **appeal** will be considered only where the author makes a case that one or more reviewer, or the editor, has clearly made a substantive mistake. Submissions not sent out for external review are subject to the same grounds for appeal as submissions that have undergone full peer review. Please address appeal requests in writing to the Editor-in-Chief.

Peer Review. Submissions that, based on editorial pre-screening, are considered of potential suitability for the journal are forwarded to experts in the field—ad hoc reviewers or members of the journal's Editorial Board—for detailed evaluation and feedback. Expert reviewers are asked to evaluate the merit of a manuscript based on the quality of the methods applied, presentation, and overall contribution to the field. Reviewers are instructed to offer a thorough, constructive, and timely evaluation of all aspects of the submission and to enumerate strengths and weaknesses. Authors are invited to recommend expert reviewers.

Wiley's policy on confidentiality of the review process is available here: **www.wileypeerreview.com/reviewpolicy**.

Revision Submission. Authors are asked to upload two versions of the revised manuscript. One version should include all tracked changes and be labelled "Manuscript with revisions" when uploaded. The other version should contain no mark up and be labelled "Manuscript" when uploaded.

Transferable Peer Review. To enable rapid publication of good quality research that is unable to be accepted for publication by the *International Journal of Eating Disorders*, we work together with Wiley's Open Access journals through **Wiley's Manuscript Transfer Program**: *Health Science Reports*, *Brain and Behavior*, *Obesity Science and Practice*, *Clincial Case Reports*, *and Molecular Genetics and Genomic Medicine*. Authors may be offered the option of having their manuscript (inc. any Supporting Information), along with any related peer reviews, automatically transferred for consideration by the Editor of the recieving journal. Authors taking up the offer to transfer will not need to reformat or rewrite their manuscript at that stage, and a publication decision will be made a short time after the transfer has taken place. The Editors of the recieving journals will accept submissions that report well-conducted research that reaches the standard acceptable for publication. These journals are a part of the Wiley Open Access portfolio (**www.wileyopenaccess.com**), and thus Article Publication Fees apply.

Editorial Policy on Sample Size and Statistics

The Methods section should include a statement about sample selection, response rate, and other factors that would impact selection or response bias and, in turn, representativeness of the sample. Inclusion of small samples requires justification and authors should be mindful of the recommendations concerning minimal sample sizes in subfields (e.g., genetic research, instrument development, etc., where adequate samples may number in the hundreds). Authors also are asked to provide information about reliability and validity of study measures as applicable to their sample.

If the study involves qualitative data, authors need to include a statement about sample size in relation to theme saturation. It is also important that the sampling strategy is driven by theory rather than convenience, the data analysis procedures are justified, and the advantage of a qualitative (vs. a simple quantitative) approach are well-described.

If the work involves cross-cultural assessment or assessment in a new language or study population, authors should provide information about local literacy in the language of assessment, the validity of (or process for validating) a translation of an assessment, and for inclusion of regional samples, a statement about the representativeness of the regional sample (or distinction from) the national sample. If statistical analyses are employed, effect size estimates should be reported in the Results section.

For additional detail regarding statistical requirements for the manuscript, see **IJED Statistical Formatting Requirements**. For more detailed background information on statistical analyses and their rationale authors are referred to **IJED Statistical Reporting Guidelines** .

Manuscripts reporting statistical tests without effect size estimates may be rejected without review.

Guidelines for Genetic Studies

Authors of manuscripts describing association studies should note that the *International Journal of Eating Disorders* has adopted Methods guidelines developed and published by the *American Journal of Medical Genetics Part B: Neuropsychiatric Genetics*. These guidelines recommend minimum sample sizes; in the case of positive findings, an adequately powered independent replication sample; and adjustments for multiple comparisons. As is required for all papers, the guidelines also require that authors report effect size estimates. For a complete description, please refer to the AJMGB Editorial Policy on Association Studies described in their **Author Guidelines**.

Please note, when referring to genetic material, the names of genes should be spelled out in full the first time they appear in the text, after which an italicized abbreviation can be substituted. Sequence variants should be described in the text and tables using both DNA and designations whenever appropriate. Sequence variant nomenclature must follow the current Human Genome Variation Society (HGVS) guidelines; see **varnomen.hgvs.org**, where examples of acceptable nomenclature are provided.

Data Sharing and Data Accessibility

Please review Wiley’s policy **here**. The *International Journal of Eating Disorders* expects but does not require data sharing.

All accepted manuscripts are required to publish a data availability statement to confirm the presence or absence of shared data.

The *International Journal of Eating Disorders* recognizes the many benefits of archiving research data. *IJED* expects you to archive all the data from which your published results are derived in a public repository. The repository that you choose should offer you guaranteed preservation (see the registry of research data repositories at **https://www.re3data.org/**) and should help you make it findable, accessible, interoperable, and re-useable, according to **FAIR Data Principles**.

The *International Journal of Eating Disorders* notes that FAIR data sharing allows for access to shared data under restrictions (e.g., to protect confidential or proprietary information) but notes that the FAIR principles encourage you to share data in ways that are as open as possible (but that can be as closed as necessary).

If you have shared data, this statement will describe how the data can be accessed, and include a persistent identifier (e.g., a DOI for the data, or an accession number) from the repository where you shared the data. If you cannot share the data described in your manuscript, for example for legal or ethical reasons, or do not intend to share the data then you must provide the appropriate data availability statement. Sample statements are available **here**. If published, all statements will be placed in the heading of your manuscript.

Human Studies and Subjects

For manuscripts reporting studies that involve human participants, a statement identifying the ethics committee that approved the study and confirmation that the study conforms to recognized standards is required, for example: **Declaration of Helsinki**; **US Federal Policy for the Protection of Human Subjects** ; or **European Medicines Agency Guidelines for Good Clinical Practice**.

Every effort should be taken to ensure the anonymity of the patient concerned, and any clinicians not involved as authors. If there is any potentially identifiable information, then it is the responsibility of the authors to seek and obtain approval from the local Institutional Review Board (IRB) (or equivalent) for the case to be reported, and a copy of that approval should be made available to the Editor on request.

Images and information from individual participants will only be published where the authors have obtained the individual's free prior informed consent. Authors do not need to provide a copy of the consent form to the publisher; however, in signing the author license to publish, authors are required to confirm that consent has been obtained. Wiley has a **standard patient consent form available** for use.

Animal Studies

A statement indicating that the protocol and procedures employed were ethically reviewed and approved, as well as the name of the body giving approval (e.g., in the USA, the Institutional Review Board (IRB) or Institutional Animal Care and Use Committee (IACUC)), must be included in the Methods section of the manuscript. Authors are encouraged to adhere to animal research reporting standards, for example the **ARRIVE reporting guidelines** for reporting study design and statistical analysis; experimental procedures; experimental animals and housing and husbandry. Authors should also state whether experiments were performed in accordance with relevant institutional and national guidelines for the care and use of laboratory animals:

- US authors should cite compliance with the US National Research Council's Guide for the Care and Use of Laboratory Animals, the US Public Health Service's Policy on Humane Care and Use of Laboratory Animals, and Guide for the Care and Use of Laboratory Animals.
- UK authors should conform to UK legislation under the Animals (Scientific Procedures) Act 1986 Amendment Regulations (SI 2012/3039).
- European authors outside the UK should conform to Directive 2010/63/EU.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers are included in all papers that report their results. The name of the trial register and the clinical trial registration number should appear at the end of the abstract along with the URL for a hyperlink, if possible. A full list of registers can be found via the **WHO International Clinical Trials Registry Platform (ICTRP)**. Contributors should make clear when registration took place relative to the start or end of data gathering. Any discrepancies between the trial protocol and the study itself must be reported and justified in the methods section of the submitted paper. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to any research reporting standards relevant to their study. A list of the most well-known guidelines is given here:

- Consolidated Standards of Reporting Trials (CONSORT)
- Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT)
- Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)
- PRISMA Protocols (PRISMA-P)
- STrengthening the Reporting of OBservational studies in Epidemiology (STROBE)
- CARE: Guidelines to increase the accuracy, transparency, and usefulness of case reports
- Consolidated criteria for reporting qualitative research (COREQ) by Tong et al. (*Int. J. Qual. Health Care* (**2007**) *19*(6): 349–357)
- STARD 2015: An Updated List of Essential Items for Reporting Diagnostic Accuracy Studies
- TRIPOD: Transparent Reporting of a multivariable prediction model for Individual Prognosis Or Diagnosis

- Consolidated Health Economic Evaluation Reporting Standards (CHEERS) by Husereau et al. (*BMC Medicine*(**2013**) *11*: 80; DOI: 10.1186/1741-7015-11-80)
- The EQUATOR Network: an author's one-stop-shop for writing and publishing high-impact health research
- FORCE11: Recommended reporting guidelines for life science resources
- ARRIVE (Animal Research: Reporting of In Vivo Experiments) guidelines
- Guidance for the Description of Animal Research in Scientific Publications from the US National Research Council's Institute for Laboratory Animal Research
- The Gold Standard Publication Checklist from Hooijmans et al. (ATLA (**2010**) *38*: 167–182)

Species Names

Upon its first use in the title, abstract, and text, the common name of a species should be followed by the scientific name (genus, species, and authority) in parentheses. For well-known species, however, scientific names may be omitted from article titles. If no common name exists in English, only the scientific name should be used.

Sequence Data

Nucleotide sequence data can be submitted in electronic form to any of the three major collaborative databases: DDBJ, EMBL, or GenBank. It is only necessary to submit to one database as data are exchanged between DDBJ, EMBL, and GenBank on a daily basis. The suggested wording for referring to accession-number information is: ‘These sequence data have been submitted to the DDBJ/EMBL/GenBank databases under accession number U12345’. Addresses are as follows:

- DNA Data Bank of Japan (DDBJ): www.ddbj.nig.ac.jp
- EMBL Nucleotide Archive: ebi.ac.uk/ena
- GenBank: www.ncbi.nlm.nih.gov/genbank

Proteins sequence datashould be submitted to either of the following repositories.

- RCSB Protein Data Bank (PDB): www.rcsb.org/pdb.
- Protein Information Resource (PIR): pir.georgetown.edu
- SWISS-PROT: expasy.ch/sprot/sprot-top

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript.

Potential sources of conflict of interest include, but are not limited to: employment at a for-profit treatment center where data collection occurred, employment at a for-profit corporation if the corporation manufactures or sells products used in the research (e.g., medications; equipment used in a treatment tested as part of the research), patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company.

The existence of a conflict of interest does not preclude publication. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships. These conflicts of interest should be disclosed in the relevant section of the submission questionnaire and in the manuscript. If the authors have no conflict(s) of interest to declare, they must also state this.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **www.crossref.org/services/funder-registry**.

Authorship

The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

1. Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;
2. Been involved in drafting the manuscript or revising it critically for important intellectual content;
3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section (for example, to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

Joint first or senior authorship: In the case of joint first authorship, a footnote should be added to the author listing, e.g. 'X and Y should be considered joint first author' or 'X and Y should be considered joint senior author.'

Authorship responsibilities: Eligibility for authorship requires that authors have made substantive contributions to the work described in the manuscript, have read and approved the manuscript in its current form, and have approved the ordering of authorship. All authors agree that, once a manuscript has been submitted, the subsequent addition, removal or change of authorship order requires the approval of all authors (including making such changes as part of a resubmission). Such changes in revised versions of a manuscript should be brought to the attention of the Editor in the response letter.

ORCID

As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. If the submitting author is not already registered with ORCID, they can do so here: **orcid.org/register**; this takes around 2 minutes to complete. For more information, visit **www.wileyauthors.com/orcid**.

Publication Ethics

The *International Journal of Eating Disorders* is a member of the **Committee on Publication Ethics (COPE)**. Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read the *Top 10 Publishing Ethics Tips for Authors* at **www.wileyauthors.com/ethics** ; a link to **Wiley's Publication Ethics Guidelines** can also be found there.

Return to the Guideline Sections

6. AUTHOR LICENSING

If a paper is accepted for publication, the author identified as the formal corresponding author will receive an email prompting them to log in to Author Services, where via the Wiley Author Licensing Service (WALS) they will be required to complete a copyright license agreement on behalf of all authors of the paper.

Authors may choose to publish under the terms of the journal's standard copyright agreement, or **OnlineOpen** under the terms of a Creative Commons (CC) License.

General information regarding licensing and copyright is available **here**. To review the Creative Commons License options offered under OnlineOpen, please **click here**. (Note that certain funders mandate that a particular type of CC license has to be used; the Wiley Author Compliance Tool, available at **www.wileyauthors.com/compliancetool**, provides assistance to authors in checking for any open-access mandates from their funder(s).)

Self-Archiving Definitions and Policies

Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. For more detailed information about self-archiving definitions and policies, visit **www.wileyauthors.com/self-archiving**.

Open Access Fees

Authors choosing to publish using OnlineOpen will be charged a fee. A list of Article Publication Charges for Wiley journals is available at **www.wileyauthors.com/APCpricing**.

Funder Open Access

For more information on Wiley's compliance with the open-access policies of specific funders, visit **www.wileyauthors.com/funderagreements**.

Return to Guideline Sections

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Articles Received in Production

Signing the License

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services** . The author will be asked to sign a publication license at this point. Further details are given in **Section 6** of these Author Guidelines.

Proofs

Once the paper is typeset, the author will receive an email notification with the URL to download a PDF typeset page proof, as well as associated forms and full instructions on how to correct and return the file.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process—authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt.

Questions regarding the production of articles accepted for publication in the *International Journal of Eating Disorders* should be directed to the Production Editor: **eat@wiley.com**

Publication Charges

There are **no mandatory charges** to authors publishing in the *International Journal of Eating Disorders*.

Authors may choose to publish in an open access format through OnlineOpen, which carries a fee (see the section on Author Licensing).

Color figures may be published online free of charge; however, the journal charges for publishing figures in color in print. If the author supplies color figures at Early View publication, they will be invited to complete a color charge agreement in RightsLink for Author Services. The author will have the option of paying immediately with a credit or debit card, or they can request an invoice. If the author chooses not to purchase color printing, the figures will be converted to black and white for the print issue of the journal.

Early View

The journal offers rapid publication via Wiley's Early View service. **Early View** (online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Note there may be a delay after corrections are received before the article appears online, as the proofs need to be reviewed and processed. Once the article is published on Early View, no further changes are possible. The Early View article is fully citable and carries an online publication date and Digital Object Identifier (DOI) for citations.

Video Abstracts

A video abstract can be a quick way to make the message of your research accessible to a much larger audience. Wiley and its partner Research Square offer a service of professionally produced video abstracts, available to authors of articles accepted in this journal. You can learn more about it at **www.wileyauthors.com/videoabstracts**. If you have any questions, please direct them to **videoabstracts@wiley.com**.

Return to Guideline Sections

8. POST PUBLICATION

Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

Authors may order print copies of the article. Instructions are sent at proofing stage. Alternatively, authors may use the following link: **caesar.sheridan.com/reprints/redir.php?pub=10089&acro=eat** or email **chris.jones@sheridan.com**.

Promoting an Article

Wiley's Promotional Toolkit is a resource designed to help authors disseminate their work to the fullest extent through their networks and beyond. Authors can find the toolkit and other ideas on how to promote their research here: **www.wileyauthors.com/maximize**.

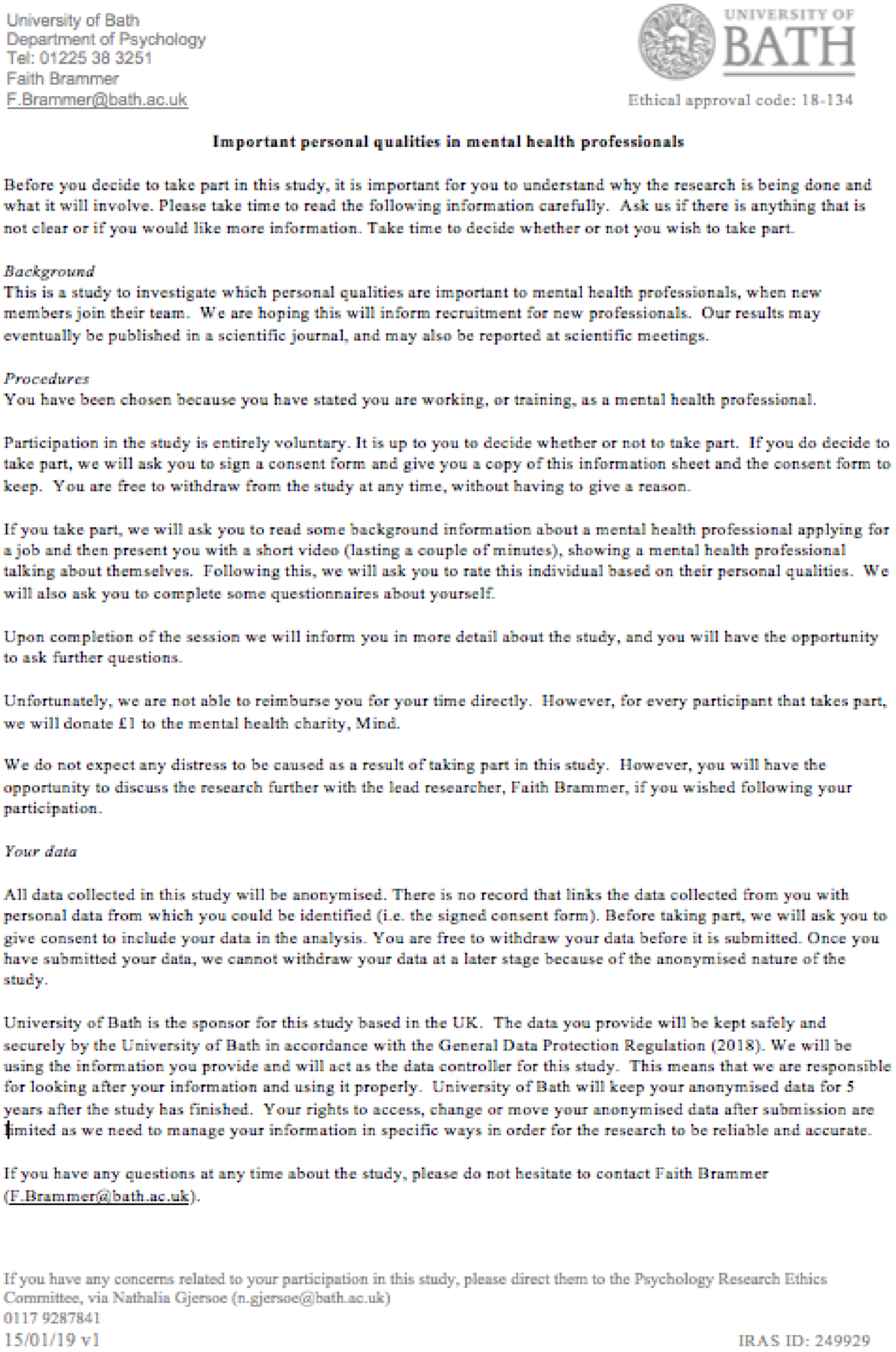
Authors intending to issue a press release through their institution or affiliation are kindly asked to inform the Editorial Office at their earliest convenience.

Measuring the Impact of an Article

Wiley also helps our authors **measure the impact** of their research through citation tracking, and specialist partnerships with Kudos (**www.wileyauthors.com/ kudos**) and Altmetric (**www.wileyauthors.com/altmetric**).

Return to Guideline Sections

Appendix 3A: Information Sheet



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH

Ethical approval code: 18-134

Important personal qualities in mental health professionals

Before you decide to take part in this study, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Background
This is a study to investigate which personal qualities are important to mental health professionals, when new members join their team. We are hoping this will inform recruitment for new professionals. Our results may eventually be published in a scientific journal, and may also be reported at scientific meetings.

Procedures
You have been chosen because you have stated you are working, or training, as a mental health professional.

Participation in the study is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part, we will ask you to sign a consent form and give you a copy of this information sheet and the consent form to keep. You are free to withdraw from the study at any time, without having to give a reason.

If you take part, we will ask you to read some background information about a mental health professional applying for a job and then present you with a short video (lasting a couple of minutes), showing a mental health professional talking about themselves. Following this, we will ask you to rate this individual based on their personal qualities. We will also ask you to complete some questionnaires about yourself.

Upon completion of the session we will inform you in more detail about the study, and you will have the opportunity to ask further questions.

Unfortunately, we are not able to reimburse you for your time directly. However, for every participant that takes part, we will donate £1 to the mental health charity, Mind.

We do not expect any distress to be caused as a result of taking part in this study. However, you will have the opportunity to discuss the research further with the lead researcher, Faith Brammer, if you wished following your participation.

Your data

All data collected in this study will be anonymised. There is no record that links the data collected from you with personal data from which you could be identified (i.e. the signed consent form). Before taking part, we will ask you to give consent to include your data in the analysis. You are free to withdraw your data before it is submitted. Once you have submitted your data, we cannot withdraw your data at a later stage because of the anonymised nature of the study.

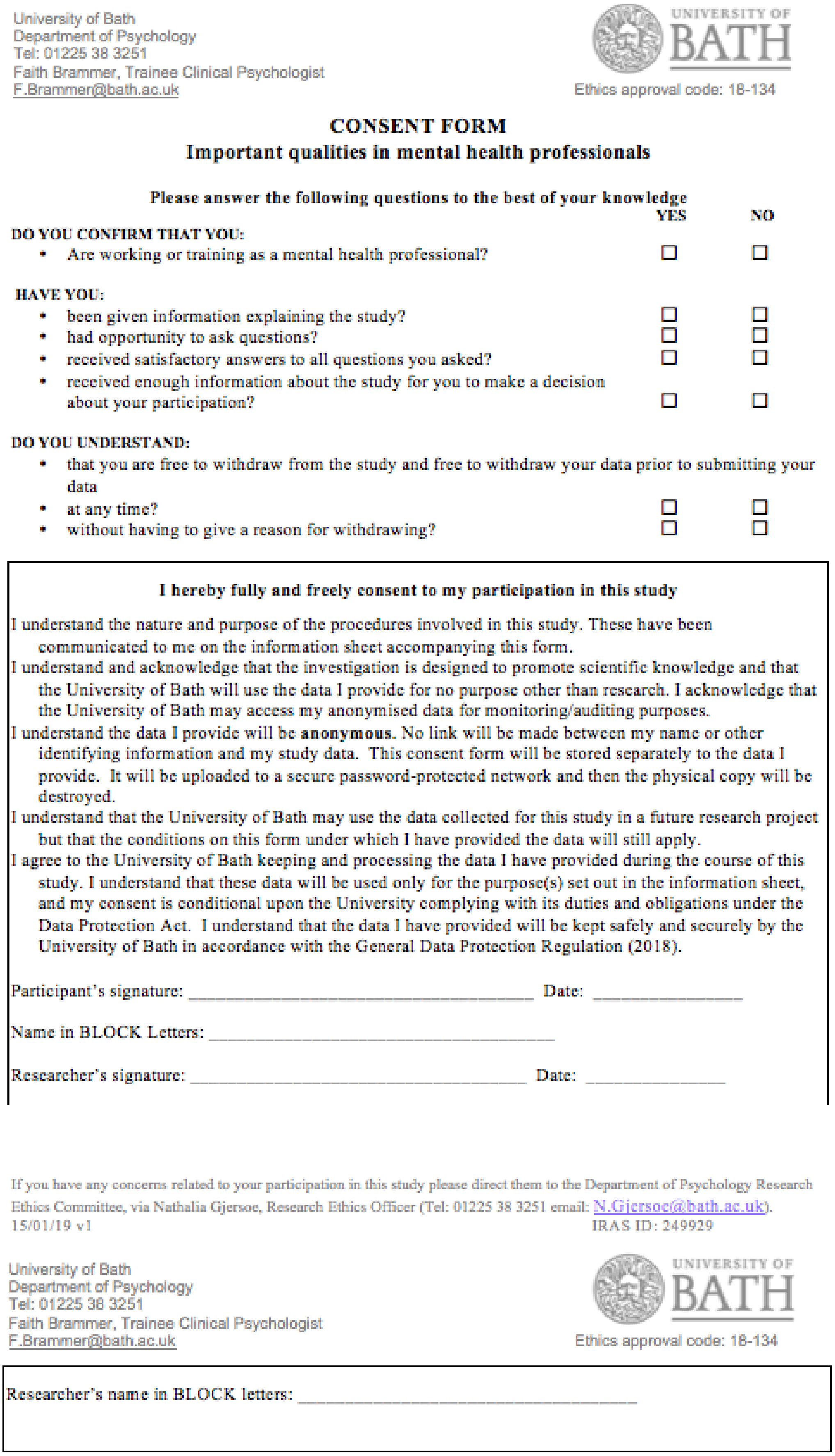
University of Bath is the sponsor for this study based in the UK. The data you provide will be kept safely and securely by the University of Bath in accordance with the General Data Protection Regulation (2018). We will be using the information you provide and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. University of Bath will keep your anonymised data for 5 years after the study has finished. Your rights to access, change or move your anonymised data after submission are limited as we need to manage your information in specific ways in order for the research to be reliable and accurate.

If you have any questions at any time about the study, please do not hesitate to contact Faith Brammer (F.Brammer@bath.ac.uk).

If you have any concerns related to your participation in this study, please direct them to the Psychology Research Ethics Committee, via Nathalia Gjersoe (n.gjersoe@bath.ac.uk)
0117 9287841
15/01/19 v1

IRAS ID: 249929

Appendix 3B: Consent Sheet



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer, Trainee Clinical Psychologist
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH

Ethics approval code: 18-134

CONSENT FORM

Important qualities in mental health professionals

Please answer the following questions to the best of your knowledge

	YES	NO
DO YOU CONFIRM THAT YOU:		
• Are working or training as a mental health professional?	☐	☐
HAVE YOU:		
• been given information explaining the study?	☐	☐
• had opportunity to ask questions?	☐	☐
• received satisfactory answers to all questions you asked?	☐	☐
• received enough information about the study for you to make a decision about your participation?	☐	☐
DO YOU UNDERSTAND:		
• that you are free to withdraw from the study and free to withdraw your data prior to submitting your data		
• at any time?	☐	☐
• without having to give a reason for withdrawing?	☐	☐

I hereby fully and freely consent to my participation in this study

I understand the nature and purpose of the procedures involved in this study. These have been communicated to me on the information sheet accompanying this form.

I understand and acknowledge that the investigation is designed to promote scientific knowledge and that the University of Bath will use the data I provide for no purpose other than research. I acknowledge that the University of Bath may access my anonymised data for monitoring/auditing purposes.

I understand the data I provide will be **anonymous**. No link will be made between my name or other identifying information and my study data. This consent form will be stored separately to the data I provide. It will be uploaded to a secure password-protected network and then the physical copy will be destroyed.

I understand that the University of Bath may use the data collected for this study in a future research project but that the conditions on this form under which I have provided the data will still apply.

I agree to the University of Bath keeping and processing the data I have provided during the course of this study. I understand that these data will be used only for the purpose(s) set out in the information sheet, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act. I understand that the data I have provided will be kept safely and securely by the University of Bath in accordance with the General Data Protection Regulation (2018).

Participant's signature: ______________________________________ Date: ________________

Name in BLOCK Letters: ______________________________________

Researcher's signature: ______________________________________ Date: _______________

If you have any concerns related to your participation in this study please direct them to the Department of Psychology Research Ethics Committee, via Nathalia Gjersoe, Research Ethics Officer (Tel: 01225 38 3251 email: N.Gjersoe@bath.ac.uk).

15/01/19 v1

IRAS ID: 249929

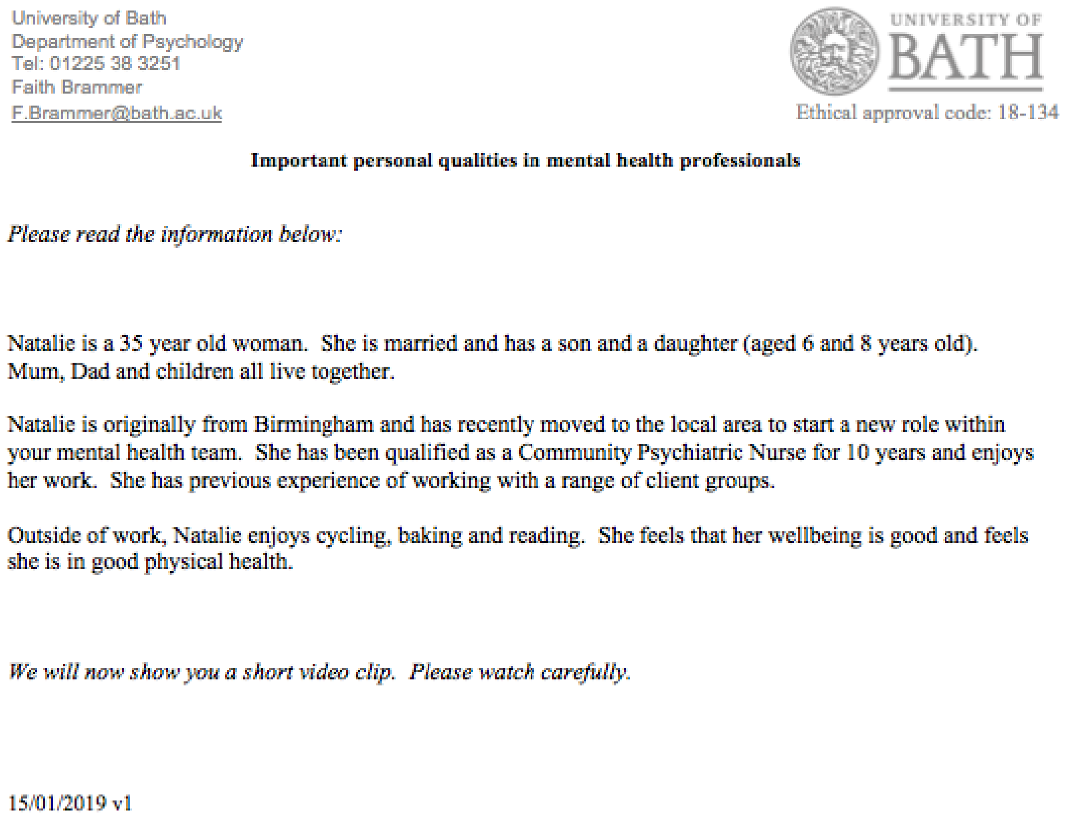
University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer, Trainee Clinical Psychologist
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH

Ethics approval code: 18-134

Researcher's name in BLOCK letters: ______________________________________

Appendix 3C: Background Information, Condition 1 (Control)



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH

Ethical approval code: 18-134

Important personal qualities in mental health professionals

Please read the information below:

Natalie is a 35 year old woman. She is married and has a son and a daughter (aged 6 and 8 years old). Mum, Dad and children all live together.

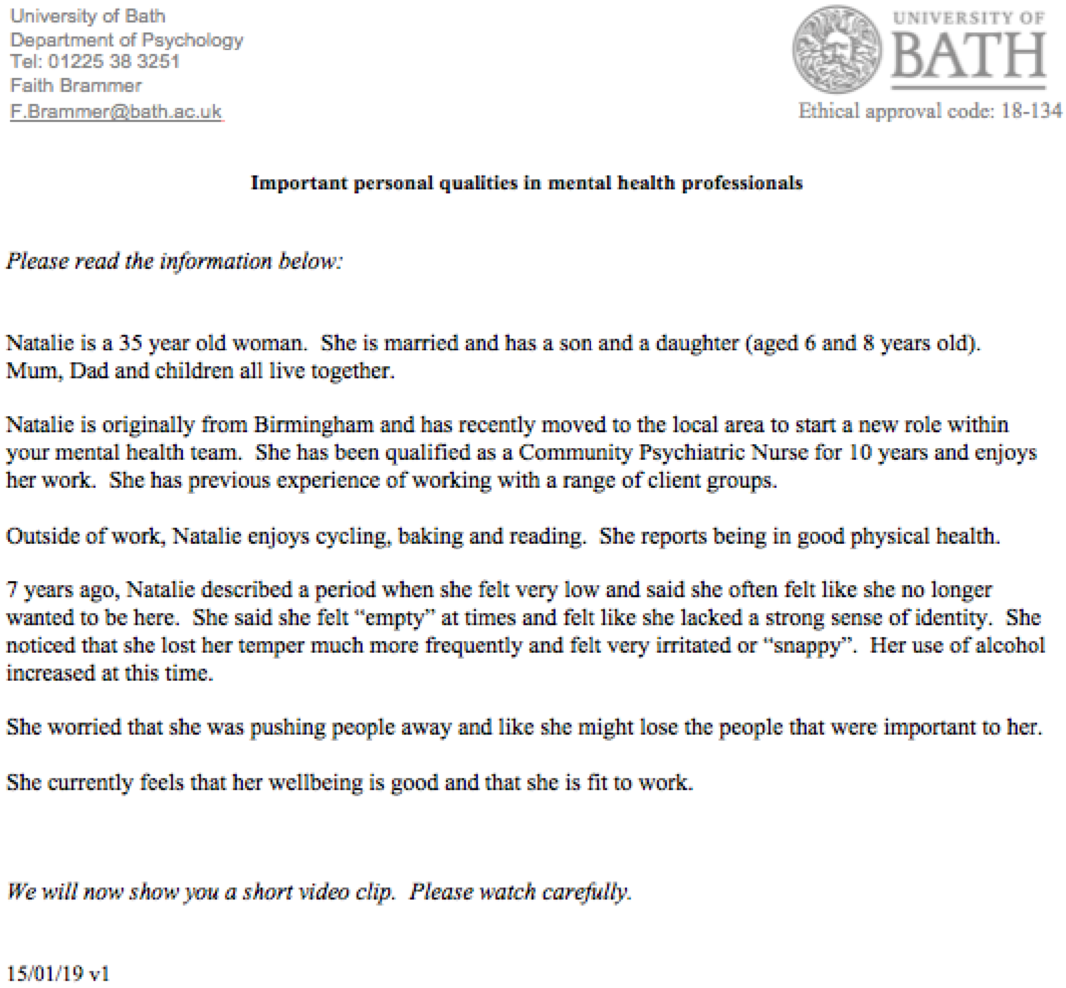
Natalie is originally from Birmingham and has recently moved to the local area to start a new role within your mental health team. She has been qualified as a Community Psychiatric Nurse for 10 years and enjoys her work. She has previous experience of working with a range of client groups.

Outside of work, Natalie enjoys cycling, baking and reading. She feels that her wellbeing is good and feels she is in good physical health.

We will now show you a short video clip. Please watch carefully.

15/01/2019 v1

Appendix 3D: Background Information, Condition 2 (Behavioural Description)



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

Ethical approval code: 18-134

Important personal qualities in mental health professionals

Please read the information below:

Natalie is a 35 year old woman. She is married and has a son and a daughter (aged 6 and 8 years old). Mum, Dad and children all live together.

Natalie is originally from Birmingham and has recently moved to the local area to start a new role within your mental health team. She has been qualified as a Community Psychiatric Nurse for 10 years and enjoys her work. She has previous experience of working with a range of client groups.

Outside of work, Natalie enjoys cycling, baking and reading. She reports being in good physical health.

7 years ago, Natalie described a period when she felt very low and said she often felt like she no longer wanted to be here. She said she felt "empty" at times and felt like she lacked a strong sense of identity. She noticed that she lost her temper much more frequently and felt very irritated or "snappy". Her use of alcohol increased at this time.

She worried that she was pushing people away and like she might lose the people that were important to her.

She currently feels that her wellbeing is good and that she is fit to work.

We will now show you a short video clip. Please watch carefully.

15/01/19 v1

Appendix 3E: Background Information, Condition 3a (Depression Diagnosis)

University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH

Ethical approval code: 18-134

Important personal qualities in mental health professionals

Please read the information below:

Natalie is a 35 year old woman. She is married and has a son and a daughter (aged 6 and 8 years old). Mum, Dad and children all live together.

Natalie is originally from Birmingham and has recently moved to the local area to start a new role within your mental health team. She has been qualified as a Community Psychiatric Nurse for 10 years and enjoys her work. She has previous experience of working with a range of client groups.

Outside of work, Natalie enjoys cycling, baking and reading. She reports being in good physical health.

7 years ago, Natalie described a period when she felt very low and said she often felt like she no longer wanted to be here. She said she felt “empty” at times and felt like she lacked a strong sense of identity. She noticed that she lost her temper much more frequently and felt very irritated or “snappy”. Her use of alcohol increased at this time.

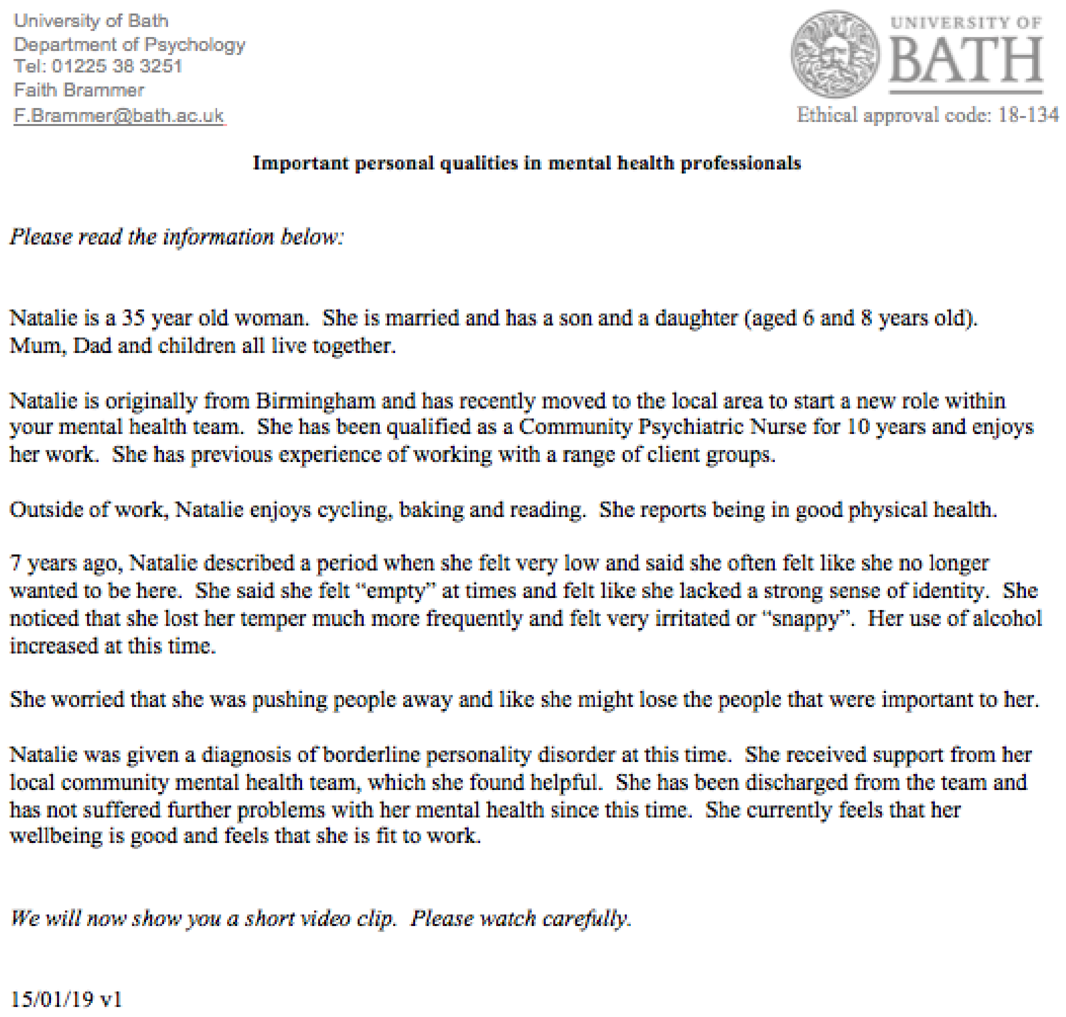
She worried that she was pushing people away and like she might lose the people that were important to her.

Natalie was given a diagnosis of depression at this time. She received support from her local community mental health team, which she found helpful. She has been discharged from the team and has not suffered further problems with her mental health since this time. She currently feels that her wellbeing is good and feels that she is fit to work.

We will now show you a short video clip. Please watch carefully.

15/01/2019 v1

Appendix 3F: Background Information, Condition 3b (BPD Diagnosis)



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH
Ethical approval code: 18-134

Important personal qualities in mental health professionals

Please read the information below:

Natalie is a 35 year old woman. She is married and has a son and a daughter (aged 6 and 8 years old). Mum, Dad and children all live together.

Natalie is originally from Birmingham and has recently moved to the local area to start a new role within your mental health team. She has been qualified as a Community Psychiatric Nurse for 10 years and enjoys her work. She has previous experience of working with a range of client groups.

Outside of work, Natalie enjoys cycling, baking and reading. She reports being in good physical health.

7 years ago, Natalie described a period when she felt very low and said she often felt like she no longer wanted to be here. She said she felt “empty” at times and felt like she lacked a strong sense of identity. She noticed that she lost her temper much more frequently and felt very irritated or “snappy”. Her use of alcohol increased at this time.

She worried that she was pushing people away and like she might lose the people that were important to her.

Natalie was given a diagnosis of borderline personality disorder at this time. She received support from her local community mental health team, which she found helpful. She has been discharged from the team and has not suffered further problems with her mental health since this time. She currently feels that her wellbeing is good and feels that she is fit to work.

We will now show you a short video clip. Please watch carefully.

15/01/19 v1

Appendix 3G: Video Script

Hi everybody!

My name’s Natalie and I’m going to be joining the team as the new community psychiatric nurse in a couple of months.

I’m really looking forward to meeting you all properly and just wanted to say hello before I start and give you a bit of background about me.

I was born in London and grew up there. I’ve got an older brother and sister and we all went to school together.

So, I qualified as a CPN 10 years ago. I trained at Plymouth and really enjoyed living near the sea while I was there. I really enjoyed my training experience and I’d wanted to be a nurse for a long time. I met my husband while I was training and he got a job in Birmingham when I finished so we moved there. I’ve been working in Birmingham since then in a variety of different roles. I started out in an adult community mental health team and worked mostly with people with depression and anxiety. I also worked with an early intervention for psychosis team from there. I’ve recently worked in CAMHS for a couple of years and worked mostly with younger children. I really enjoyed working in different roles but am ready for a bit of a change.

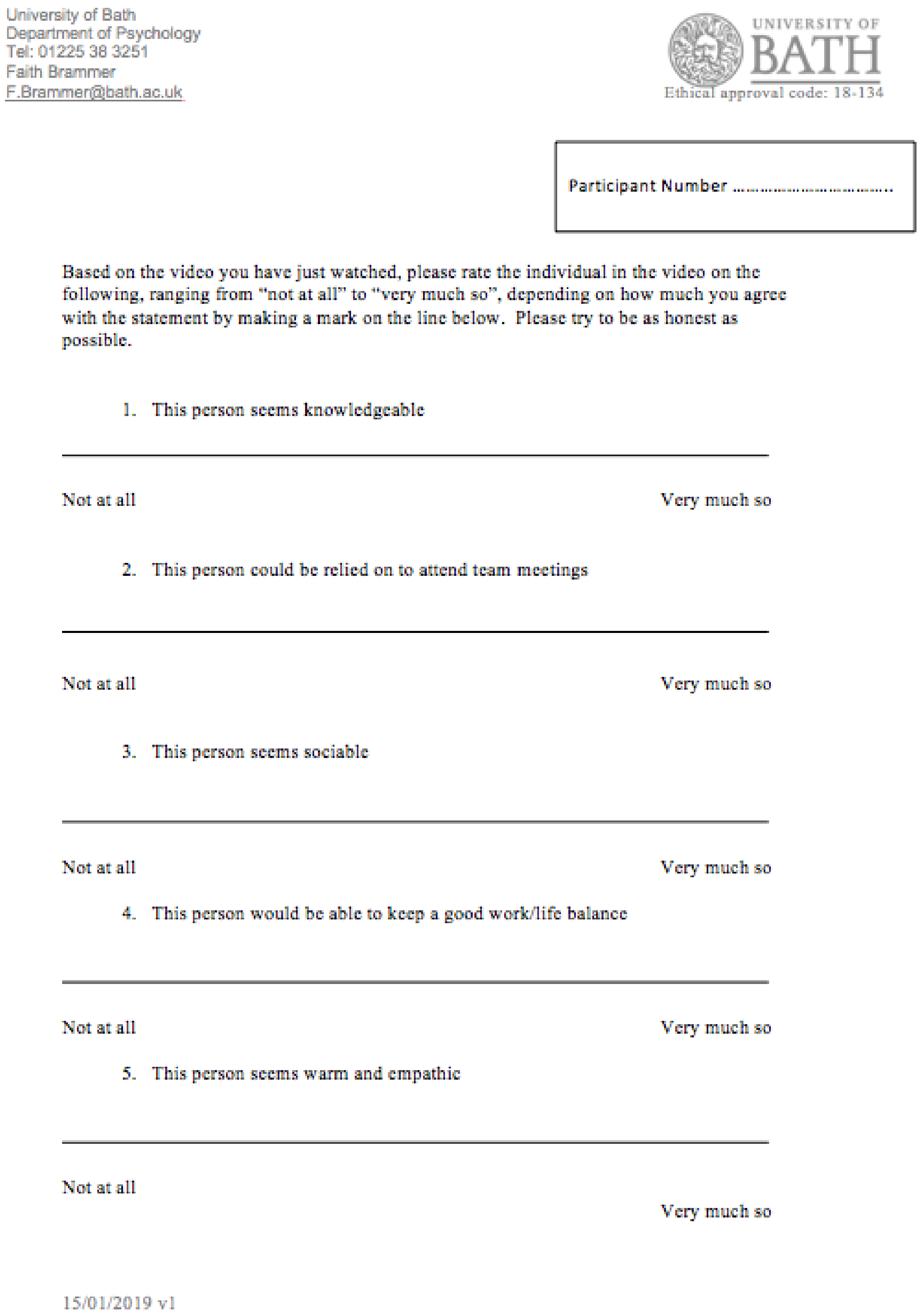
I’m really looking forward to moving and getting to know the area a bit more.

So that’s a bit about me! I’m really looking forward to meeting you all properly in a couple of months.

Link to video clip:

https://youtu.be/h-V5hwHMhCo

Appendix 3H: Judgement of New Colleague Scale (JONCS)



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH
Ethical approval code: 18-134

Participant Number ……………………………..

Based on the video you have just watched, please rate the individual in the video on the following, ranging from "not at all" to "very much so", depending on how much you agree with the statement by making a mark on the line below. Please try to be as honest as possible.

1. This person seems knowledgeable

Not at all — Very much so

2. This person could be relied on to attend team meetings

Not at all — Very much so

3. This person seems sociable

Not at all — Very much so

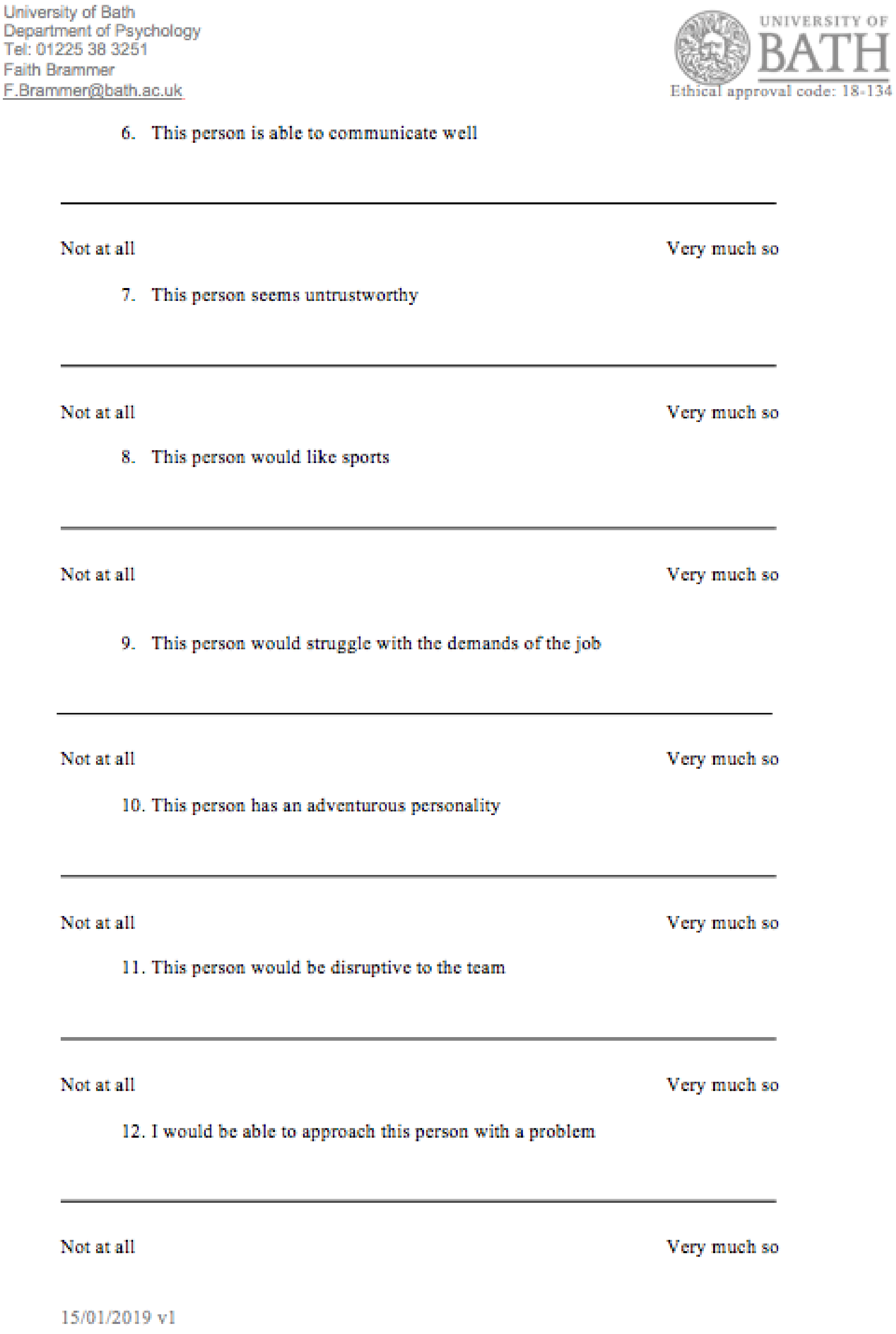
4. This person would be able to keep a good work/life balance

Not at all — Very much so

5. This person seems warm and empathic

Not at all — Very much so

15/01/2019 v1



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH
Ethical approval code: 18-134

6. This person is able to communicate well

Not at all ______________________________ Very much so

7. This person seems untrustworthy

Not at all ______________________________ Very much so

8. This person would like sports

Not at all ______________________________ Very much so

9. This person would struggle with the demands of the job

Not at all ______________________________ Very much so

10. This person has an adventurous personality

Not at all ______________________________ Very much so

11. This person would be disruptive to the team

Not at all ______________________________ Very much so

12. I would be able to approach this person with a problem

Not at all ______________________________ Very much so

15/01/2019 v1

13. This person seems fun and easy going

Not at all | Very much so

14. This person appears judgemental

Not at all | Very much so

15. This person appears to be safe

Not at all | Very much so

16. This person would keep to their word

Not at all | Very much so

17. This person would be able to cope with difficult situations

Not at all | Very much so

18. This person seems relaxed

Not at all | Very much so

19. This person is dressed inappropriately

Not at all | Very much so

20. This person seems competitive

Not at all Very much so

21. This person seems competent

Not at all Very much so

22. This person would require their own professional help

Not at all Very much so

23. This person would have strong religious beliefs

Not at all Very much so

24. This person has good family values

Not at all Very much so

25. I would expect this person to be self-reflective

Not at all Very much so

26. This person would struggle to build relationships with clients

Not at all Very much so

27. This person would be a danger to others

Not at all — Very much so

28. This person would require the same amount of supervision as others

Not at all — Very much so

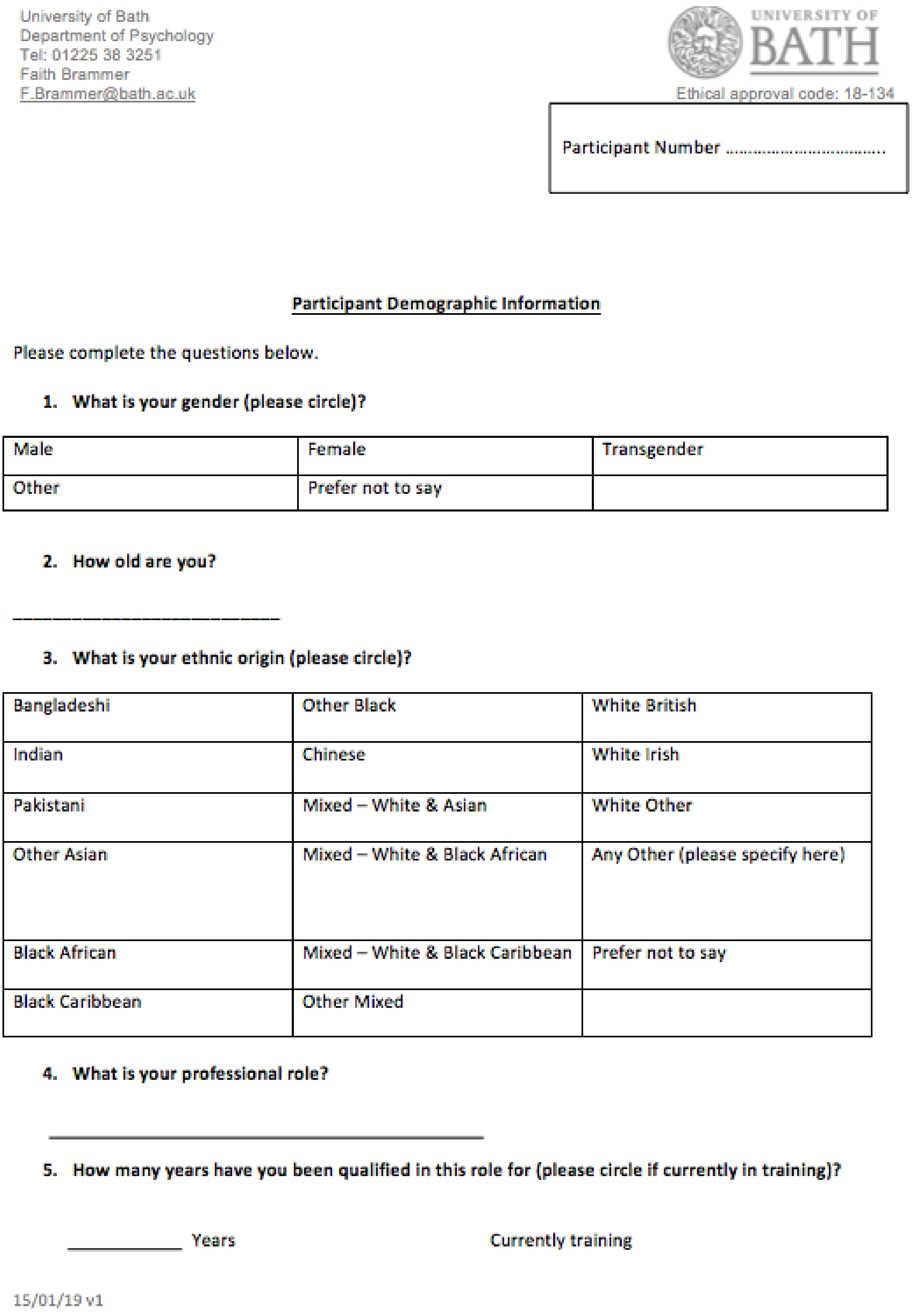
29. This person seems committed to improving quality

Not at all — Very much so

30. This person would have a lot of friends

Not at all — Very much so

Appendix 3I: Demographics Questionnaire



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH

Ethical approval code: 18-134

Participant Number ……………………………..

Participant Demographic Information

Please complete the questions below.

1. **What is your gender (please circle)?**

Male	Female	Transgender
Other	Prefer not to say	

2. **How old are you?**

____

3. **What is your ethnic origin (please circle)?**

Bangladeshi	Other Black	White British
Indian	Chinese	White Irish
Pakistani	Mixed – White & Asian	White Other
Other Asian	Mixed – White & Black African	Any Other (please specify here)
Black African	Mixed – White & Black Caribbean	Prefer not to say
Black Caribbean	Other Mixed	

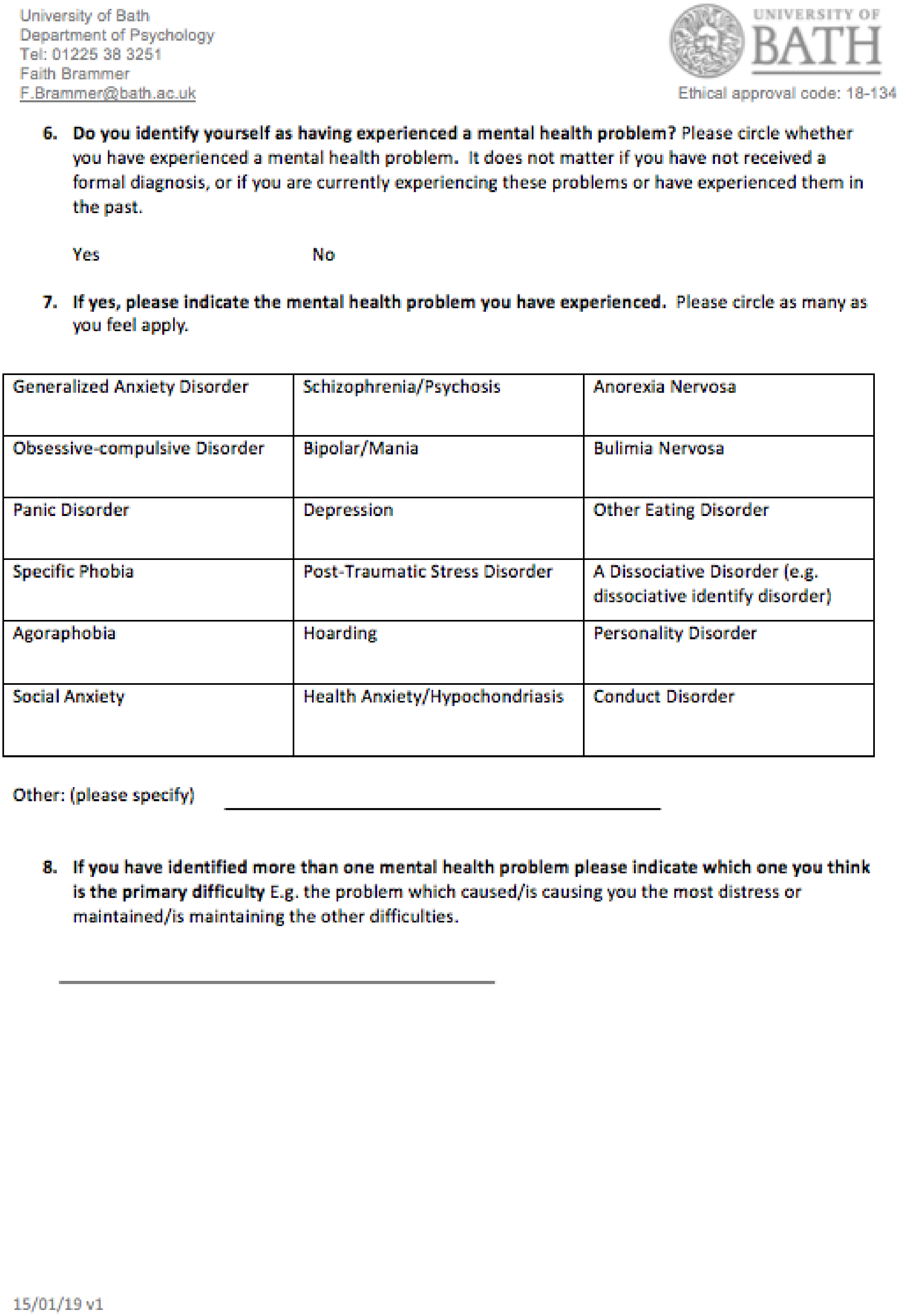
4. **What is your professional role?**

____

5. **How many years have you been qualified in this role for (please circle if currently in training)?**

____________ Years Currently training

15/01/19 v1



University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH
Ethical approval code: 18-134

6. **Do you identify yourself as having experienced a mental health problem?** Please circle whether you have experienced a mental health problem. It does not matter if you have not received a formal diagnosis, or if you are currently experiencing these problems or have experienced them in the past.

Yes No

7. **If yes, please indicate the mental health problem you have experienced.** Please circle as many as you feel apply.

Generalized Anxiety Disorder	Schizophrenia/Psychosis	Anorexia Nervosa
Obsessive-compulsive Disorder	Bipolar/Mania	Bulimia Nervosa
Panic Disorder	Depression	Other Eating Disorder
Specific Phobia	Post-Traumatic Stress Disorder	A Dissociative Disorder (e.g. dissociative identify disorder)
Agoraphobia	Hoarding	Personality Disorder
Social Anxiety	Health Anxiety/Hypochondriasis	Conduct Disorder

Other: (please specify) ________________________

8. **If you have identified more than one mental health problem please indicate which one you think is the primary difficulty** E.g. the problem which caused/is causing you the most distress or maintained/is maintaining the other difficulties.

____

15/01/19 v1

Appendix 3J: Warwick-Edinburgh Mental Well-being Scale

The Warwick–Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick–Edinburgh Mental Well-being Scale (WEMWBS)

Appendix 3K: Self-Stigma of Mental Illness Scale – Short Form

SSMIS-SF

Participant Number ………………

The public has believed many different things about persons with serious mental health problems over the years, including some things that could be considered offensive.
We would like to know what you think most of the public as a whole, or most people in general, believe about persons with serious mental health problems at the present time.
Please answer the following items using the 9-point scale below.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
I Strongly Disagree	I disagree	I moderately disagree	I mildly disagree	I Neither Agree or Disagree	I mildly agree	I moderately agree	I agree	I Strongly Agree

I think the public believes...

1. _____ most persons with mental health problems are to blame for their problems.

2. _____ most persons with mental health problems are unpredictable.

3. _____ most persons with mental health problems will not recover or get better.

4. _____ most persons with mental health problems are dangerous.

5. _____ most persons with mental health problems are unable to take care of themselves.

Now please answer the following items using the same scale.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
I Strongly Disagree	I disagree	I moderately disagree	I mildly disagree	I Neither Agree or Disagree	I mildly agree	I moderately agree	I agree	I Strongly Agree

I think...

1. _____ most persons with mental health problems are to blame for their problems.

2. _____ most persons with mental health problems are unpredictable.

3. _____ most persons with mental health problems will not recover or get better.

4. _____ most persons with mental health problems are dangerous.

5. _____ most persons with mental illness are unable to take care of themselves.

Please answer the questions below based on your own experiences of mental health problems, or as if you have a mental health problem.

Now please answer the following items using the same scale.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
I Strongly Disagree	I disagree	I moderately disagree	I mildly disagree	I Neither Agree or Disagree	I mildly agree	I moderately agree	I agree	I Strongly Agree

Because I have a mental health problem...

1. _____ I am unable to take care of myself.

2. _____ I will not recover or get better.

3. _____ I am to blame for my problems.

4. _____ I am unpredictable.

5. _____ I am dangerous.

Finally, please answer the following items using the same scale.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
I Strongly Disagree	I disagree	I moderately disagree	I mildly disagree	I Neither Agree or Disagree	I mildly agree	I moderately agree	I agree	I Strongly Agree

I currently respect myself less...

1. _____ because I am unable to take care of myself.

2. _____ because I am dangerous.

3. _____ because I am to blame for my problems.

4._____ because I will not recover or get better.

5. _____ because I am unpredictable.

Appendix 3L: Debrief

University of Bath
Department of Psychology
Tel: 01225 38 3251
Faith Brammer
F.Brammer@bath.ac.uk

UNIVERSITY OF BATH
Ethical approval code: 18-134

Debriefing Information

Thank you for taking part in this project. Your contribution is very much appreciated.

This project has been investigating the way that mental health professionals view other mental health professionals who have had their own mental health problems. We are hoping to understand whether judgements about potential colleagues are affected by that person having had a historical mental health diagnosis. We are hoping that this study will make a valuable contribution to the existing literature about the potential difficulties of disclosing mental health problems in the workplace, and in reducing stigma associated with experiencing mental health problems. We apologise that we were unable to reveal the true aims at the outset of the study and hope that this did not cause you any distress.

Given the nature of the study, we ask that you not discuss the study with other mental health professionals who may take part.

Although we hope this study did not cause any distress to you, we are aware that it may raise difficult issues for some people. Below is a list of organisations and websites that may contain information useful to you. We would also advise you to seek professional supervision, if appropriate.

TALK TO US
If things are getting to you

116 123
jo@samaritans.org
samaritans.org
SAMARITANS

Mind Infoline:
Call 0300 123 3393
or text 86463

https://www.mind.org.uk/

Opening hours: Monday – Friday, 9 am – 6 pm.

We apologise that we are unable to reimburse you for your participation. Instead, we will make a donation of £1 to Mind, the mental health charity, for every participant who takes part in the study.

Thank you again for participating. If you would like to speak to us about the project please get in touch.

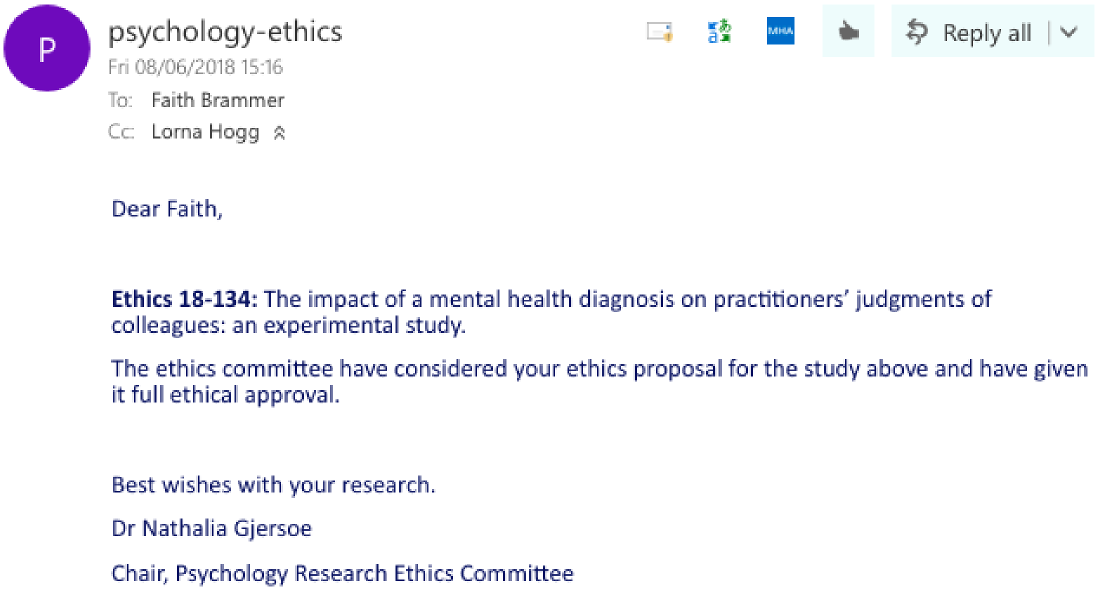
Email – F.Brammer@bath.ac.uk

You can also speak to the supervisors of the project, Cathy Randle-Phillips, Lorna Hogg, and Falguni Nathwani (Clinical Psychologists)
Email – C.M.Randle-Phillips@bath.ac.uk, lorna.hogg@hmc.ox.ac.uk; falguni.nathwani@nhs.net
Our address is: Department of Psychology, University of Bath, Claverton Down Bath, BA2 7AY

If you have any concerns about the ethics of this research study, please contact the Bath University Psychology Department Research Executive Officer, Dr. Nathalia Gjersoe Email: psychology-ethics@bath.ac.uk Phone: 01225 38 4322

15/01/19 v1

Appendix 3M: Confirmation of Ethical Approval, University of Bath



psychology-ethics
Fri 08/06/2018 15:16
To: Faith Brammer
Cc: Lorna Hogg

Dear Faith,

Ethics 18-134: The impact of a mental health diagnosis on practitioners' judgments of colleagues: an experimental study.

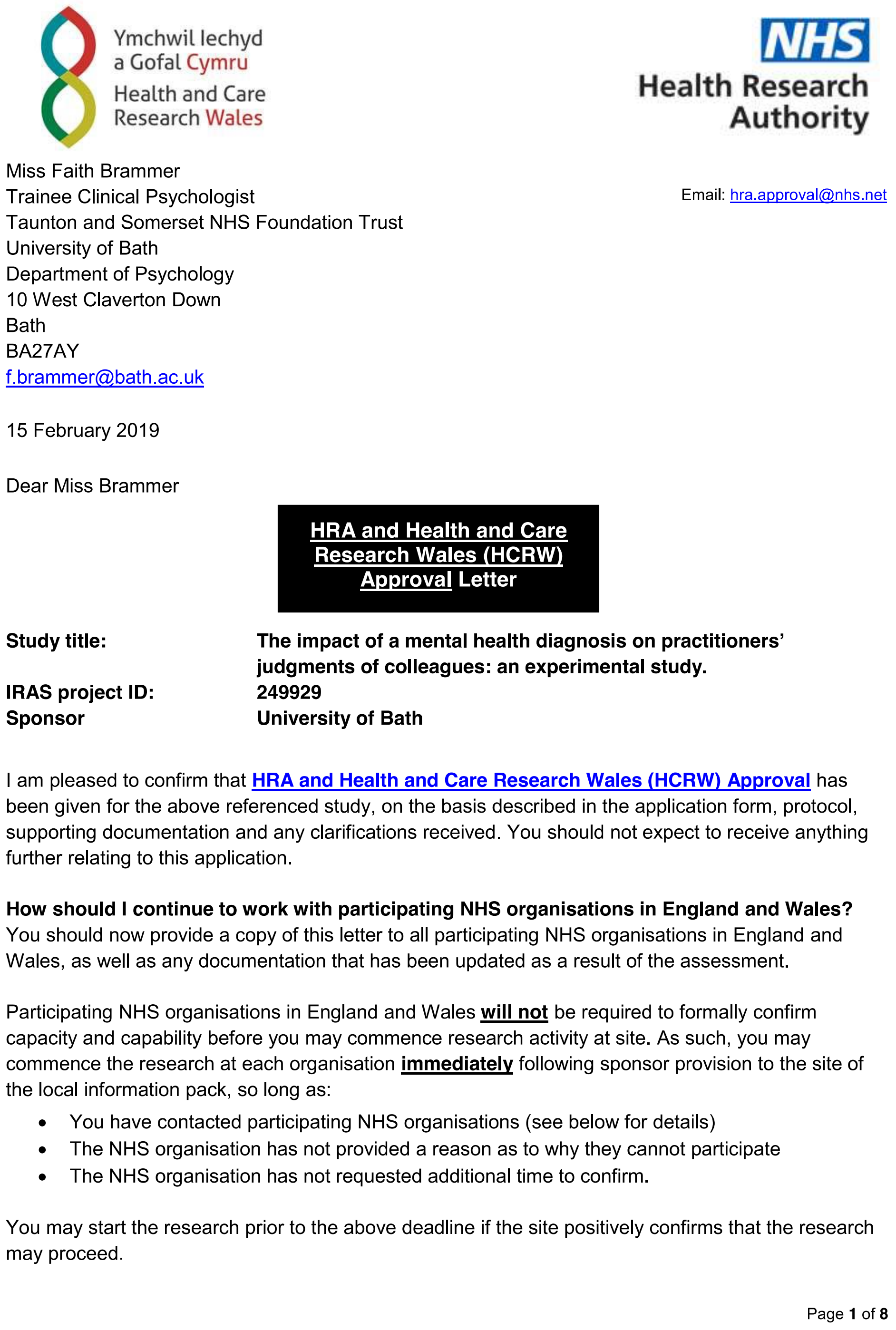
The ethics committee have considered your ethics proposal for the study above and have given it full ethical approval.

Best wishes with your research.

Dr Nathalia Gjersoe

Chair, Psychology Research Ethics Committee

Appendix 3N: Confirmation of Ethical Approval, NHS Health Research Authority



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net

Miss Faith Brammer
Trainee Clinical Psychologist
Taunton and Somerset NHS Foundation Trust
University of Bath
Department of Psychology
10 West Claverton Down
Bath
BA27AY
f.brammer@bath.ac.uk

15 February 2019

Dear Miss Brammer

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The impact of a mental health diagnosis on practitioners' judgments of colleagues: an experimental study.**
IRAS project ID:	**249929**
Sponsor	**University of Bath**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation **immediately** following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

Appendix 3O: Stigma and Health: Submission Guidelines.

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

To submit to the Editorial Office of Patrick W. Corrigan, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc).

Manuscript Types and Length

Stigma and Health accepts both regular articles and brief reports.

Articles should not exceed 20 pages inclusive of the introduction, methods, results, and discussion. Tables, figures and references may be outside of this page limit; however, the combined number of tables and figures should not exceed 5. Authors should include the page count, number of figures/tables, and number of references on the title page of the manuscript.

Authors are encouraged to move tables and figures not directly pertinent to the understanding of the manuscript text into the online-only supplemental material. Please see Supplementing Your Article With Online Material for more details.

Brief reports should be a maximum 1,800 words (excluding abstract, references, and table/figure), plus no more than 15 references and one table or figure.

Authors may request consideration of longer papers or additional tables/figures by providing clear justification in a cover letter to the editor.

Manuscripts based in the following realms are also encouraged:

- Qualitative studies
- Survey research
- Quantitative tests of hypotheses about the form and impact of stigma
- Theoretical reviews and pioneering reports on innovations
- Research studies on methods meant to erase the stigma of mental and physical illnesses
- First person essays about experience with stigma

The journal will likewise consider lengthier theory-based papers with permission from the editor.

Masked Review

This journal has adopted a policy of masked review for all submissions. The title page should include all authors' names and institutional affiliations and full contact information for the corresponding author. The first page of text should omit this information but should include the title of the manuscript and the date it is submitted. Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association*, 6th Edition (2010). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

For authors interested in additional resources on manuscript writing, APA Style's Journal Article Reporting Standards offer guidelines on what information should be included in all manuscript sections for qualitative, quantitative, and mixed-methods research. For more information, including checklists and flowcharts, visit the APA Style JARS website.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
  Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566
- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
  Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments). On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK
  Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK
  Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.