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The Development and Evaluation of a Resilience-Focused Therapy Protocol for Stress in Everyday Life

A thesis presented in partial fulfilment of the requirements for the degree of

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Saralla Chettiar

Abstract

Psychological resilience is increasingly recognised as an important factor in helping individuals adapt to everyday stress, maintain psychological wellbeing, and reduce the risk of stress-related psychological difficulties. Although numerous resilience interventions have been developed, relatively few have been grounded in an explicit theoretical framework or examined how resilience develops over time within individuals. The present study sought to address these gaps through the development, evaluation and refinement of the Psychological Resilience Treatment Manual (PRTM), a modular cognitive-behavioural intervention based on the Three Psychological Resilience (3-PR) model proposed by de Terte and Stephens (2014). The details of this manual were derived from a critical review of the literature and the incorporation of empirically supported principles of behaviour change in clinical treatment.

The study was conducted in two phases. Phase 1 utilised a single-case experimental design involving ten participants to evaluate the effectiveness of the PRTM in reducing perceived stress and psychological distress while enhancing wellbeing and adaptive coping. Participants completed measures of perceived stress, total stress symptoms, general wellbeing and coping across baseline, intervention and follow-up periods. Results indicated overall reductions in perceived stress and psychological distress, improvements in wellbeing and increases in adaptive coping following participation in the intervention.

Phase 2 employed an intensive daily diary methodology with two participants to examine resilience development at an idiographic level. Daily diary entries, supplemented by quantitative measures, provided detailed insight into how resilience developed and was experienced within everyday life. Although both participants demonstrated improved outcomes following the intervention, the diary data revealed distinct pathways of change. One participant's resilience development appeared to occur primarily through planning, organisation, active coping and problem-solving, whereas the other participant's resilience development appeared to occur through emotional awareness, interpersonal reflection and experiential learning. These findings indicated that resilience may emerge through multiple pathways rather than through a single mechanism of change.

The study contributes to the resilience literature in several ways. First, it provides support for the effectiveness of a theoretically grounded modular resilience intervention. Second, it offers clues as to how resilience develops within naturalistic contexts. Third, it demonstrates that individuals may engage with and benefit from the same intervention through different processes that reflect their existing strengths, coping styles, and ways of engaging with challenges. In doing so, the study provides idiographic insight into multiple pathways of resilience development and supports contemporary cognitive-behavioural, individualised and process-based perspectives that emphasise flexibility and individual differences in psychological change. Consequently, the study contributes ecologically valid, process-oriented evidence demonstrating how the same intervention may be experienced and utilised differently by different individuals, thereby providing a detailed idiographic account of how multiple pathways to resilience development unfold in everyday life.

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Preface

My interest in resilience emerged from my work as a Clinical Psychologist in Penang, Malaysia. Over more than fifteen years of clinical practice, I have had the privilege of working with individuals facing a wide range of challenges, including academic pressures, occupational stress, health concerns, relationship difficulties, caregiving responsibilities, trauma, grief, and significant life transitions. Many came to therapy during some of the most difficult periods of their lives. While I was often focused on helping them manage distress and develop practical coping skills, I found myself increasingly fascinated by a deeper question: why were some individuals able to adapt, recover and even grow despite adversity, while others continued to struggle despite having access to similar resources and support?

This question stayed with me long after therapy sessions ended. It became a recurring theme in my clinical work and eventually led me to undertake doctoral studies at Massey University in 2018. At the time, I did not fully appreciate how much this journey would challenge my assumptions, shape my professional identity, and influence my understanding of resilience. What began as an academic interest gradually evolved into a much deeper exploration of how resilience develops and how it can be nurtured in everyday life.

Throughout this journey, I sought to bridge the gap between research and clinical practice by developing an intervention that could be both theoretically grounded and practically useful for individuals experiencing stress and adversity. The present thesis documents the development and evaluation of the Psychological Resilience Treatment Manual (PRTM). The intervention was initially informed by the 3-PR model developed by Associate Professor Ian de Terte and colleagues, which provided an important theoretical foundation for understanding resilience. As the research progressed, however, the intervention evolved through an ongoing process of literature review, clinical reflection, participant feedback, and empirical evaluation. In many ways, the development of the manual mirrors my own development as a clinician and researcher, shaped by both scientific evidence and the realities of working with people facing real-life challenges.

The doctoral journey was considerably longer and more complex than I had originally anticipated. The COVID-19 pandemic created significant disruptions to recruitment, intervention delivery, supervision arrangements, and research timelines. During these tumultuous years, I was required to repeatedly adapt, revise plans and persevere through circumstances beyond my control. There were periods when timelines shifted, supervision arrangements changed and the completion of the thesis seemed increasingly distant. At times, I questioned whether the journey would ever reach its conclusion. Looking back, however, these challenges taught me as much about resilience as any journal article. They reinforced the importance of flexibility, persistence, patience and the ability to continue moving forward despite setbacks, uncertainty and prolonged periods of delay. In many ways, the doctoral journey became a personal lesson in resilience, teaching me that resilience is often not demonstrated through dramatic achievements, but through the quiet determination to continue despite obstacles, discouragement and uncertainty.

An important influence during the latter stages of this doctoral journey was Professor Emeritus Ian M. Evans, whose supervision helped shape my understanding of resilience. His emphasis on understanding how and why people change encouraged me to look beyond intervention outcomes and consider the *processes* through which resilience develops. Through his guidance, I came to appreciate the importance of exploring participants lived experiences, a perspective that significantly influenced the design and direction of this thesis. I am also deeply grateful to Professor Kirsty Ross for her continuous support, encouragement and thoughtful

feedback throughout the final stages of the doctoral process. Her guidance and careful review of the thesis were invaluable in bringing this journey to completion.

Several important milestones occurred throughout this journey. The publication of *The Psychological Resilience Treatment Manual: An Evidence-Based Intervention Approach* in 2022 represented an important step in translating the research into a practical resource for clinicians and helping professionals, an achievement that I am extremely proud of. Becoming an author was never something I had anticipated when I first embarked on my doctoral studies. In many respects, I became an accidental author, as the book emerged naturally from years of clinical practice, supervision, research and the gradual development of the resilience intervention. Seeing the work evolve from an idea into a published resource has been one of the most rewarding aspects of this journey.

The resilience model and intervention approach were also recognised internationally at the International Law Enforcement and Public Health Conference in Edinburgh, Scotland, in 2019, where the work was identified as a highly commendable contribution to public health and safety. As someone who began this project simply wanting to understand resilience more deeply, receiving such recognition was both humbling and encouraging. It reinforced my belief that resilience-focused interventions have relevance across a broad range of populations and settings.

This thesis also reflects changes in my own understanding of resilience. At the beginning of the project, I was primarily interested in whether resilience interventions could reduce stress and improve wellbeing. By the conclusion of the research, I had become equally interested in understanding how resilience develops and why individuals often arrive at similar outcomes through different pathways. I came to appreciate that resilience is not a single skill or characteristic, but a dynamic process that unfolds differently for different people.

The development of the Psychological Resilience Treatment Manual has also been an evolving process. Although this thesis presents the current version of the intervention, I do not view the manual as a finished product. Rather, it represents one stage in an ongoing programme of development and refinement. Following the completion of my doctoral studies, I intend to continue revising and refining the manual in response to emerging evidence, clinical experience, and participant feedback, with the aim of producing a revised edition for future publication.

I am deeply grateful to the participants who generously shared their experiences and entrusted me with their stories. Their willingness to engage in the research, particularly during periods of personal challenge and uncertainty, provided insights that extended far beyond what could be captured through psychometric measures alone. They reminded me that resilience is not merely a theoretical concept, but something that is lived, practised and demonstrated in everyday life.

Looking back, this thesis represents far more than a doctoral project. It reflects a journey of professional growth, intellectual curiosity, perseverance, and personal learning. The process has deepened my appreciation of resilience not only as a psychological construct but also as a profoundly human experience. It is my hope that the findings contribute not only to the resilience literature but also to the development of practical, evidence-informed approaches that help individuals navigate the ordinary challenges of life with greater confidence, flexibility and hope.

CHAPTER ONE: RESILIENCE

Overview: Resilience as a Dynamic and Adaptive Process

The concept of resilience has always intrigued me. It is an important topic, grown exponentially in terms of across psychology, education, health, sports and even public policy. It is now clear that resilience covers a variety of phenomena. Resilience has garnered huge interest in both research and clinical practice, reflecting its relevance to mental health and adaptation. Today, it is considered to be a key explanatory mechanism for how individuals withstand adversity, manage stress, and sustain wellbeing in the face of challenges (Calitz & Santana, 2018; Clompus & Albarran, 2016; Luthar et al., 2000). Its appeal lies in both its simplicity and versatility.

On a basic level, resilience refers to the ability to "bounce back" from stressful situations or trauma (Neenan, 2009). At the same time, it is a multidimensional construct that encompasses cognitive processes, behavioural strategies, and social resources (de Terte & Stephens, 2014). This breadth has enabled resilience to become a "catch-all" concept, broadly applicable to common psychological problems such as anxiety, stress, burnout and adjustment difficulties.

Despite its widespread use, resilience is not without challenges as a construct. It has been defined in multiple ways; sometimes as a trait, sometimes as a process, and sometimes as an outcome (Masten, 2014; Rutter, 2012; Wolke et al., 2025). A longstanding debate in resilience research concerns whether resilience is innate or acquired. In its initial understanding in the field of psychology, resilience was characterized as a personality trait. Personality factors such as optimism, confidence, and emotional stability are consistently correlated with resilience (Fletcher & Sarkar, 2012). These individual differences may predispose some individuals to appraise stressors more positively, regulate emotions effectively, or engage more persistently with challenges.

However, this early conceptualization has been challenged by later research, which portrays resilience as a dynamic, context-dependent process shaped by the interaction between individual characteristics and environmental influences. Studies have shown that resilience can fluctuate across the lifespan, depending on changing circumstances and experiences (Hill et al., 2024). Furthermore, past experiences play a critical role in determining how individuals respond to new stressors; the adaptive processes triggered by adversity are influenced by the person's previous exposure to, and recovery from, challenging events (Seery et al., 2010).

Importantly, acknowledging resilience as a process does not dismiss the importance of individual differences. People vary in their biological dispositions, temperament, family context and personality traits, which can make resilience easier or harder to develop (Luthar et al., 2000; Rutter, 2012). Yet, these differences do not imply fixed capacities; rather, they highlight that resilience can be strengthened through learning, practice and environmental support (Masten, 2001; Ungar, 2011). In other words, while some individuals may begin with certain advantages, everyone has the potential to cultivate resilience through experience and guided intervention.

This current theoretical trend means that the understanding of resilience has evolved from its original trait conceptualization to the contemporary process conceptualization (Hill et al., 2024). Bonanno (2021) echoed different stressors may require varied adaptational processes, including coping strategies, in order to successfully demonstrate resilience. This shift toward a process-oriented definition allowed resilience to be seen as accessible to all individuals, not just those with exceptional inherent qualities.

Origins of the Resilience Construct

While varied definitions of resilience were noted in the literature (Bonanno, 2004; Eggerman, 2010; Masten, 2014; Neenan, 2009; Rutter, 2012; Southwick et al., 2014; Yehuda, 2007), there is still no agreed definition of resilience. The most salient conceptualisation of

resilience is as a process of personal adaptation, an ability to rebound from adversities (Calitz & Santana, 2018; Clompus & Albarran, 2016).

The Kauai Longitudinal Study (Werner, 1993) is widely recognised as the cornerstone of modern resilience research and remains especially influential in advancing understanding of the social foundations of development and adaptive functioning across the lifespan. Conducted on the Hawaiian island of Kauai, this study followed 698 children born in 1955, a cohort largely composed of indigenous Hawaiian, Filipino and Japanese-American families from birth to adulthood. While the majority of the children were born without complications, approximately one-third of the cohort were identified as high-risk due to exposure to significant adversities such as poverty, family instability, limited educational opportunities and parental mental health difficulties. However, one-third of these high-risk children developed into "resilient" adults. This outcome profoundly shifted the focus of developmental psychology from vulnerability and deficit to strength and adaptation. It demonstrated that resilience is not an exceptional quality possessed by few, but a common human capacity shaped by cultural, familial and social processes.

A key insight from the Kauai study that I applied in my research is that resilience is deeply embedded in culture and community. The protective factors that enabled positive development among high-risk children were not purely psychological or individual. Instead, they were grounded in the collectivist cultural values that characterised the island's communities. Central to this was the Hawaiian concept of 'ohana,' which extends the notion of family beyond biological kin to include neighbours, teachers, church members and community elders. (Incidentally, this concept is the equivalent of the New Zealand Māori concept of whānau.) These extended social networks functioned as vital systems of support, providing children with stability, guidance and a sense of belonging even when their immediate family environments were disrupted. Moreover, Werner (1993) found that resilient children often demonstrated active

coping styles, characterised by assertiveness, autonomy, a sense of responsibility, independence, curiosity, persistence, optimism and an achievement-oriented attitude toward life.

Werner's (1993) long-term follow-up revealed that the children identified as resilient continued to demonstrate adaptive functioning and psychosocial competence well into adulthood. Werner's longitudinal evidence therefore demonstrated that resilience is a lifelong developmental process. The coping skills, self-beliefs, and cultural values fostered in childhood evolve into stable competencies that support wellbeing, social integration and prosocial engagement in later life.

The cultural significance of Werner's findings extends beyond Hawai'i to other collectivist societies, including Malaysia, where family cohesion, community interdependence and spiritual values (while varied) play comparable roles in fostering resilience. Similar to the Hawaiian concept of ohana, Malaysian cultural systems rooted in values such as "gotong-royong" (mutual cooperation), filial piety and religious faith promote communal solidarity and emotional connectedness. These collective values act as buffers against stress by ensuring that individuals rarely face hardship in isolation. Thus, the Kauai study not only marked the beginning of empirical resilience research but also highlighted the universal importance of culture as a context for human adaptation. It reminds contemporary scholars that resilience cannot be fully understood without considering the social, cultural and relational environments that shape how individuals interpret and respond to adversity.

Together, these viewpoints demonstrate that resilience is most effectively perceived as a multidimensional construct, functioning concurrently at the individual, community and systemic levels (Luthar et al., 2000). This comprehensive conceptualization lays the groundwork for exploring the established advantages of resilience across various fields.

The Documented Benefits of Resilience

The benefits of resilience are consistently documented across a wide range of studies. Resilient individuals display reduced psychological distress when facing adversity (Robertson et al., 2015), more rapid recovery following trauma (Bonanno, 2004) and higher overall levels of wellbeing (Enns et al., 2016). Resilience process also functions as a buffer against the development of mental health problems such as depression and anxiety, hereby reducing the burden on individuals and healthcare systems (Fletcher & Sarkar, 2012).

Beyond psychological outcomes, resilience has also been linked to better physical health, reflecting the strong connections between stress, immune functioning and physical illness, as well as the importance of support from parents and schools. Ozbay et al. (2007) noted that positive social support can enhance resilience to stress and suggested that different types of support may be important at different stages of life. For example, parental support may play a more significant role during early childhood, whereas instrumental support becomes increasingly important in young adulthood. Similarly, Southwick et al. (2014) argued that enhancing resilience among children and adolescents may be more effectively achieved by equipping schools and parents with adequate resources such as access to nutritious meals and parenting education rather than focusing solely on interventions at the level of the individual child or adolescent.

Over time, research has demonstrated that resilience is associated with a wide range of psychological, behavioural and social benefits, explaining why it has become so central to mainstream psychology.

First, resilience can be understood as a dynamic process involving adaptive mechanisms that help protect mental health by buffering individuals against stress and vulnerability. Rather than simply reflecting good mental health, resilience represents the ongoing capacity to maintain or regain psychological stability in the face of adversity, thereby reducing the likelihood of

conditions such as stress, depression, or anxiety (Booth & Neill, 2017; Enns et al., 2016; Robertson et al., 2015;).

Second, resilience processes are strongly linked to enhanced wellbeing. Individuals who engage in resilience processes report greater life satisfaction, happiness and general psychological wellbeing (Clauss-Ehlers & Wibrowski, 2007; Wu et al., 2020). Rather than merely preventing negative outcomes, resilience fosters flourishing and optimal functioning by helping individual manage adversities (Li et al., 2016; Taylor, 2017).

Third, adaptive coping strategies, such as problem-solving, mindfulness and self-care, are both predictors and outcomes of resilience. Some individuals are able to demonstrate good coping flexibility and emotional regulation when confronted with stress (de Terte & Stephens, 2014; Freire et al., 2018; Wilson, 2016). This raises an important implication: if coping and regulatory skills are key components of resilience, then individuals who lack or underuse these skills may benefit from targeted interventions designed to teach and reinforce them.

Fourth, resilience contributes to stress reduction. Empirical studies show that resilience-building interventions lower stress levels among university students and individuals in high-risk occupations such as first responders and healthcare workers (Enrique et al., 2019; Palma-Gomez et al., 2020). These interventions work by enhancing adaptive processes that improve recovery and emotional regulation when under stress.

Fifth, resilience supports academic and social adjustment in students and young adults. It facilitates adaptation to different stages of life, reduces acculturative stress among students and encourages greater engagement with counselling and support services (Akhtar & Kroener-Herwig, 2019; Khawaja & Stallman, 2011; Lari et al., 2025). These findings underscore the importance of resilience as an adaptive process that promotes both educational success and psychological wellbeing.

Sixth, resilience enhances flexibility and growth. Resilient individuals tend to display higher levels of self-compassion, openness to change and growth-oriented mindsets, enabling them to adapt positively to diverse challenges (Meneghel et al., 2019; Nassif & Wells, 2014; Wilson, 2016).

Finally, resilience has a broader preventive and therapeutic impact. Digital and internet-delivered resilience interventions have been shown to reduce stigma, increase accessibility and lower barriers to treatment, while still promoting stress prevention and wellbeing (Egan et al., 2024; Herrero et al., 2019; Richards et al., 2016). This demonstrates the scalability of resilience interventions across populations.

Could this indicate that resilience is not only a means of protection but also as a pathway to transformation? Taken together, these documented benefits explain resilience's enduring popularity as both a research construct and a target for intervention. Conceptualized as a process, resilience not only protects against negative outcomes but also enables individuals to thrive. These outcomes highlight resilience's dual role: it shields against vulnerability while simultaneously fostering thriving. As such, resilience research offers a framework for understanding not just survival but also flourishing in the face of life's inevitable challenges.

This flexibility also indicates that resilience can be cultivated and strengthened through deliberate practice and targeted interventions that promote adaptive coping across contexts. Research demonstrates that coping strategies can be taught, social networks can be fostered and cognitive processes such as positive reappraisal can be enhanced through training (Clauss-Ehlers & Wibrowski, 2007).

Resilience should be seen as a capacity that fluctuates over time and context, meaning that individuals may show resilience in one domain (e.g., academic performance) while struggling in another (e.g., relationships) (Hill et al., 2024).

This conceptualisation has important practical implications: if resilience can be acquired, then it can be explicitly targeted in therapeutic settings, making it a crucial area for intervention.

Next Steps

While conceptualization resilience into an intervention is recommended, a robust theoretical framework is required. Resilience cannot be simplified to a definitive collection of specific factors that consistently predicts an individual's ability to exhibit resilience when faced with a stressor (Hill et al., 2018). Instead, effective adaptation to any particular stressor appears to rely on the dynamic interplay of various components, which may encompass psychological, physiological, environmental factors and sociocultural influences, with the relative contribution of each varying according to the individual, the stressor, and the context (Hill et al., 2024; Tilley et al., 2020). These are the broad domains of influence on resilience that will be emphasised in my thesis. Among the numerous models of resilience that have been proposed, the Three-Part Model of Psychological Resilience (3-PR) developed by de Terte and Stephens (2014) is one of the most influential frameworks, identifying three broad domains as critical to resilience. The 3-PR categorizes resilience into three interconnected domains: (a) cognitive, which includes adaptive reappraisal processes, problem-solving and reframing; (b) constructive behaviour, which covers self-care practices and active coping strategies; and (c) environment, which details social support and external resources. This multidimensional framework provides a useful structure for translating resilience theory into practical intervention components.

Recent research also has highlighted the importance of understanding change processes when developing, evaluating and applying evidence-based therapeutic manuals, particularly those consisting of multiple modular elements. A clearer understanding of how change occurs is essential for effectively individualising treatment (Chorpita et al., 2020; Chorpita & Daleiden, 2013; Evans, 2013; Evans & Fletcher, 2013).

Traditional therapy outcome research has tended to rely on broad indicators of improvement, often overlooking the specific processes through which change unfolds over time.

Evans and Fletcher (2013), as well as Gaines and Goldfried (2024), have argued that within-session and between-session change processes are frequently neglected in the evaluation of Cognitive Behavioural Therapy (CBT), though probably not in practice. Outcomes are typically reported as general improvements in symptoms or sometimes in well-being, while insight into particular mechanisms driving these changes is limited. This highlights the need for a more process-oriented perspective, particularly in understanding how specific mechanisms of change operate within modular interventions and how these can be tailored to individual clients (Weisz et al., 2012; Watson, 2023).

In response to this gap, the first phase of this research involved the development and publication of the *Psychological Resilience Treatment Manual* (PRTM; Chettiar & de Terte, 2022), a structured intervention manual designed to operationalise the Three-Part Model of Psychological Resilience (3-PR) into practical therapeutic modules incorporating intervention elements related to its three core resilience domains. The manual was designed to be accessible and usable by therapists without extensive prior training in CBT. This aligns with the argument that psychological interventions should include practical, well-grounded procedures that can be implemented by a wide range of helping professionals (Kazdin, 2023). Accordingly, the manual included structured exercises and homework assignments that could be readily applied in therapeutic settings.

Phase 1 involved working directly with New Zealand based participants who presented with a range of everyday psychological difficulties, similar to those typically seen in mental health clinics. Quantitative data was collected and reviewed to gauge intervention effectiveness. More importantly, observations were made when the modular nature of the intervention raised important questions about how these changes occurred. For a qualitative perspective, detailed

case notes were maintained throughout the intervention process, similar to standard clinical practice. Perhaps resilience may not be fully captured through standardised quantitative measures alone; participants' experiences may be highly sensitive to situational and contextual factors, which may not be adequately reflected in self-report questionnaires included for quantitative data. This limitation underscores the value of incorporating qualitative and process-oriented methods to better capture the complexity of resilience. It also supports the argument that resilience interventions should be individualised rather than strictly manualised.

To achieve this, Phase 2 of the research, was initiated. In this phase a closer interaction between individual psychological resources, daily experiences and environmental or social influences was documented. To detail these changes, participants were asked to record their daily experiences, emotions and responses. This approach draws on the Experience Sampling Method (ESM), a well-established technique for capturing real-time psychological processes (Verhagen et al., 2016; Russell & Gajos, 2020; Trull & Ebner-Priemer, 2009). Diary methods, while less intensive, also provide valuable qualitative insights and align well with narrative approaches to understanding lived experience (Herron et al., 2018). Overall, this thesis aimed to develop a resilience intervention that integrates coping mechanisms, social support and self-care strategies known to enhance resilience. In addition, it explored the use of qualitative and experience-sampling approaches to better understand the processes underlying therapeutic change.

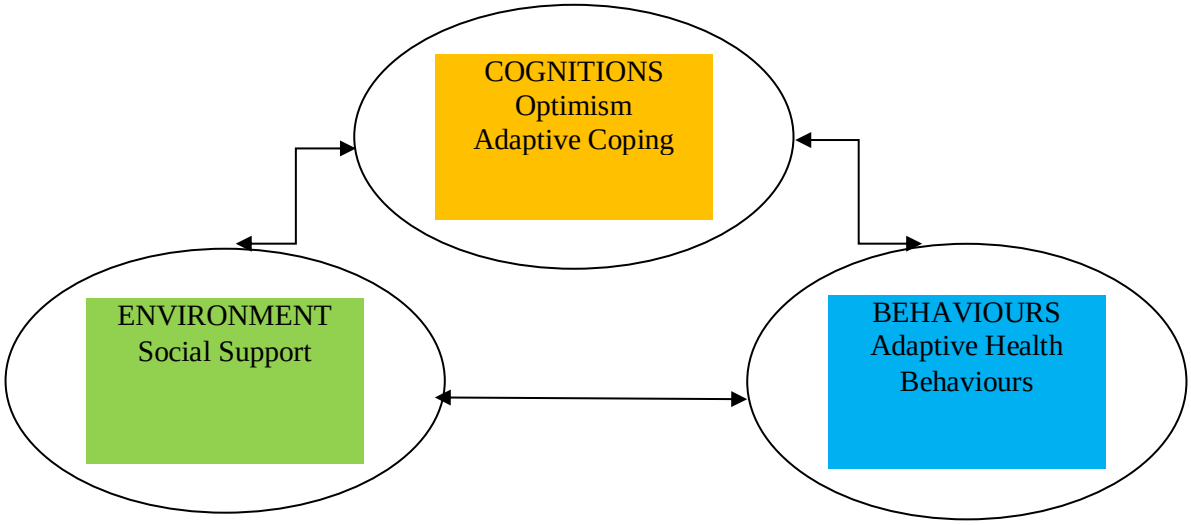
CHAPTER TWO: THE DEVELOPMENT OF A TREATMENT MANUAL

Overview: Conceptualising the Model in This Thesis

This thesis conceptualised resilience training through an interpretation of the 3-PR framework proposed by de Terte et al. (2014b). The 3-PR model identifies three primary domains: cognitive coping strategies, behavioural adaptive health behaviours (including physical exercise, rest, relaxation and good nutrition), and environmental social support as main categories of influence, each representing a distinct yet functional pathway through which individuals adapt to stress and increase resilience. This three-element structure provided a clear framework for understanding and strengthening resilience as a dynamic, multi-dimensional process.

Figure 1

The Three-part model of psychological resilience (3-PR) (de Terte et al., 2014)



Note. Reproduced from *The Development of a Three-Part Model of Psychological Resilience* by de Terte et al., (2014). p.417. *Stress and Health, 30,* p. 416-424. Copyright 2014 by the Copyright Clearance Center (CCC) Marketplace.

At the time I began to develop a manual to fit this three-component model, there was a considerable body of literature supporting how in general the 3-PR model aligned with various areas of needed intervention. For example, the 3-PR had been applied across different populations, including university students and individuals in high-risk occupations, demonstrating its flexibility and utility in practice (Chettiar & de Terte, 2022; de Terte & Stephens, 2014).

Previous empirical evidence, not directly related to resilience models, supported my inclusion of the three domains, with research suggesting that adaptive cognitive coping, behavioural (adaptive health behaviours) and access to supportive social environments all contribute significantly to psychological wellbeing and resilience outcomes, specifically stress reduction, enhanced wellbeing and improved psychological functioning. Cognitive coping strategies such as positive reappraisal, mindfulness and optimism have been shown to regulate emotional responses and foster adaptive appraisal of stressors (Lazarus & Folkman, 1987; Taylor, 2017; Li et al., 2016). Behavioural adaptive health behaviours, conceptualised within the current study as self-care practices, include activities such as maintaining good sleep hygiene, engaging in regular physical activity and cultivating self-compassion. These practices contribute to physiological recovery, emotional regulation and the maintenance of psychological wellbeing (Neff et al., 2007; Akhtar & Kroener-Herwig, 2019). And thirdly, environmental social support acts as a buffering resource, promoting belongingness, validation and instrumental assistance that facilitate recovery and adaptation (Calitz & Santana, 2018; Hobfoll & Lilly, 1993).

Together, these domains represent the core mechanisms of resilience identified across psychological, occupational and educational research. Their inclusion ensured that the manual targeted both individual skills and systemic supports, thereby enhancing its ecological validity and applicability across diverse contexts.

The manual was also developed with consideration for cultural and contextual adaptability, recognising that resilience is influenced by broader social, cultural and environmental factors and therefore requires flexibility across diverse populations and settings. Furthermore, the intervention conceptualised resilience as a process of change, whereby resilience capacities are progressively strengthened through ongoing engagement with cognitive coping strategies, adaptive health behaviours and self-care practices, and environmental social support.

The intervention evaluated throughout this thesis was delivered using the *Psychological Resilience Treatment Manual* (PRTM) (Chettiar & de Terte, 2022), an intervention manual that I developed and subsequently published. The manual was designed as a practical resource to assist therapists in delivering a structured, modular resilience intervention grounded in cognitive behavioural therapy (CBT) principles and the Three-Part Model of Psychological Resilience (3-PR; de Terte & Stephens, 2014). It contains therapist guidelines, psychoeducational material, structured therapeutic exercises, participant worksheets, homework activities and relapse prevention strategies that can be flexibly implemented according to individual client needs. As the PRTM has already been published, it is not reproduced in full within this thesis. Instead, the purpose of this chapter is to describe the theoretical, empirical and clinical foundations that informed its development and explain how these components were translated into a structured therapeutic intervention.

Literature Review and Development of the Psychological Resilience Treatment Manual (PRTM)

Guided by these empirical foundations, I further developed the treatment manual by operationalising the 3-PR framework into practical intervention components designed to facilitate resilience development within these primary components. As stated, the overall

framework was informed by the resilience model proposed by de Terte and Stephens (2014), which identified coping skills, self-care and social support as key domains associated with resilience. However, the content and activities included within the manual could not be based solely on the theoretical model. It required a combination of theoretical, empirical and clinical sources. In order to include validated intervention strategies needed for the implementation of the overall model, it was necessary to extract from the empirical literature what were emerging as the most promising clinical practices. To ensure comprehensive coverage of the available material, I undertook a structured review of the resilience literature as applied to the kinds of clients for which the 3-PR framework had originally been devised.

Search Strategy and Selection Criteria

Electronic Massey database searches were conducted using combinations of the following keywords: coping strategies, cope, coping skills, coping mechanisms, or resilience; university students, college students, or postgraduate students; and stress, wellbeing, or mental health. The search was restricted to peer-reviewed studies published between 2010 and 2020. University and college student populations were selected as the primary focus because they represented individuals exposed to significant academic, social and developmental stressors while remaining broadly comparable to the target population of individuals experiencing elevated stress in everyday life.

Studies were included if they examined resilience, coping, wellbeing, stress management, or psychological adaptation among university, college, or postgraduate students and reported findings related to coping strategies, self-care behaviours, social support, gratitude, mindfulness, cognitive reframing, metacognitive awareness, or resilience-building interventions.

Studies were excluded if they did not examine coping-related constructs relevant to resilience development, including active coping, passive coping, self-care behaviours and social

support. A secondary screening process excluded studies focusing primarily on post-traumatic stress disorder (PTSD), post-traumatic growth (PTG), schizophrenia spectrum disorders, bipolar disorders, suicidal ideation, psychotic disorders requiring specialised treatment, substance abuse, elderly populations aged 70 years and above, children and adolescents, acute or chronic medical illnesses, personality traits, biomarkers or neuroimaging, natural disasters, animal studies and non-English language publications.

The final review comprised 39 empirical studies (see Appendix A.). The review was not intended to be a formal systematic or scoping review. Rather, its purpose was to identify resilience-related factors consistently associated with adaptive psychological adaptation and to guide the development of the intervention manual.

Empirical Contributions to Manual Development

The reviewed studies represented a broad international evidence base, with research conducted across North America, Europe, Australia, Asia, Canada and the Middle East. Most studies employed quantitative methodologies (n=34), alongside four qualitative studies and one mixed-methods study. The development of the treatment manual was informed by this broad body of empirical literature examining coping, resilience, stress and psychological wellbeing across diverse populations. Given that Phase 1 primarily involved tertiary students, the literature review focused predominantly on university, college, postgraduate and international student populations. However, the relationships among coping, resilience and psychological wellbeing identified within the literature are generally applicable across a range of populations and contexts. Across the reviewed studies, coping and resilience were the most frequently examined constructs, although related concepts such as self-compassion, gratitude, mindfulness and stress tolerance were also commonly investigated.

The literature review served two primary purposes. First, it provided empirical support for the resilience domains proposed by de Terte and Stephens (2014). Second, it identified therapeutic strategies that could be incorporated into the intervention modules. Collectively, the findings showed that resilience is strengthened through increasing adaptive coping, self-care behaviours and social support while reducing reliance on passive coping strategies.

Coping Styles, Constructs and Associations

Active Coping. Active coping refers to purposeful cognitive and behavioural efforts to address stressors directly through problem-solving, cognitive restructuring, planning and adaptive action rather than avoidance (Carver et al., 1989). Active coping behaviours were consistently associated with positive outcomes, including lower stress levels, improved wellbeing and increased resilience among university students. In particular, the use of problem-solving and active coping strategies predicted higher psychological wellbeing, improved adjustment during transitions and reduced avoidance, self-blame, loneliness and academic stress (Akhtar & Kroener-Herwig, 2019; Coiro et al., 2017; Deasy et al., 2014; Eisenbarth, 2019; Gloria & Steinhardt, 2016; Gustems et al., 2019; Li et al., 2018; Straud & McNaughton-Cassill, 2019; Vasileiou et al., 2019).

These coping strategies were also linked to higher resilience (Wu et al., 2020). For example, reframing negative events, an active coping strategy contributed to improved psychological wellbeing (Eisenbarth, 2019), while students who utilised active coping strategies developed stronger solution-focused skills and demonstrated greater resilience (Gonzales & Artuc-Garde, 2014). Active coping strategies, particularly reflective problem-focused approaches, were further associated with increased utilisation of student support services and lower psychological distress (Julal, 2013).

Similarly, higher engagement in active coping strategies such as restraint coping was associated with reduced depressive symptoms (Kato, 2020).

In the PRTM, this domain focused on helping participants develop these skills by identifying and challenging unhelpful thinking patterns such as self-blame, catastrophising and avoidance, while fostering more balanced and adaptive appraisals of stressful situations. Self-monitoring techniques, including Discrete Thought Tracking (DTT), were used to increase awareness of the relationship between thoughts, emotions, and behaviours and to facilitate metacognitive awareness.

Passive Coping. In contrast, passive coping strategies, which may reduce negative feelings in the short term, were associated with reduced overall wellbeing and resilience, as well as increased stress among university students. Self-blame, denial, rumination and avoidance were linked to higher levels of depression, anxiety, somatisation and interpersonal stress (Coiro et al., 2017). Passive coping strategies were also identified as stronger predictors of stress and poor mental health outcomes than problem-focused strategies (Eisenbarth, 2019; Moret-Tatay et al., 2016). Students who relied on venting and avoidance coping demonstrated lower academic resilience (Meneghel et al., 2019). Over time, greater use of passive coping strategies contributed to decreased resilience and wellbeing, alongside increased stress levels (Deasy et al., 2014; Denovan & Macaskill, 2013; Freire et al., 2018). Collectively, these findings reinforced the importance of replacing maladaptive coping strategies with adaptive coping approaches to reduce psychological distress.

Self-Care Practices. The literature review provided support for the inclusion of self-care as a resilience-enhancing component, although the evidence extended beyond physical health behaviours alone. The original 3-PR model (de Terte et al., 2014) conceptualised behavioural adaptive health behaviours as activities such as exercise, relaxation and adequate sleep. However, the literature reviewed in the present study suggested a broader

conceptualisation of self-care that encompasses not only behaviours that promote physical health but also psychological and emotional practices that support resilience and overall wellbeing. Constructs such as acceptance (Meneghel et al., 2019), mindfulness (Moeller et al., 2020; Herrero et al., 2019; Smeets et al., 2014; Stallman et al., 2019), self-compassion (Enrique et al., 2019; Herrero et al., 2019; Smeets et al., 2014), self-kindness (Smeets et al., 2014), exercise (Deasy et al., 2014; Giamos et al., 2017), nutrition (Stallman et al., 2019) and positive self-talk (Denovan & Macaskill, 2013; Krypel & Henderson, 2020) were associated with increased resilience, enhanced psychological wellbeing and reduced stress among university students. Collectively, these practices reflect a broader process of attending to one's physical and psychological needs. Therefore, the self-care domain within the PRTM retained the original emphasis on physical wellbeing behaviours while incorporating these additional empirically supported components. This broader conceptualisation was intended to strengthen both the theoretical and practical relevance of the intervention while remaining consistent with the underlying principles of the original 3-PR framework.

Social Support. Social support was another important factor associated with improved wellbeing, resilience and stress reduction (Bland et al., 2012; Chao et al., 2012; Denovan & Macaskill, 2013; Giamos et al., 2017; Korbmacher & Wright, 2020; Li et al., 2018; Lin, 2016; McCarthy et al., 2018; Meneghel et al., 2019). As a form of active coping, increased social support was linked to greater stress tolerance and psychological wellbeing (Bland et al., 2012).

Supplementary Coping Constructs and Associations. Several studies highlighted the effectiveness of supplementary activities such as psychoeducation, metacognitive exercises and gratitude activities in reducing stress and improving wellbeing. Psychoeducation (McCarthy et al., 2018), metacognitive skills training (Freire et al., 2018) and gratitude interventions (Lin, 2018; Wilson, 2016) were associated with improved coping and psychological wellbeing.

Overall, the empirical evidence examining coping strategies and related constructs among tertiary students, including university, college and postgraduate students provided an important foundation for the development of the psychological resilience treatment manual. Coping styles and constructs demonstrated varying associations with coping outcomes depending on whether they were adaptive or maladaptive. Collectively, the findings indicated that increasing adaptive coping strategies, self-care activities and social support, while reducing reliance on passive coping strategies, contributed to improved psychological wellbeing, increased resilience and reduced stress among university students, including international students.

Application of Findings to Manual Development

The findings from the literature review confirmed the potential of focusing the Psychological Resilience Treatment Manual (PRTM, Chettiar & de Terte, 2022) around three interrelated domains: (1) The intra-psychological cognitive/emotional skills of active coping and passive coping (reduction of maladaptive coping) (2) Self-care and physical well-being; and (3) social support. The final manual therefore reflects an integration of theoretical foundations, empirical evidence and clinical experience in working with individuals experiencing daily stress. The review provided both empirical support for the resilience domains underpinning the manual and guidance regarding the CBT therapeutic strategies most likely to enhance resilience.

Modular Design of the Psychological Resilience Treatment Manual

While the literature review implicitly indicated that certain psychological topics are important, it did not necessarily indicate how these should be introduced to real-life clients. What is called “Cognitive-Behaviour Therapy (CBT)” is actually a blend of *targeted* psychological functions with therapeutic *strategies* designed to enable clients to implement

them. For example, the CBT treatment loosely called “problem solving therapy,” means imparting the defined skill to analyse problems in a constructive way by means of training exercises in which clients learn the best ways to go about solving a problem. Thus, all CBT therapies consist of a definition of healthy functioning combined with exercises and strategies designed to learn and implement these new psychological skills.

My task in developing modules for a treatment manual required integrating targeted goals with established cognitive-behavioural therapy techniques, including cognitive restructuring, behavioural activation, mindfulness, self-compassion training, communication skills training, problem-solving therapy and goal-setting interventions. These evidence-based methods were used to *operationalise* the resilience domains proposed by de Terte and Stephens (2014).

The 3-PR framework is particularly suitable for translation into a structured manual because it identifies clear, observable and teachable components. Based on this structure, the current thesis develops a modular intervention that systematically addresses these domains as therapeutic exercises. Each domain can be mapped to specific, well-established therapeutic techniques known to generally influence participants and exercises for them to follow and practice.

According to Chorpita et al. (2005), modularity refers to the process of breaking complex activities into smaller, simpler components that can function independently. More specifically, modules are self-contained functional units that interact with other units within a larger system while maintaining stable operations independently. Modular designs have been described as consisting of visible design rules such as standardized guidelines that regulate interactions among modules and hidden design parameters, which are the internal features governing each module’s operation.

My manual aspired to embody the principles of modularity by ensuring that each module functions as an independent yet integrated component within a broader intervention system aimed at developing participant's resilience skills in targeted areas. Each module follows a standardized structure to facilitate smooth integration with other modules, including the unified transfer of information such as homework assignments, progress monitoring and goal attainment. At the same time, each module remains operationally self-contained, such that the omission, substitution, or rearrangement of other modules does not compromise its internal functioning. Without having to reproduce the entire manual, the following therapeutic activities are examples of the way in which interventions were operationalised.

Psychoeducation Regarding Cognitive Appraisals and Cognitive Restructuring

In designing the cognitive strategies of this model, evidence indicating that cognitive coping strategies such as positive reappraisal, mindfulness and optimism regulate emotional responses and promote adaptive appraisal of stressors was drawn upon (Lazarus & Folkman, 1987; Taylor, 2017; Li et al., 2016). Within the operationalised version of the model, this component was structured to help participants develop awareness of their cognitive and behavioural reactions to stress. The intervention began by facilitating awareness of passive coping, recognising that such responses are often automatic and may represent an important starting point for change. I emphasised that passive coping such as avoidance, denial, self-blame, or behavioural disengagement is not inherently "wrong," but rather reflects an individual's current means of managing distress when other strategies feel inaccessible. This perspective helped normalise participants' experiences and provided a foundation for developing more adaptive coping approaches.

Early sessions focused on providing psychoeducation regarding the psychology of coping and the ways in which individuals commonly respond to stress. Particular emphasis was placed on coping strategies such as venting, self-distraction and withdrawal, which may offer short-term

relief but often do not resolve underlying stressors. Through guided discussion, reflective exercises and role-play activities, participants examined examples of behavioural disengagement and self-distraction activities, exploring how these can reinforce avoidance cycles and delay emotional processing.

A significant focus of this stage is helping participants identify self-blame and denial tendencies, exploring how these cognitive patterns influence self-efficacy (Bandura, 2000) and emotional wellbeing. By bringing these processes into awareness, participants can begin to challenge unhelpful narratives (Beck, 1979) and experiment with alternative ways of responding to stress.

Metacognitive reflection was integrated throughout this phase to encourage participants to "think about their thinking" (Flavell, 1979). This process involved observing thought patterns without judgement and recognising the dynamic relationship between thoughts, emotions and behaviours. To support this process, a simple countdown technique, involving counting slowly from ten to one, was introduced as a means of interrupting maladaptive or intrusive thinking. This brief pause was intended to help participants disengage from automatic negative thoughts, regulate emotional intensity and create cognitive space for more deliberate and adaptive responses. The use of this technique was designed to strengthen self-regulation and enhance participants' sense of control during stressful situations (Evans, 2026).

Finally, relapse prevention principles (Marlatt & Gordon, 1985) were incorporated into the intervention, emphasising that coping and resilience are dynamic processes that require ongoing adjustment. Participants were encouraged to anticipate periods of heightened stress and develop plans for re-engaging with adaptive coping strategies when needed. Participant worksheets were also included to reinforce learning and facilitate skill application. By beginning with awareness of passive coping patterns, the intervention sought to foster insight, self-compassion and readiness for change, helping participants recognise their current coping

approaches before progressing towards more active and constructive strategies for resilience development.

Following the passive coping module and the development of insight into unhelpful coping cycles, participants progressed to modules focusing on self-care behaviours and social support. Active coping was intentionally positioned as the final stage of the intervention sequence. This placement enabled participants to revisit and integrate learning from earlier modules, applying the self-awareness, self-care and interpersonal skills developed throughout the programme. Returning to coping strategies at this stage provided an opportunity to consolidate and reinforce these skills, facilitating their application in daily life. Framing active coping as both a culmination and a continuation of the intervention reflects the principle that resilience is an ongoing process requiring regular reflection, adaptation and renewal.

In introducing active coping, I provided psychoeducation on how stress manifested across cognitive, emotional and behavioural functions. Participants were guided to identify their individual stress responses and reflected on the specific challenges they faced when coping with adversity. Exploration of the stress response process and participants' existing coping repertoires facilitated the identification of coping strengths as well as areas for further skill development.

A key element incorporated into this module was restraint coping (Kato, 2020), which encourages participants to pause, reflect and respond thoughtfully rather than react impulsively during stressful situations. Through guided exercises and discussion, participants were encouraged to tolerate emotional discomfort, delay immediate reactions and implement more constructive coping strategies once the initial intensity of stress had subsided. This practice supports emotional regulation and prevents the escalation of stress responses.

To deepen self-awareness, self-monitoring activities were incorporated through the use of Discrete Thought Tracking (DTT), in which participants recorded their thoughts, emotions

and behaviours in response to stressful situations. This process promotes metacognitive insight and helps clients identify patterns that either support or hinder resilience. Building on these insights, participants are then encouraged to use problem-solving techniques and positive cognitive reframing in order to promote adaptive appraisal and enhance perceived control.

Supplementary exercises such as gratitude journaling (Wilson, 2016; Lin, 2016) and the use of humour (Eisenbarth, 2019) as an adaptive coping strategy are integrated to cultivate optimism, broaden perspective and foster emotional balance. These activities reinforce the shift from negative rumination to adaptive reflection.

Through this cognitive domain, the intervention aimed to strengthen participants' capacity for reflective awareness, emotional regulation and adaptive appraisal, thereby enhancing their ability to manage future stressors with greater psychological flexibility and resilience.

Behavioural Strategies: Guided Practice of Self-care Routines, Stress Management Plans and Goal Setting

The behavioural therapeutic strategies of the model focused on interpreting cognitive insight into purposeful action and routines. Having developed awareness of their coping patterns and strengthened their reflective capacity, participants are guided to engage in self-care routines, structured stress management plans and goal-directed behaviours that promote wellbeing and resilience.

In this phase, participants were encouraged to adopt the guiding principle of "getting active and getting better." This involved re-engaging with everyday routines that boost physical health and al balanced lifestyle, including movement, nutrition, rest and relaxation. Informal mindfulness practices (Kabat-Zinn, 1990; Stahl & Goldstein, 2010), such as mindful eating, were introduced to help participants integrate savouring experiences into ordinary daily activities rather than limiting mindfulness to formal meditation practices. These simple and accessible

techniques were intended to enhance grounding and present-moment awareness in everyday life.

A key focus of this phase was the cultivation of self-compassion (Neff et al., 2007), whereby participants were encouraged to relate to themselves with kindness rather than self-criticism when facing setbacks or difficulties. Through guided reflection and experiential exercises, participants explored the differences between self-indulgence and genuine self-care, reinforcing the understanding that sustainable wellbeing arises from balance and intentionality rather than avoidance or overexertion.

Relaxation training and stress management strategies were incorporated within this phase. Participants were taught to recognise the physiological signs of stress and utilise techniques such as deep breathing and grounding exercises to regulate physiological arousal. In addition, participants were encouraged to create time and space for restorative activities by developing structured routines that prioritised rest, recreation and personal reflection.

An important aspect of these interventions is meaning-making: helping participants connect their everyday actions to personal values and life goals. Through guided journaling and discussion, they explored how small behavioural choices contribute to a broader sense of purpose and direction. This promotes intrinsic motivation and reinforces the belief that wellbeing can be intentionally cultivated (Tilley et al., 2019).

Each behavioural strategy concluded with a relapse prevention discussion and a participant's worksheet, which was incorporated across all modules. These tools support participants in consolidating new habits, anticipating barriers and maintaining progress beyond the structured sessions.

Through this behavioural domain, my aim was to help participants move from awareness to consistent action embedding self-care, mindfulness and goal-setting practices into daily life so that resilience becomes a self-sustaining process.

Environmental Influences: Social Support

The environmental elements of the model focused on strengthening social and contextual resources that buffer stress and promote adaptation. Social support acts as a protective mechanism, fostering belongingness, validation and instrumental assistance that facilitate recovery and enhance wellbeing (Calitz & Santana, 2018; Cohen & Wills, 1985; Hobfoll & Lilly, 1993).

In this intervention component, I drew on various perspectives of social support. Different forms of support were explored, including structural and functional support, as well as emotional (empathy, care and understanding), instrumental or material (practical assistance) and informational or cognitive support (guidance, feedback and advice) based on Sipple et al. (2015). To provide a conceptual foundation, Hobfoll's (1989) Conservation of Resources framework, discussing the objects, conditions, personal characteristics and energies that constitute valuable resources was presented. This helped participants understand how social support interact to maintain resilience.

Through guided reflection, participants were invited to map their existing support systems, identifying where they experienced strength and where gaps may exist. Participants were encouraged to consider both the availability and quality of their supports, as well as the personal value they attached to social connection and mutual care. This process helped reinforce the understanding that seeking and accepting support is an adaptive coping skill rather than a sign of weakness.

Each week, participants reviewed opportunities they had to access, offer, or receive different forms of social support. These discussions reinforced the importance of reciprocity and ongoing engagement with supportive networks. This process of continuous reflection promoted accountability and helped participants integrate support-seeking behaviours into their regular coping routines (Staats, 1994).

Consistent with the other intervention elements, these treatment modules concluded with a relapse prevention component and participant worksheet. These tools guided participants in anticipating barriers to help-seeking such as self-reliance, stigma, or fear of burdening others and in developing personalised strategies for maintaining connection during times of stress.

Together, these elements of cognitive, behavioural and environmental domains represented the broad core domains of resilience. Their inclusion ensured that the manual addressed both individual coping capacities and broader self-care behaviours and social resources, thereby enhancing its ecological validity and applicability across diverse contexts.

Cultural and Contextual Adaptability

The 3-PR's model's emphasis on the social and environmental domains ensures cultural relevance in its application. In Phase 1 of implementation of this intervention, participants were residing in New Zealand, where cultural dynamics may differ significantly. While some participants were international students from collectivist backgrounds, the broader social context tends to emphasize individual autonomy. However, New Zealand's sociocultural framework is largely based on Māori perspectives, particularly models such as Te Whare Tapa Whā as well as concepts, such as whānau. These frameworks are embedded across multiple levels of society, (including within Pākehā communities) and promote relational wellbeing, collective responsibility and interconnectedness. As a result, culturally embedded forms of resilience such as seeking social support and collective problem-solving can still be meaningfully expressed within the intervention despite the broader individualistic context.

Process of Change

Having operationalised the three main domains into a modular intervention accessible and usable by less experienced therapists without extensive prior training in CBT, it is important to emphasise the role of change processes. When analysing a therapeutic technique, strategy, or intervention it is useful to consider the process of change. Following a change model allow us to distinguish between purpose or goal of the intervention and the learning or psychological processes that are designed to help the participant achieve those psychological outcomes (Chorpita et al., 2020; Chorpita & Daleiden, 2013; Evans & Fletcher, 2013).

Traditional therapy outcome research has tended to rely on broad indicators of improvement, often overlooking the specific processes through which change unfolds over time. For example, a therapist will ask the client to imagine an anxiety provoking scenes while using reframing and relaxation techniques. The desired outcome of such an intervention may be behavioural changes such as a reduction in feelings of anxiety and an ability to stop avoiding situations that have elicited it in the past. An outcome like that can easily be measured by observing behaviour in real life situations and from self-reported change in feelings.

Exposure to a feared situation without experiencing strong anxiety will result, through basic conditioning processes, in a reduction in the anxiety response based on classical conditioning principle of extinction. Thus, for every known CBT technique there is the purpose (defined in terms of anticipated change) and the learning or cognitive principle that is being invoked to achieve that change.

In the next chapter, Chapter 3, Phase 1 of this study will be discussed in detail, including the study context, participants' characteristics and recruitment process, as well as the measures used to obtain feedback.

CHAPTER THREE: AN EVALUATION STUDY OF THE MANUAL: DESIGN AND METHODOLOGY.

Overview

In this chapter, Chapter 3, the first phase of my research is presented: an evaluation of the manual developed and described in Chapter 2. This chapter outlines methodology, including study design, ethical procedures, participant inclusion and exclusion criteria, recruitment procedures and the measures used. It also briefly describes the procedures followed with each participant, along with any relevant modifications made during the course of the study. In addition, supervision received and a brief overview of my therapeutic approach are provided. The quantitative and descriptive findings are presented in the following chapter, Chapter 4.

Study Design

A single-case (n = 1) experimental design (SCED) - using an A-B design with follow-up case series - was used with 10 participants in order to evaluate changes over time associated with the intervention. Baseline data collected prior to treatment served as a comparison point for changes observed during the intervention phase, while a follow-up phase examined the durability and maintenance of improvements post-intervention. SCED was selected because it is recognised as a useful design for evaluating psychological interventions and exploring the feasibility and acceptability of novel treatments beyond primary outcome measures (Smith, 2012). The inclusion of repeated measures across baseline, intervention and follow-up phases enabled ongoing monitoring of participant progress and provided preliminary insights into patterns of change and participant responsiveness to the intervention over time.

During the baseline phase, participants completed weekly self-report questionnaires. These same measures were administered periodically throughout the intervention phase (Weeks 4, 8, 12 and 16) and again during follow-up at one month and three months post-intervention. Across all phases, participants were assessed exclusively using repeated self-report measures to track changes in coping behaviours, psychological distress and subjective wellbeing over time.

In addition, all participants received the intervention according to a standardised sequential modular structure. Passive coping strategies were introduced during Weeks 1-4, self-care strategies during Weeks 5-8, social support strategies during Weeks 9-12 and active coping strategies during Weeks 13-16.

Ethics

Ethical approval was applied for and granted by Massey University Human Ethics Committee: Southern B, Application 18/49. Following this approval, recruitment commenced by sending request letters and participant information sheets to three agencies (e.g. Police National Headquarters, New Zealand Defence Force (NZDF), NZ Firefighters and Communication Centre Workers from Fire and Emergency Services and Massey International Student Support). Past experience in Massey University research studies had indicated these agencies were useful sources in the community to access individuals living with some degree of daily occupational stress.

Participant Inclusion and Exclusion Criteria

Anyone interested in participating in the study had to be

- 18 years of age by January 2019
- A Police Officer, or Military member of the New Zealand Defence Force (NZDF), or Fire-fighter (NZFS)
- A resident of the Wellington region or full- time, part-time or extramural Undergraduate and Postgraduate domestic student (NZ Citizen or Permanent Resident) at Massey University (Wellington, Albany or Palmerston North campus).

Individuals who reported having clinical diagnoses of schizophrenia, bipolar disorder, and/or having strong suicidal ideations or intent, were currently on any antipsychotic medications, or currently in psychological treatment, were excluded from the study.

Recruitment of Participants

My participants for this study represented a diverse range of demographic, cultural, educational and occupational backgrounds, which provided an opportunity to evaluate the intervention across varied life circumstances and stress presentations. Participants included undergraduate and postgraduate students, international students, frontline and emergency service workers. They varied considerably in age, cultural identity, family responsibilities, occupational demands and prior mental health experiences.

This was a non-randomised intervention study where participants were recruited when inclusion and exclusion criteria were met. Recruitment advertisements were posted on social media platforms such as Facebook and flyers were displayed in strategic locations across the Massey University Wellington campus (e.g., the Library, Student Health and Counselling Services, Massey at Wellington Student Association and the Student Common Room). A

recruitment request letter outlining the study, along with the participant information sheet, was emailed to relevant organisations, including Police National Headquarters, the New Zealand Defence Force (NZDF) and Fire and Emergency New Zealand (FENZ). Interested participants were required to contact me via email to express their interest. I then provided further details about the study, including the participant information sheet, consent form and brief screening questionnaire.

Participants were subsequently sent a full "starter pack," which included the participant information sheet, the Perceived Stress Scale-14 (PSS-14) as a screening measure, a demographic questionnaire and a consent form.

Participants who met all inclusion criteria and achieved a Perceived Stress Scale-14 score above the cut-off of 28 were deemed eligible and included in the study. A total of ten participants were recruited. Each participant received NZD $160 as compensation for their involvement over the duration of the study. This was provided in four instalments of $40 at different stages of the study, in the form of shopping centre gift cards, grocery vouchers, or petrol vouchers.

The final sample consisted primarily of female participants, with one male participant. Eight participants were students (including undergraduate, postgraduate and extramural students), while one male participant was a firefighter with Fire and Emergency New Zealand and another participant was an authorised officer working alongside district police officers. In Appendix B, I have provided clinical case notes and a brief description for each participating client.

Measures: Formal

The following psychometric instruments were chosen as they all had well-established empirical evidence of good test/re-test reliability and internal consistency. More importantly, these measures were reflective of the study's aim to assess coping styles, general mental health difficulties such as stress and psychological wellbeing in study participants and not psychopathology in both general and clinical settings. The instruments themselves are provided in Appendix C, for readers interested in the details of such measures. Please note that all of the measures are freely available on the Internet.

Brief-COPE

The Brief-COPE (Carver, 1997) is a 28-item, 4-point Likert scale, self-report instrument. This questionnaire measures 14 coping strategies, which are categorised as either adaptive or nonadaptive coping constructs (2 items per strategy). The Likert scale ranges between 1 to 4, therefore the possible values for each Brief-COPE subscale range between 2 and 8 (Carver, 1997). Adaptive coping strategies include coping constructs such as use of emotional support, positive reframing, acceptance, religion, humour, active coping, planning and use of instrumental support and nonadaptive coping strategies include venting, denial, substance use, behavioural disengagement, self-distraction and self-blame. A higher score on both the adaptive and nonadaptive categories indicates more frequent use of that coping approach (Rahman et al., 2020). The descriptive labels on the Likert scale are: 1, I haven't been doing this at all; 2, I've been doing this a little bit; 3, I've been doing this a medium amount; and 4, I've been doing this a lot. The Brief-COPE has demonstrated satisfactory psychometric properties, with previous studies reporting good internal consistency for both its adaptive and maladaptive coping scales, supporting its reliability as a measure of coping strategies across different populations (Mahmoud et al., 2012).

In my study, only four subscale scores were administered: self-blame, acceptance, emotional support and active coping.

The Hopkins Symptoms Checklist-21

This questionnaire measures participants' distress level of the symptoms they experienced over the past 7 days. There are three scales: General Feelings of Distress (GFD); Somatic Distress (SD); and Performance Difficulty (PD). These three scales can be totalled to obtain a total distress score. The sum of the scores of the 21 items ranges from 21-84. A higher score on each scale indicates higher total symptoms distress. The descriptive labels on this Likert scale were: 1, Not at all; 2, A little bit; 3, Quite a bit; and 4, Extremely.

The General Wellbeing Schedule

The General Wellbeing Schedule (Dupuy, 1978) is a self-report questionnaire consisting of 18 items which measure one's subjective feelings of psychological wellbeing and distress. The first 14 questions use a 6-point rating scale that represents either intensity or frequency. The remaining 4 items use a 0-10 rating scale. The total score from the18 items can thus range from 0-110, with higher scores indicating stronger subjective feelings of psychological wellbeing (Nakayama et al., 2000). The three levels of distress are sectioned accordingly: 0 to 60 reflect "severe distress"; 61 to 72 "moderate distress"; and 73 to 110 "positive wellbeing" (Taylor & Foreyt, 2003). The descriptive labels on the Likert scale are: 0, In very low spirits; 1, In low spirits mostly; 2, I've been up and down in spirits a lot; 3, In good spirits mostly; 4, Very good spirits; 5, In excellent spirits. Psychometric evaluations of the instrument have consistently demonstrated good test–retest reliability and internal consistency (Leonardson et al., 2003; Nakayama et al., 2000; Taylor et al., 2003).

Perceived Stress Scale-14 (PSS-14)

The Perceived Stress Scale-14 (Cohen et al., 1983) is a self-report questionnaire. It measures an individual's subjective perspective (Ribeiro et al., 2020), namely the degree to which situations in one's life are appraised as stressful. The Perceived Stress Scale encapsulates participants' appraisal of whether life conditions and experienced events surpass their adaptive capacity (Harris et al., 2023). Pretorius (2023) has further noted that the unidimensional nature of the Perceived Stress Scale is applicable across diverse contexts and groups of people, facilitating standardised comparisons. This author concluded that the Perceived Stress Scale is an adaptable tool for both clinical assessments and research studies, especially in situations that necessitate a quick and general assessment of perceived stress without delving into the intricate aspects of the stress experience (Pretorius, 2023). Perceived Stress Scale-14 scores are obtained by reversing the scores on the seven positive items, e.g., 0=4, 1=3, 2=2, etc. and then summing across all 14 items. Items 4, 5, 6, 7, 9, 10 and 13 are the positively stated items. The sum of the 14 items ranges from 0-56. Higher scores indicate higher perceived stress. As there is no clear published cut-off for the clinical significance of Perceived Stress Scale-14, the median score of 28 points was selected as the prerequisite eligibility score for participants to be accepted in this study.

Other Details and Modifications

All face-to-face interventions were conducted at Wellington Psychology Clinic, Massey University. However, deviations from the original protocol occurred due to the onset of the COVID-19 pandemic, which necessitated the suspension of all face-to-face sessions and a transition to an internet-based e-Intervention format. As a result, delivery mode varied across participants: Participants 1 and 2 completed the full 16-session intervention face-to-face; Participants 3 to 5 received a combination format of face-to-face and e-Intervention sessions;

and Participants 6 to 10 completed the entire intervention remotely via the e-Intervention system.

Baseline data were collected prior to the intervention and served as a point of comparison for subsequent changes observed during the intervention phase. Participants' follow-up phase outcomes were treated as a separate stage, allowing for the assessment of the durability and maintenance of any improvements observed during the intervention.

Supervision

Typical research supervision was provided throughout the development and implementation of the intervention. Supervision focused on ensuring ethical and professional practice, monitoring participant wellbeing and maintaining consistency with the intervention framework. As the intervention was developed based on the 3-PR model, supervision during Phase 1 was also provided by Associate Professor Ian de Terte, one of the original authors of the model. This provided additional guidance regarding the application of the model within the intervention and helped ensure that the programme remained conceptually aligned with its theoretical foundations. Supervision sessions also provided opportunities to discuss participant progress and any adaptations required in response to participant needs or the transition to the e-Intervention format during the COVID-19 pandemic.

My Therapeutic Style

I followed the manual strictly and integrated a CBT-based approach that I am familiar with, introducing its components throughout the process in both face-to-face and e-Therapy sessions. I adhered to established guidelines and best-practice principles, while also considering timing, cultural sensitivity and the therapeutic relationship with participants.

Participants were informed that they were taking part in a study evaluating a resilience intervention; however, they were not informed that the Psychological Resilience Treatment Manual (PRTM) had been developed and authored by me as part of my doctoral research programme. This approach was adopted to reduce the potential for response bias that might otherwise have influenced participants' perceptions of, or responses to, the intervention.

A key focus of my work was developing metacognitive awareness in participants. This helped them become more conscious of self-blaming language, early signs of cognitive distortions and a shift from passive coping styles toward more active coping strategies.

I maintained a gentle and collaborative approach, encouraging small, manageable steps and consistently acknowledging progress without dismissing it. I also provided affirmation of participants' feelings, particularly when working with relapse prevention and individuals presenting with high self-blame, perfectionism, guilt around help-seeking, or reluctance to engage in support.

Cultural context was an important consideration throughout the study. Being of South Asian descent in Malaysia, I was naturally attuned to cultural sensitivities, particularly within Asian participants and was familiar with their family and social dynamics. This awareness informed my therapeutic relationships by encouraging culturally responsive communication, sensitivity to family expectations and interpersonal obligations, and respect for participants' individual beliefs and values.

I also integrated psychoeducation consistently, using the structured manual and familiar CBT terminology such as reframing, active versus passive coping, self-care, social support and restraint coping. I kept my language clear and avoided unnecessary jargon to reduce confusion and improve understanding. Overall, my approach remained structured, compassionate, culturally responsive and collaborative with a strong emphasis on gradual change and participant engagement.

CHAPTER FOUR: PHASE 1 STUDY: QUANTITATIVE FINDINGS

Overview

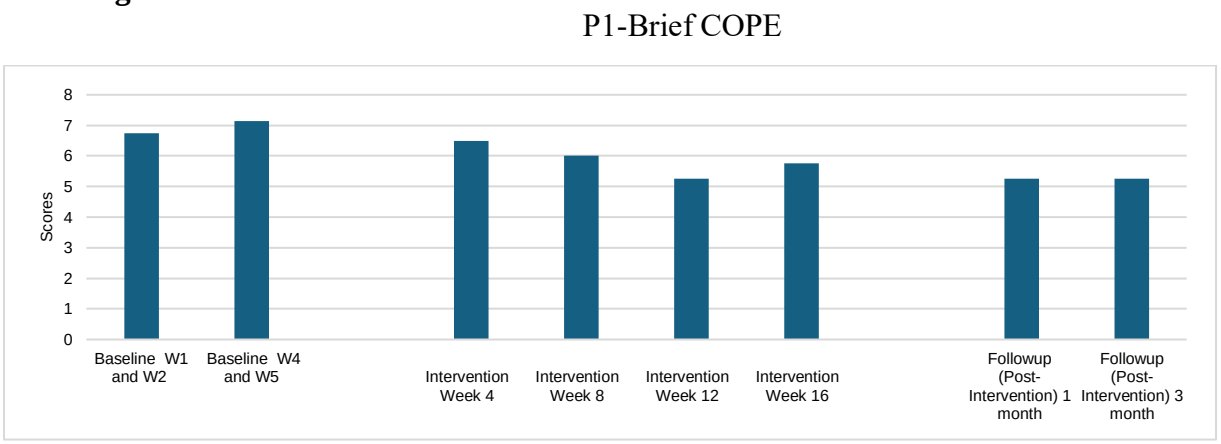
This chapter encompasses an analysis of the study's quantitative findings across all participants. It begins with graphical presentations of quantitative data for each participant. These quantitative findings provide preliminary conclusions based on the patterns and trends observed in the data. The chapter then examines limitations associated with a single-case (n) experimental design with a combination of A-B with follow-up case series, as well as issues relating to the use of multiple outcome measures.

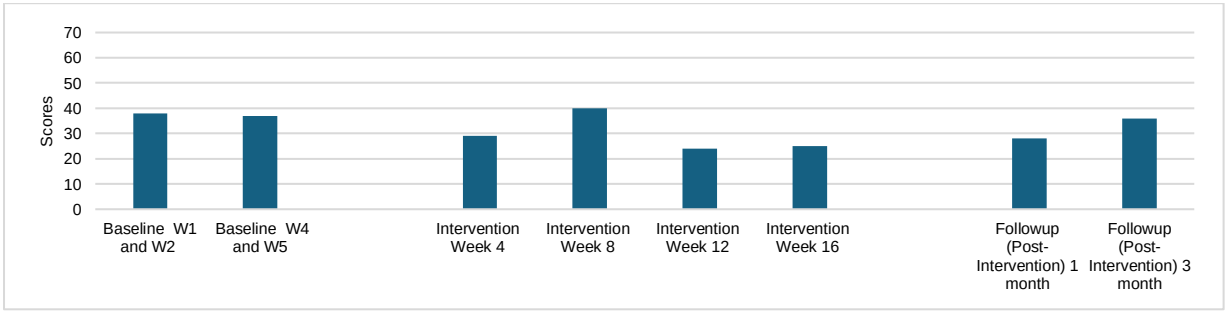
Quantitative Data

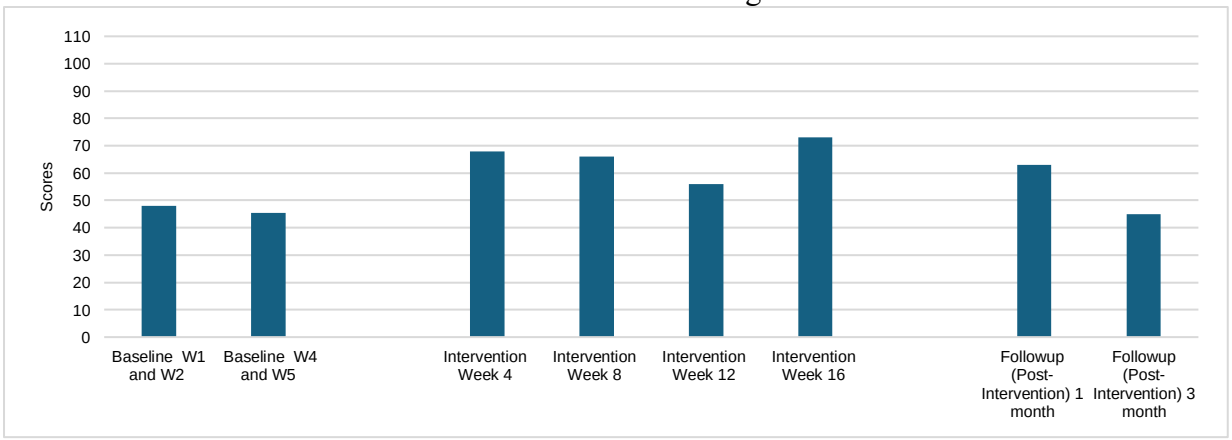
Weekly data points from the psychometric measures are presented graphically, similar to the behavioural counts that are commonly displayed in single-case studies following the typical formats of Applied Behaviour Analysis (ABA). To account for the longer baseline periods, data from some weeks have been collapsed into a single score for presentation in the following graphs. This mask the fact that for some participants, I did have pre-treatment baselines that could be up to ten weeks (ten data points) long. In the ABA tradition, it has been common to continue baselines until a "steady state" has been achieved, so that the immediate effects on behaviour can be detected following a change in contingencies. Scores on self-report instruments do not allow for this kind of precision. However, it can be noted that generally speaking, the scores during baseline remained rather steady. In other words, marked improvements simply due to the passage of time were not seen. Aggregated changes between the first few weeks and the second few weeks of baseline provided a sense of the stability seen in each participant prior to intervention. To protect participant confidentiality, all participants were assigned pseudonyms throughout the presentation of the results.

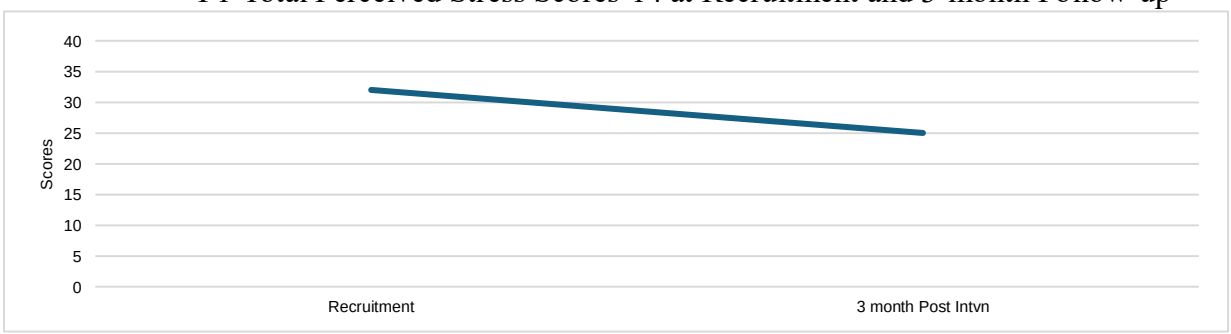
Participant 1: Kai Ling

Figure 2









Kai Ling was a single, 29-year-old international postgraduate student from Mainland China who entered the study with elevated perceived stress (PSS-14 = 32). She was highly engaged throughout the intervention, attending sessions punctually and completing therapeutic homework consistently. Following a five-week baseline period, she completed the 16-session PRTM intervention shortly before the onset of the COVID-19 pandemic.

Kai Ling's Brief-COPE scores were stable during baseline but decreased following the intervention and remained lower during intervention and follow-up. This pattern may reflect the impact of COVID-19-related stressors, including social isolation, travel restrictions and cultural displacement, which she frequently discussed in sessions.

Kai Ling's HSCL-21 distress scores were stable during baseline and decreased following the introduction of the intervention. Once the intervention was introduced, there was a reduction in level of total symptom distress. Although a temporary increase in distress was observed at Week 8, scores subsequently declined and remained lower throughout the remainder of the intervention phase. During follow-up, some improvements were retained; however, reductions in distress were not fully maintained over time.

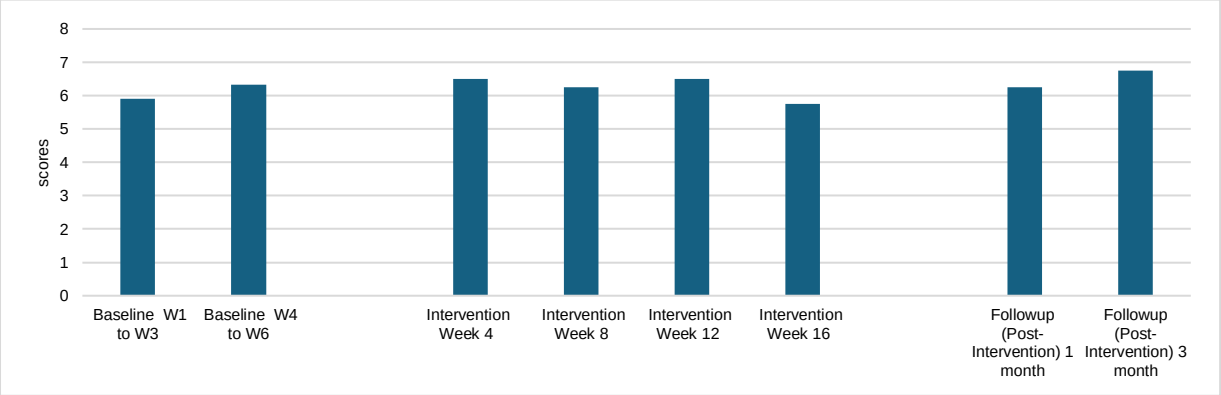
Kai Ling's General Wellbeing Schedule scores were stable and relatively low during baseline, indicating no spontaneous improvement prior to intervention. Following the introduction of the intervention, wellbeing scores increased and remained elevated throughout the intervention phase. During follow-up, wellbeing scores showed a gradual decline; although some gains were retained, improvements were not fully maintained by the three-month assessment, indicating limited durability of treatment effects after the intervention ended.

The PSS-14 indicated a reduction in Kai Ling's perceived stress from recruitment to the three-month follow-up, showing an overall improvement in her appraisal of stress following participation in the intervention.

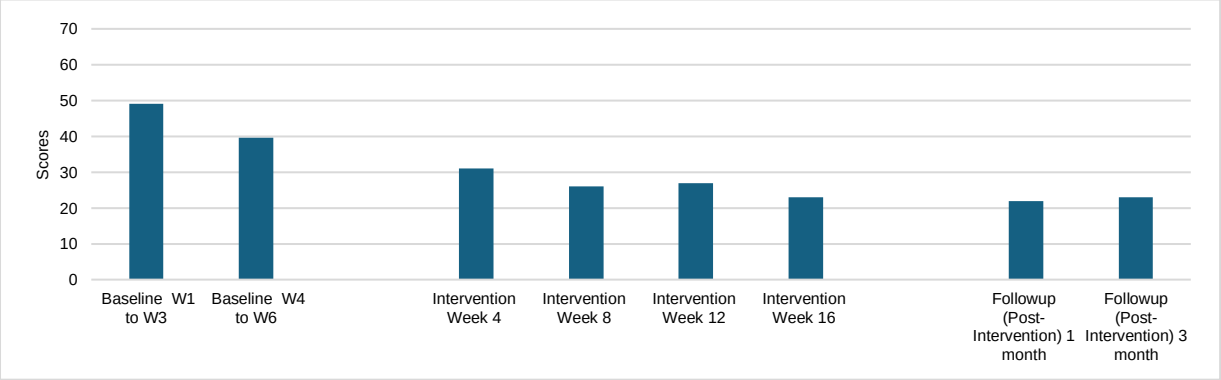
Participant 2: Selina

Figure 3

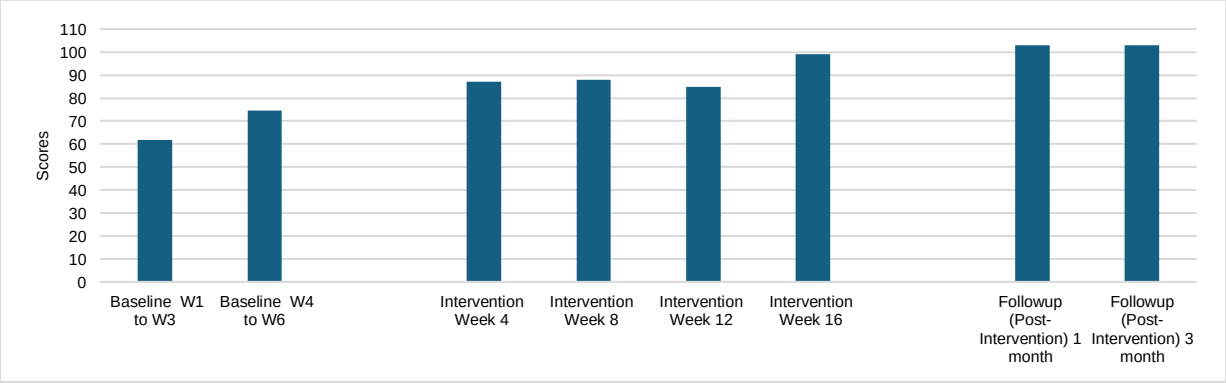
P2-Brief COPE



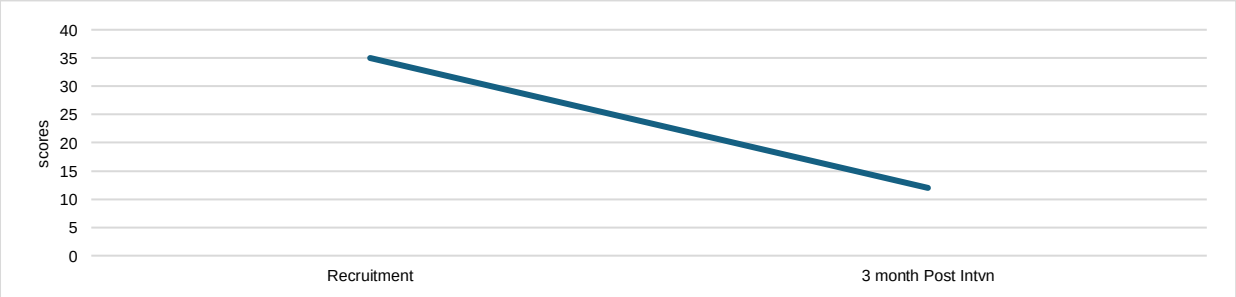
P2-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P2-General Wellbeing Schedule



P2- Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Selina was an 18-year-old domestic undergraduate student of European descent who demonstrated high levels of engagement, motivation and enthusiasm throughout the study. She met all inclusion criteria, recorded a baseline PSS-14 score of 35 and completed a six-week baseline phase prior to intervention.

Selina's Brief-COPE scores remained relatively stable during baseline, indicating little change in coping strategy use prior to intervention. Scores fluctuated throughout the intervention phase without a clear trend towards improvement. Although higher coping scores were observed at follow-up, the inconsistency of changes across assessment points shows that this improvement may reflect delayed adaptation or the gradual development of coping skills rather than a direct intervention effect.

Selina's HSCL-21 distress scores showed some fluctuation during the baseline phase. Following the introduction of the intervention, there was a pattern of sustained reduction in symptom distress over time. These improvements were maintained at follow-up, reflecting stability of gains after the intervention period. Overall, the data indicate a reduction in distress symptoms following intervention that were maintained at follow-up.

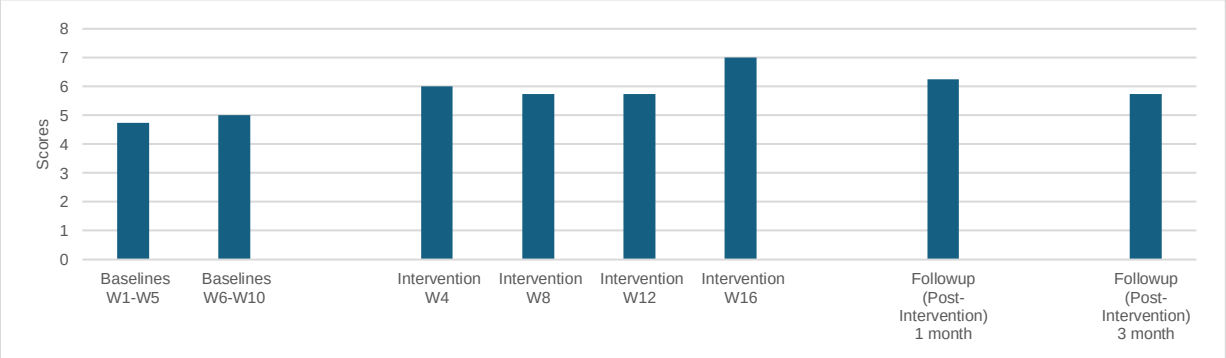
Selina's General Wellbeing Schedule scores indicated some increases during the baseline phase. Once the intervention was introduced, wellbeing scores increased further. The scores showed a consistent upward trajectory throughout the intervention phase. At follow-up, wellbeing scores showed a further increase, indicating that improvements achieved during the intervention were maintained.

The PSS-14 was used to assess Selina's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up her self-reported level of stress was noticeably lower.

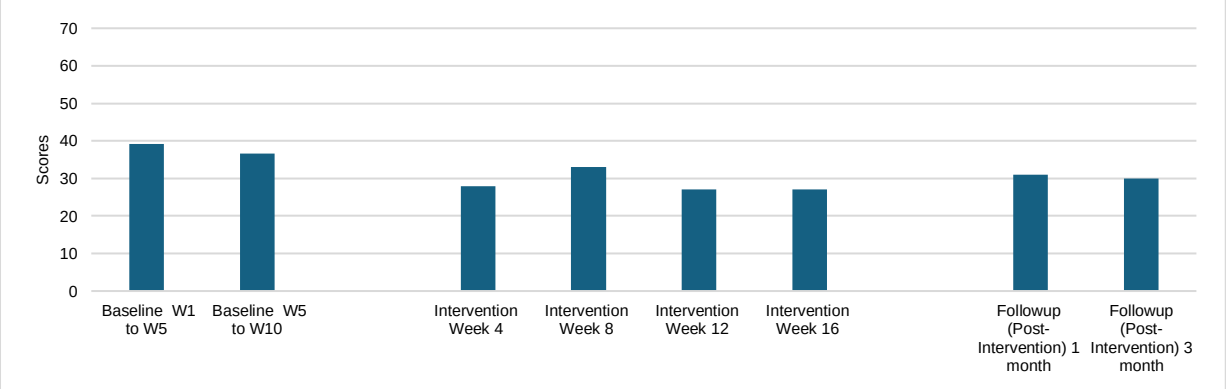
Participant 3: Michael

Figure 4

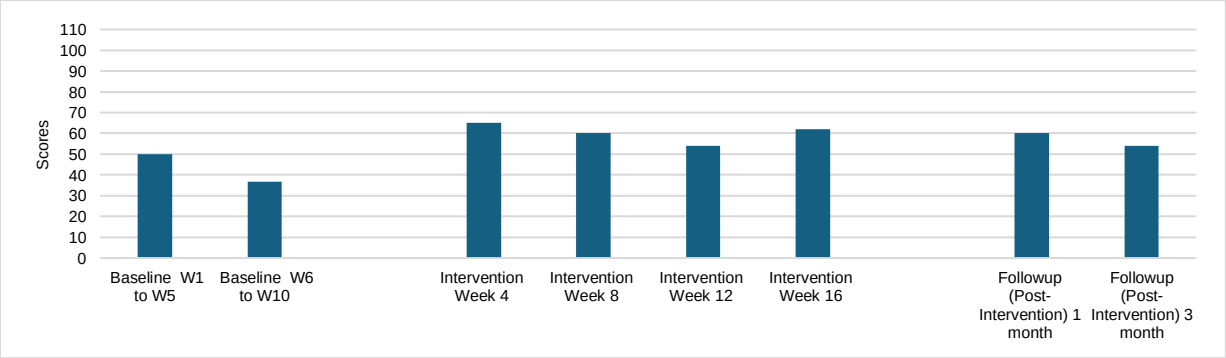
P3-Brief COPE



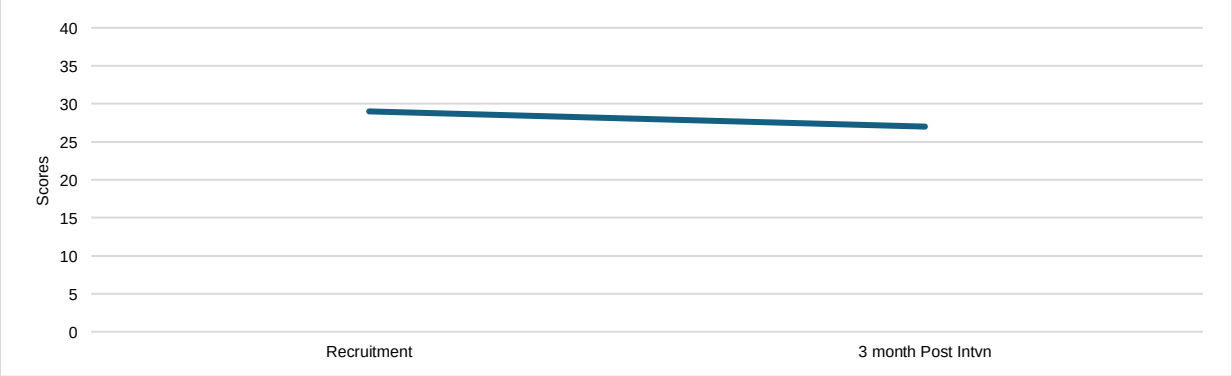
P3- Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P3-General Wellbeing Schedule



P3- Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Michael was a 39-year-old firefighter employed by Fire and Emergency New Zealand. At the time of recruitment, he was separated from his wife and living with a partner. He was motivated to challenge workplace stigma surrounding psychological support and remained highly engaged throughout the intervention. He met all inclusion criteria, recorded a baseline PSS-14 score of 29 and completed an extended ten-week baseline phase due to work commitments prior to commencing the intervention.

Michael's Brief-COPE scores remained stable during the baseline phase. Following the introduction of the intervention, a gradual upward trend in coping scores was observed, indicating increased use of coping strategies over time. Scores remained elevated during the follow-up phase, indicating maintenance of intervention gains, although a slight decline was evident relative to the one-month follow-up assessment.

Michael's HSCL-21 distress scores remained relatively stable during the baseline phase. Following the intervention, symptom distress decreased overall and remained lower across the intervention period, despite a temporary increase at Week 8. At follow-up, distress scores increased, showing that the reductions in symptom distress achieved during the intervention were not fully maintained.

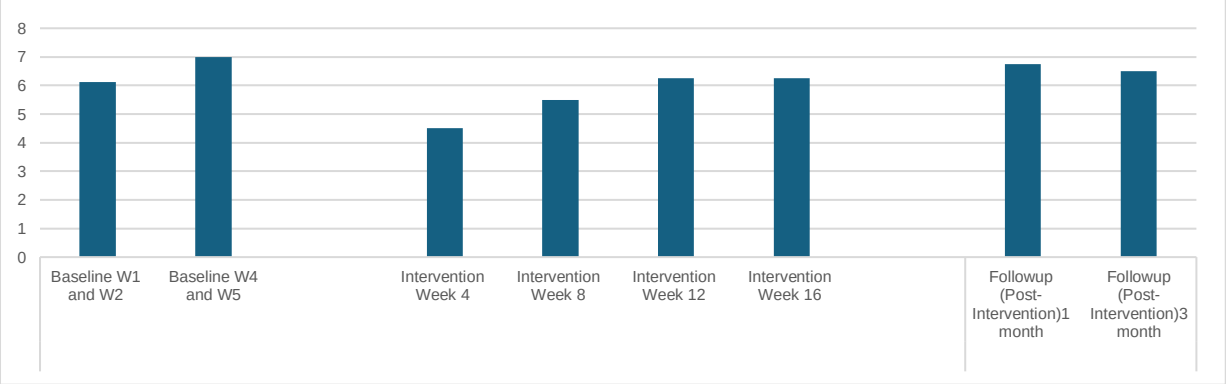
Michael's General Wellbeing Schedule scores indicated a downward trend during the baseline phase prior to intervention. Following the introduction of the intervention, wellbeing improved and was maintained throughout the intervention phase; however, at the three-month follow-up, scores showed a gradual decline. Although some of the improvement was maintained, the gains were not fully sustained over time.

The PSS-14 was administered at recruitment and again at the three-month post-intervention follow-up to evaluate Michael's perceived level of stress. Michael's scores showed a slight reduction from recruitment to the three-month follow-up, indicating a modest decrease in perceived stress over time.

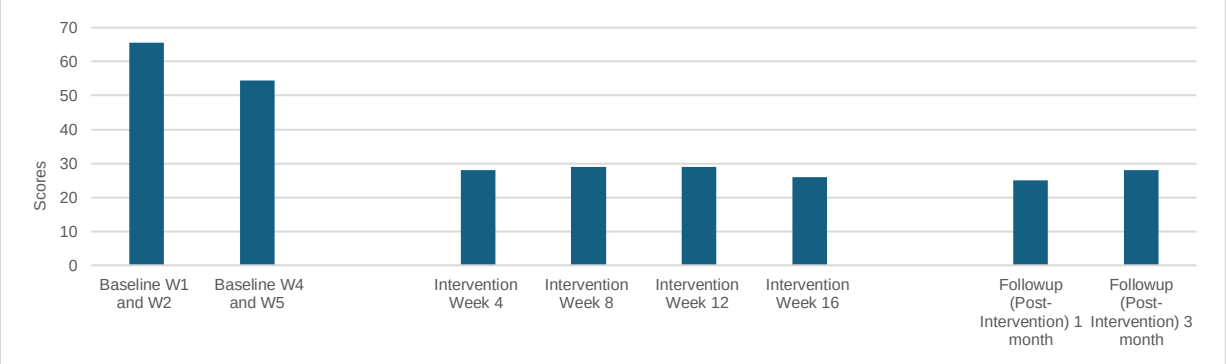
Participant 4: Jacqueline

Figure 5

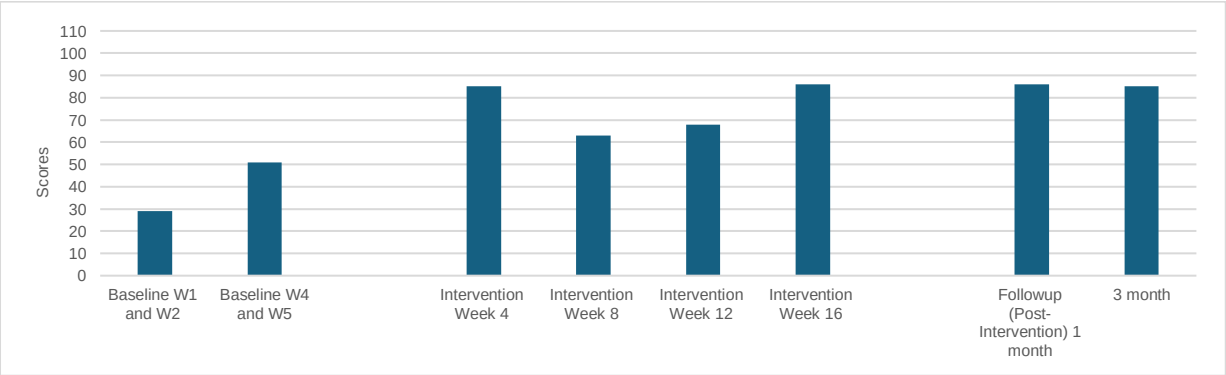
P4-Brief COPE



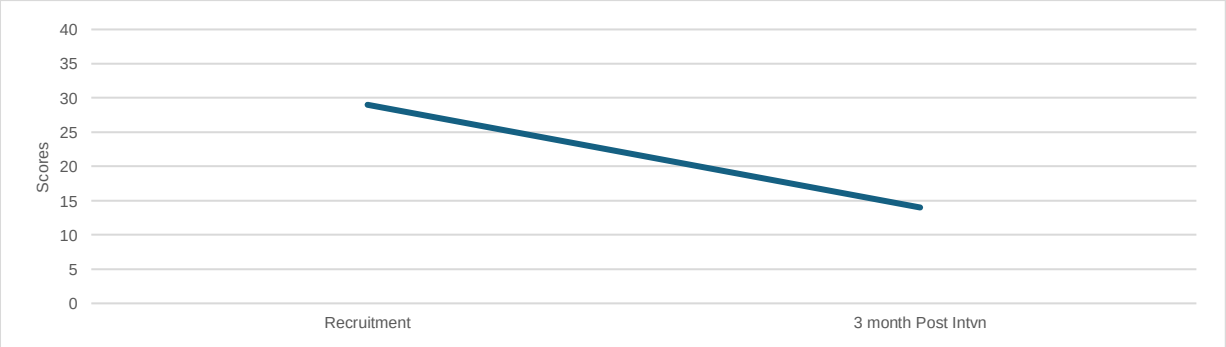
P4-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P4-General Wellbeing Schedule



P4- Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Jacqueline was a 27-year-old authorised officer working within police services who presented with elevated stress at baseline (PSS-14 = 29). She had a past history of SSRI and benzodiazepine use but was medication-free during the study. Despite significant occupational pressures during the COVID-19 pandemic, she remained highly engaged in the intervention and showed willingness to adopt more adaptive coping strategies and seek social support.

Jacqueline's Brief-COPE scores showed slight variability during the baseline phase. Following the introduction of the intervention, coping scores initially declined, likely reflecting COVID-19-related workplace stressors that she frequently mentioned during the sessions. However, coping scores subsequently increased and stabilised, with these improvements largely maintained at follow-up, indicating sustained gains in coping despite ongoing occupational demands.

Jacqueline's HSCL-21 distress scores showed some fluctuation during the baseline phase. Following the introduction of the intervention, there was a clear pattern of sustained reduction in symptom distress over time. These improvements were maintained during the follow-up phase.

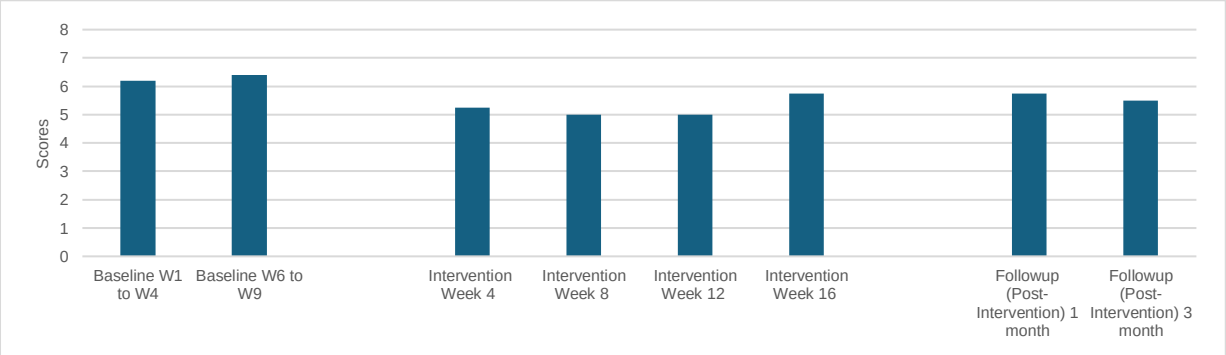
Jacqueline's General Wellbeing Schedule scores showed some improvement during the baseline phase. Following intervention, wellbeing scores increased substantially early in the intervention phase. Although some fluctuations were observed across the intervention period, general wellbeing continued to improve. These gains were maintained at follow-up, with scores remaining stable at the one-month and at the three-month follow-up phase.

The PSS-14 was used to assess Jacqueline's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up. Jacqueline's self-reported stress levels showed a marked reduction from recruitment to the three-month follow-up.

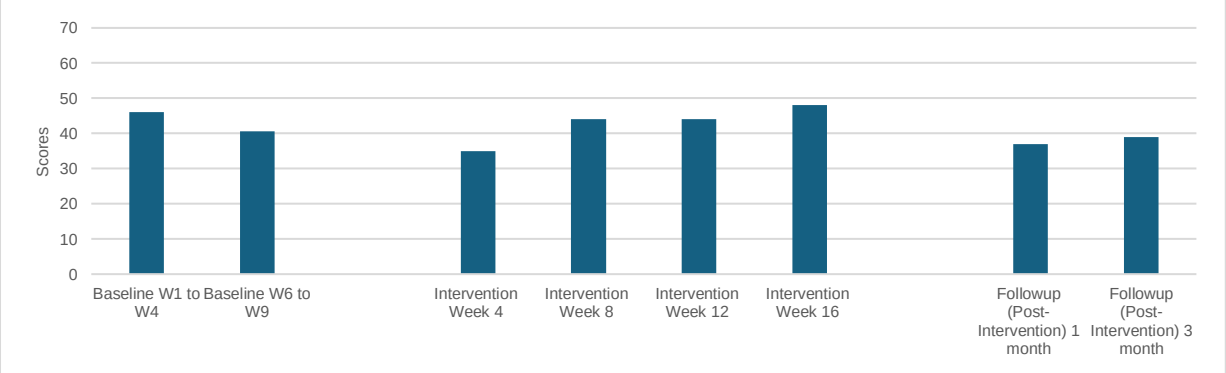
Participant 5: Siew Ping

Figure 6

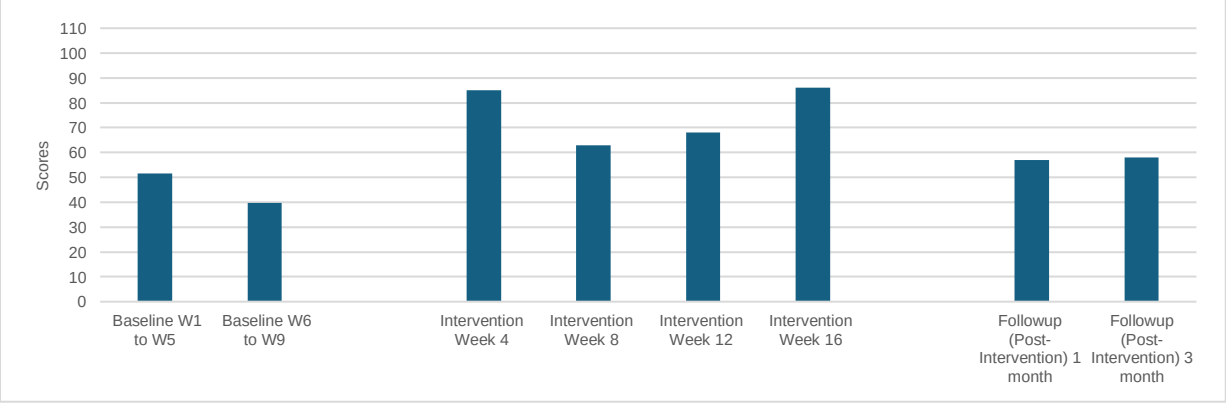
P5-Brief COPE



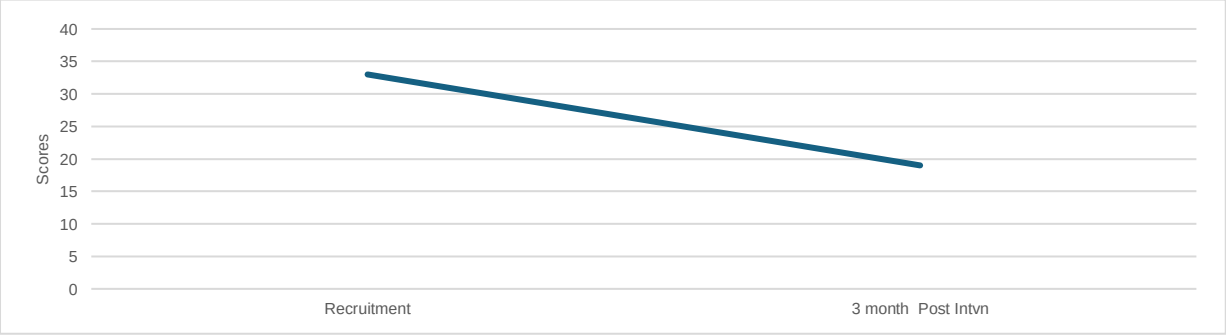
P5-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P5-General Wellbeing Schedule



P5- Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Siew Ping was a 27-year-old doctoral student of Chinese Mainland descent who presented with elevated stress at baseline (PSS-14 = 33). Her stress was primarily associated with academic demands, interpersonal challenges and uncertainty during the COVID-19 pandemic. Despite these stressors, she remained motivated and engaged throughout the intervention, demonstrating gradual improvements in coping and psychological wellbeing over time.

Siew Ping's Brief-COPE scores remained relatively stable during the baseline phase. Following the introduction of the intervention, coping scores initially declined, possibly reflecting the academic, interpersonal and COVID-19-related stressors that Siew Ping frequently discussed during the sessions. However, scores gradually improved and remained relatively stable at follow-up, despite ongoing personal and environmental stressors.

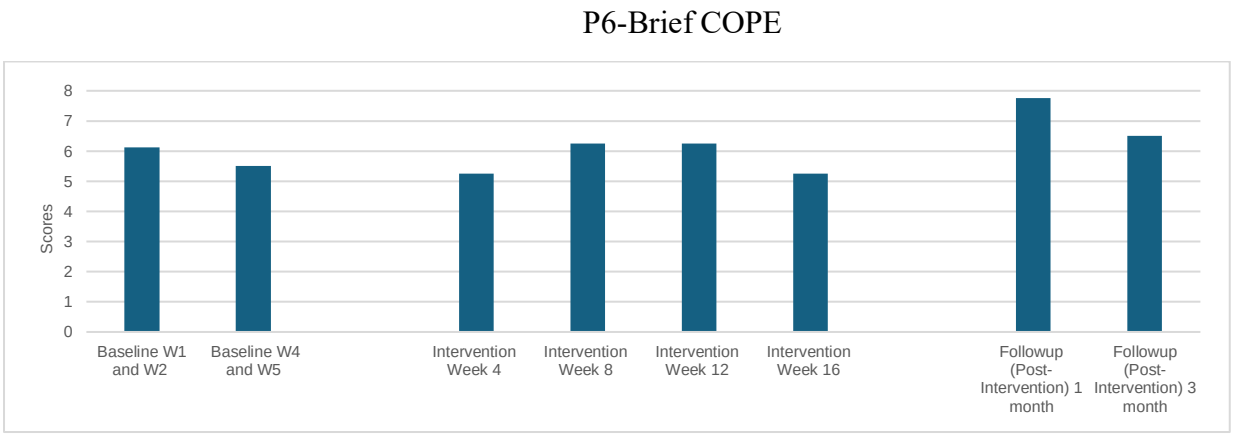
Siew Ping's HSCL-21 distress scores remained relatively stable during baseline. Although distress initially decreased following the introduction of the intervention, subsequent increases were observed during the intervention phase, likely reflecting ongoing external stressors. Distress levels declined again at follow-up, showing some improvement over time, although changes were variable across the study period.

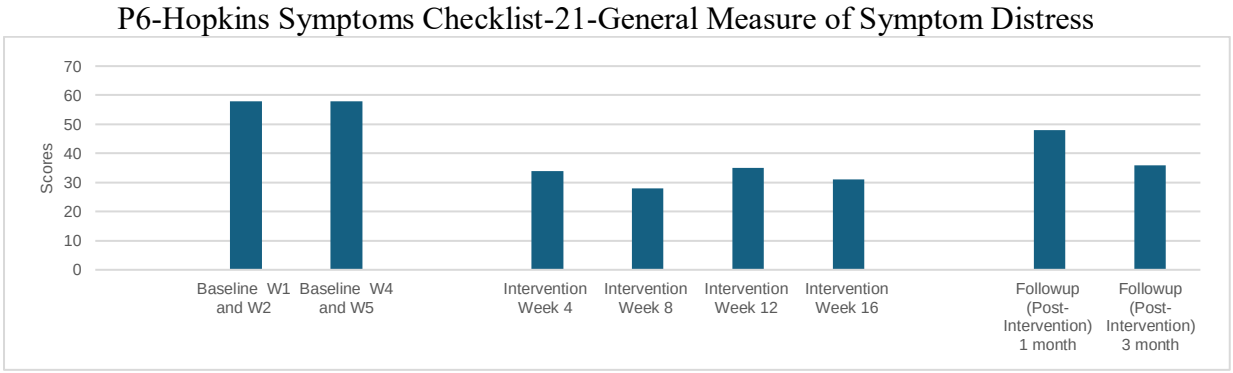
Siew Ping's General Wellbeing Schedule scores showed a decline during the baseline phase prior to intervention. Following the introduction of the intervention, general wellbeing scores increased substantially during the early intervention phase, although some fluctuations were observed across the intervention period. During the follow-up period, wellbeing scores declined but remained relatively stable over time.

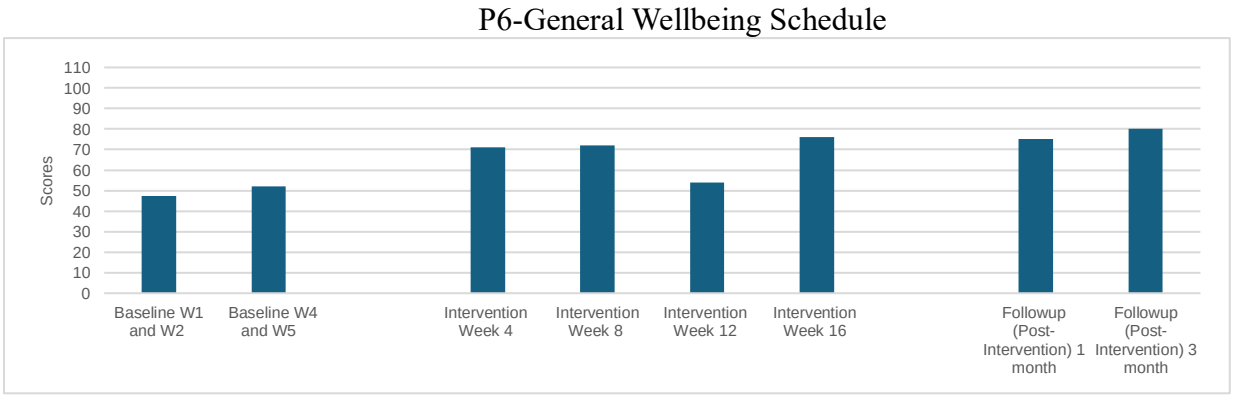
The PSS-14 was used to assess Siew Ping's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up. Siew Ping's scores showed a noticeable reduction from recruitment to the three-month follow-up.

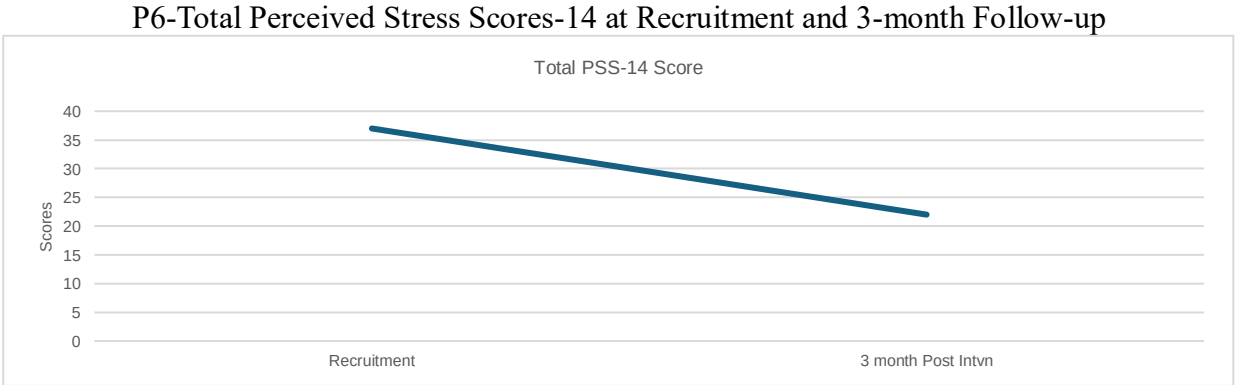
Participant 6: Eliza

Figure 7









Eliza was a 23-year-old postgraduate student with elevated stress at baseline (PSS-14 = 37) and a history of anxiety. Despite the challenges associated with the COVID-19 pandemic, she remained highly engaged throughout the intervention and demonstrated gradual improvements in self-care, social support utilisation and coping over time.

Eliza's Brief-COPE scores showed some fluctuation during the baseline phase. Following an initial decline, likely reflecting COVID-19-related stressors that she frequently discussed during the sessions, coping scores then increased during the middle stages of the intervention. Although there was a slight decline toward the later stages of the intervention phase, scores increased again during the follow-up period. Overall, the pattern reflected gradual improvement and maintenance of coping skills across the study period.

Eliza's HSCL-21 distress scores remained stable during the baseline phase. Following the introduction of the intervention, distress scores decreased and remained lower throughout the intervention phase. Although distress increased at the one-month follow-up, scores reduced again at the three-month follow-up, indicating an overall reduction in total distress with some post-intervention variability.

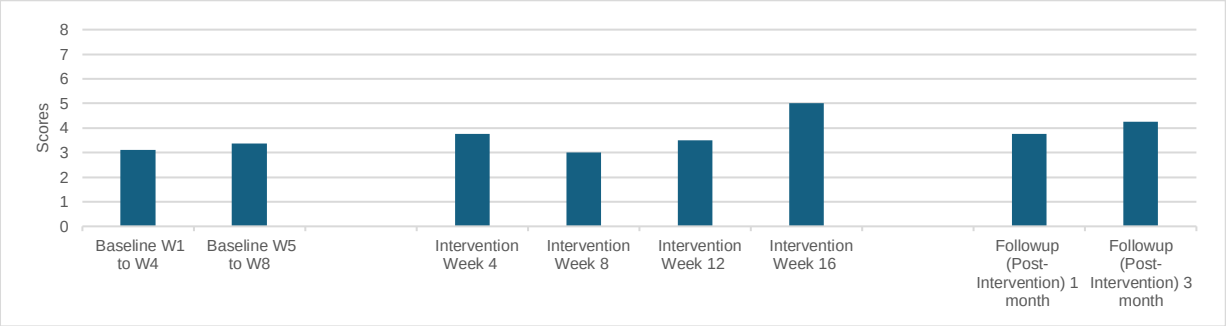
Eliza's General Wellbeing Schedule scores showed a slight increase during the baseline phase prior to intervention. During the intervention phase, wellbeing scores increased overall, although some fluctuation was observed, particularly at intervention week 12. Despite this temporary decline, wellbeing scores improved again toward the later stages of the intervention and remained high during the follow-up period. Overall, the pattern demonstrated gradual improvement in wellbeing across the study period, with gains largely maintained over time.

The PSS-14 was used to assess Eliza's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up. Eliza's scores showed a noticeable reduction from recruitment to the three-month follow-up.

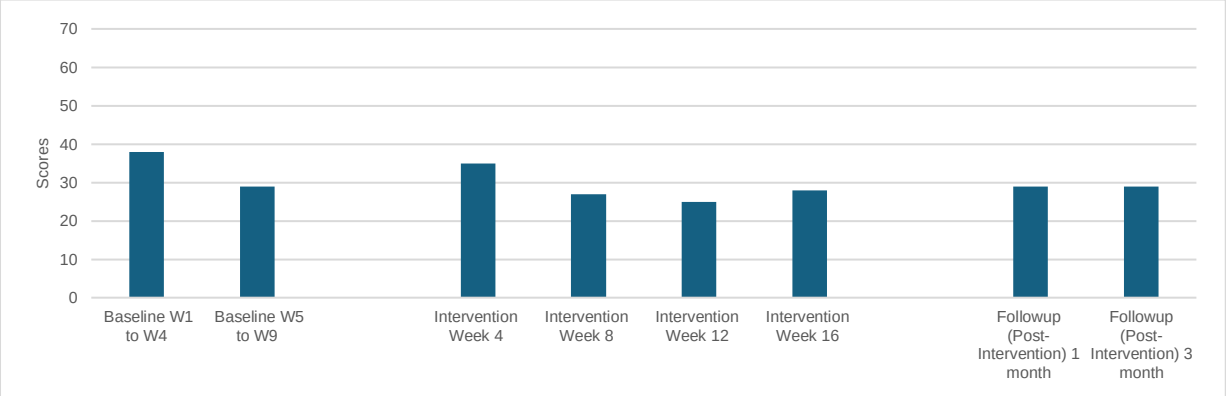
Participant 7: Rosalind

Figure 8

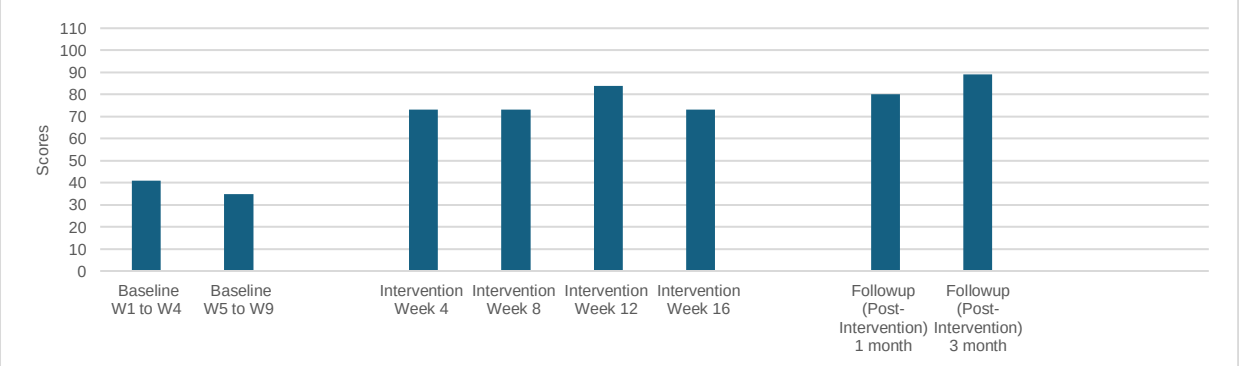
P7-Brief COPE



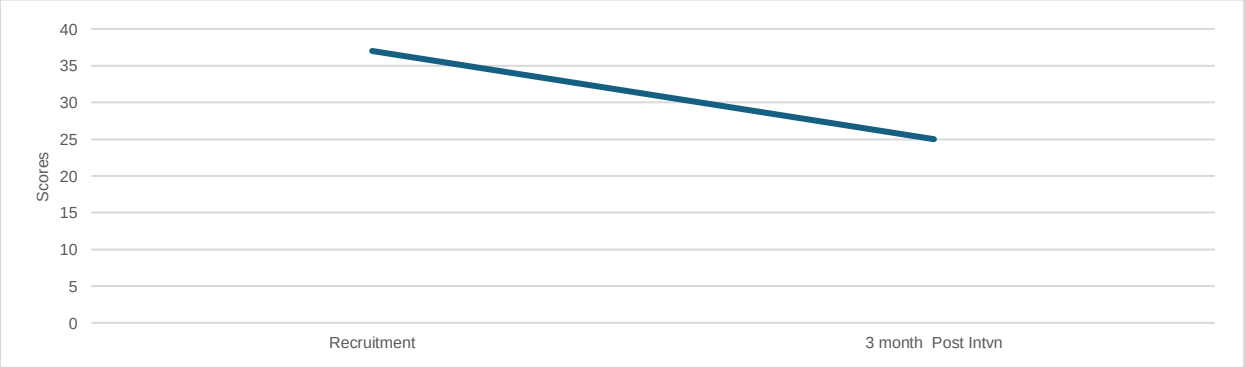
P7-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P7-General Wellbeing Schedule



P7- Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Rosalind was a 20-year-old undergraduate student who presented with elevated stress at baseline (PSS-14 = 37). Her stress was primarily related to academic, health and adjustment challenges. Despite these difficulties, she remained engaged, reflective and motivated throughout the intervention.

Rosalind's Brief-COPE scores remained relatively stable during the baseline phase. During the intervention phase, coping scores initially increased but later declined, possibly reflecting ongoing academic and COVID-19-related stressors that she frequently reported during the sessions. Coping scores then increased again toward the later stages of the intervention phase. During the follow-up phase, scores showed some decline, although there was a slight increase again at the three-month follow-up. Overall, the pattern demonstrated fluctuating but gradually improving coping across the study period.

Rosalind's HSCL-21 distress scores showed some reduction during the baseline phase prior to intervention. Following the introduction of the intervention, distress scores initially increased but gradually decreased across the intervention period, although some fluctuation was observed. During the follow-up phase, distress scores increased slightly and then remained stable at the three-month follow-up. Overall, the pattern showed fluctuating but generally reduced distress levels across the study period.

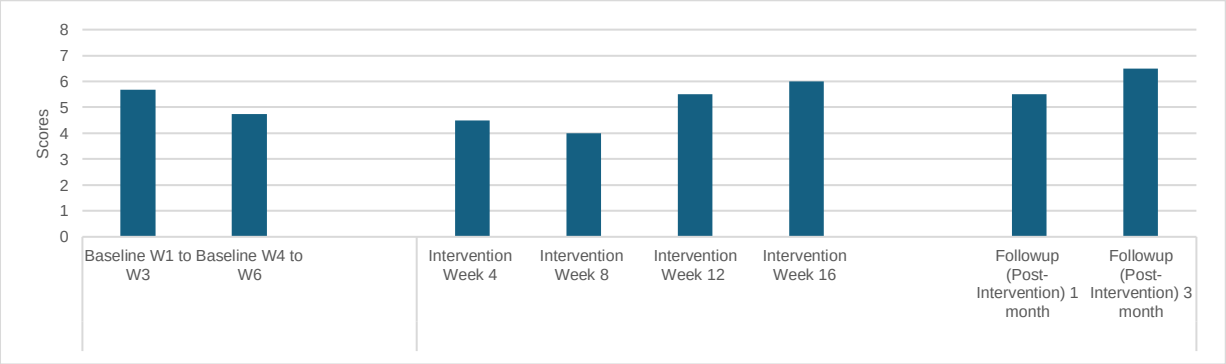
Rosalind's General Wellbeing Schedule scores showed a decline during the baseline phase prior to intervention. During the intervention phase, wellbeing scores increased substantially and remained elevated overall. During the follow-up phase, wellbeing scores remained high and showed further improvement at the three-month follow-up. Overall, the pattern showed improved wellbeing across the study period, with gains maintained over time.

The PSS-14 was used to assess Rosalind's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up. Rosalind's scores showed a reduction from recruitment to the three-month follow-up, indicating lower perceived stress over time.

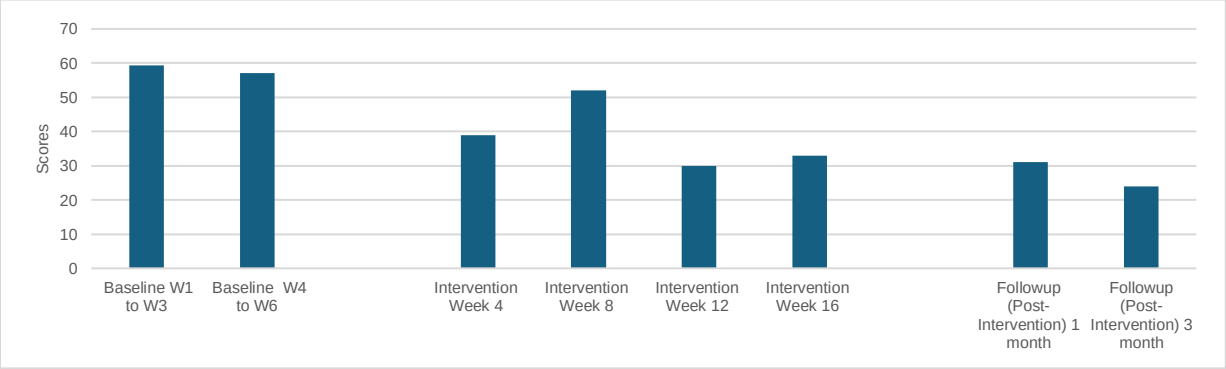
Participant 8: Christine

Figure 9

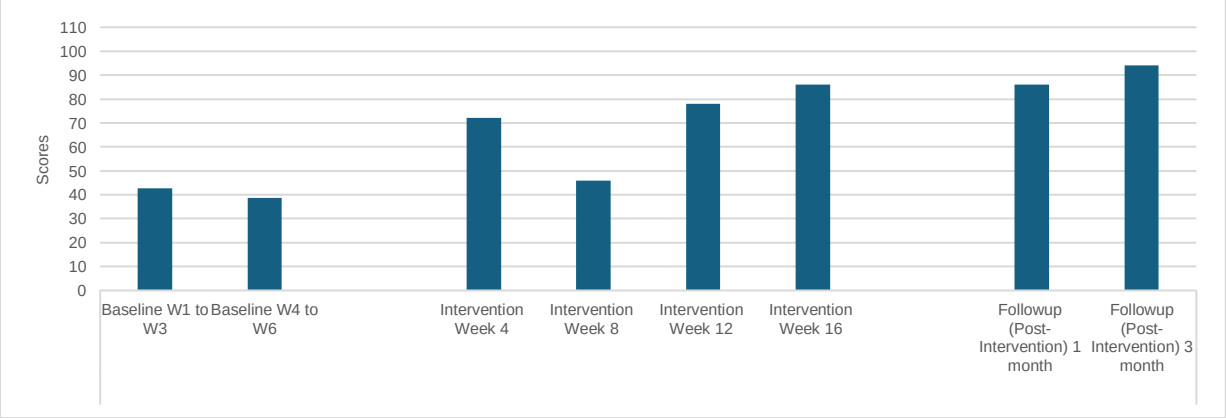
P8-Brief COPE



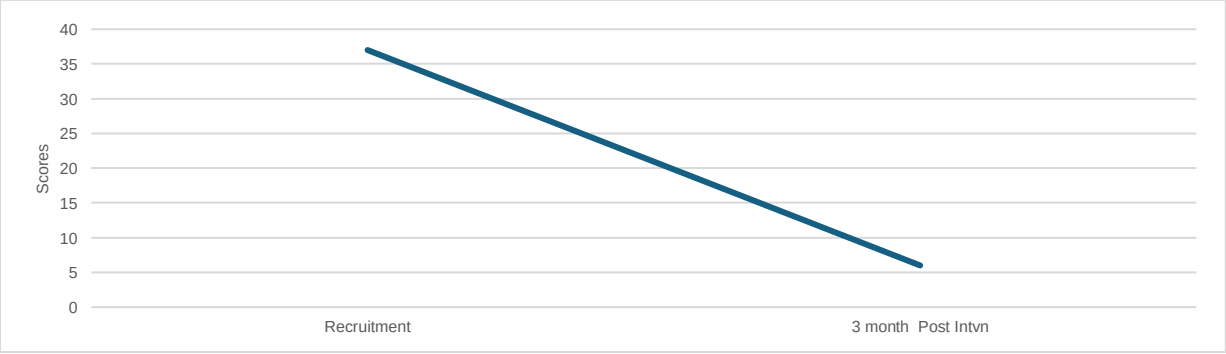
P8-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P8-General Wellbeing Schedule



P8-Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Christine was a 20-year-old undergraduate Sport Science student who entered the study with elevated stress levels (PSS-14 = 37) related to academic pressures, perfectionism, procrastination and high self-expectations. Throughout the intervention, Christine remained highly engaged, consistently attending sessions, completing assignments and reflecting thoughtfully on weekly tasks.

Christine's Brief-COPE scores declined during the baseline and early intervention phases before gradually improving throughout the remainder of the study. Coping scores remained elevated during follow-up and showed further improvement at the three-month follow-up, indicating that gains in coping were largely maintained over time.

Christine's HSCL-21 distress scores were relatively stable during the baseline phase. During the intervention phase, distress scores initially decreased, followed by a temporary increase at Intervention Week 8, before declining again across the later stages of the intervention. During the follow-up phase, distress scores remained low and showed further reduction at the three-month follow-up. Overall, the pattern demonstrated fluctuating but generally reduced distress levels across the study period.

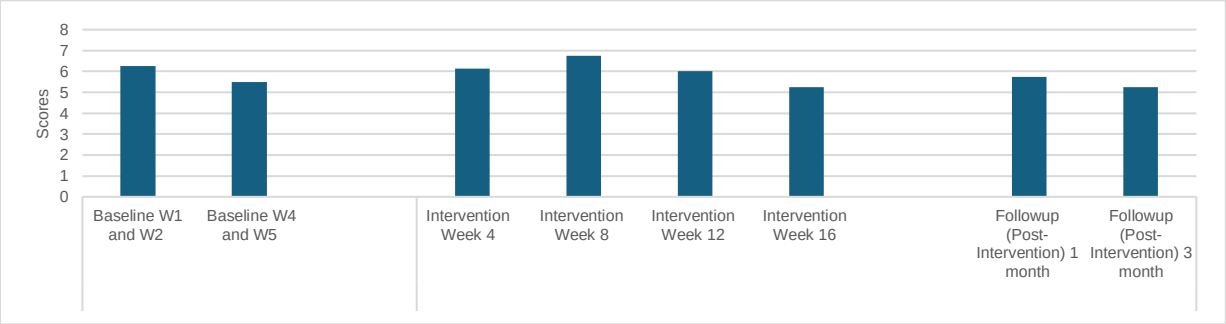
Christine's General Wellbeing Schedule scores remained relatively stable during the baseline phase and improved overall throughout the intervention period, despite a temporary decline at Intervention Week 8. General Wellbeing scores subsequently increased and remained elevated during intervention. At follow-up phase, further improvement was observed at the three-month follow-up, showing sustained improvements in psychological wellbeing over time.

The PSS-14 was used to assess Christine's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up. Christine's scores showed a substantial reduction from recruitment to the three-month follow-up, indicating markedly lower perceived stress over time.

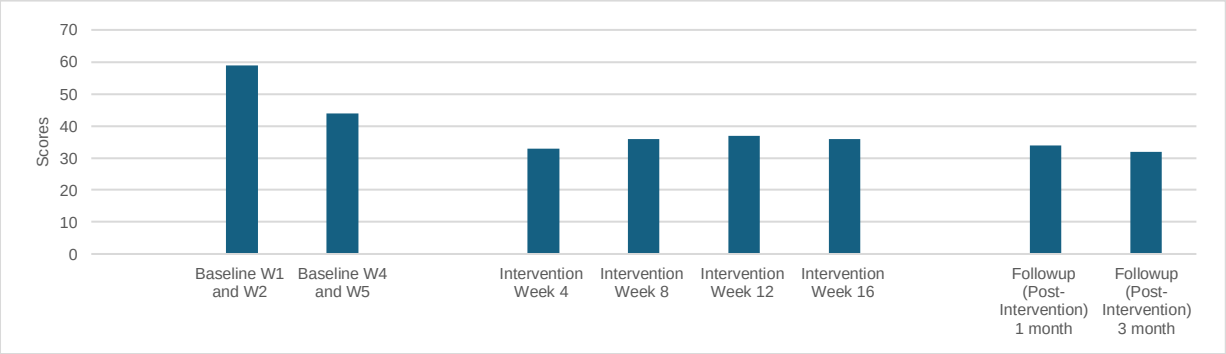
Participant 9: Mary

Figure 10

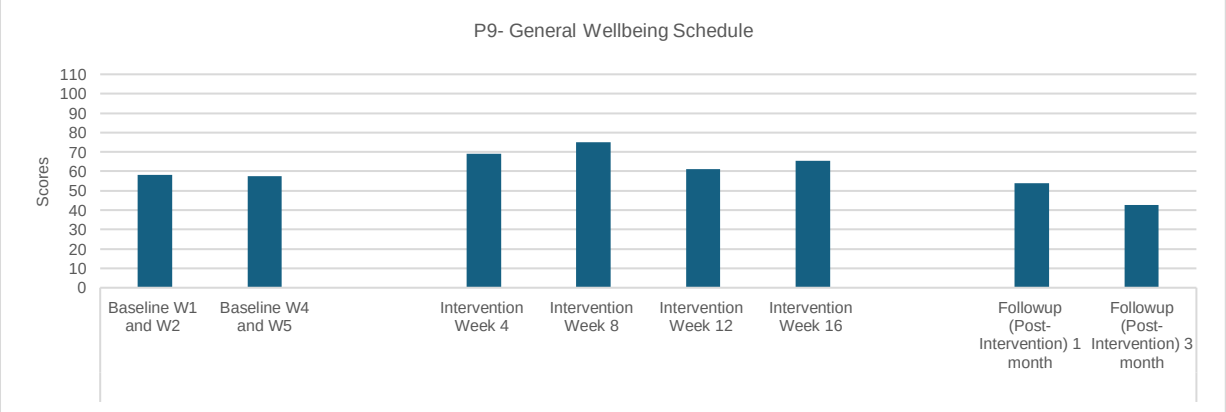
P9-Brief COPE



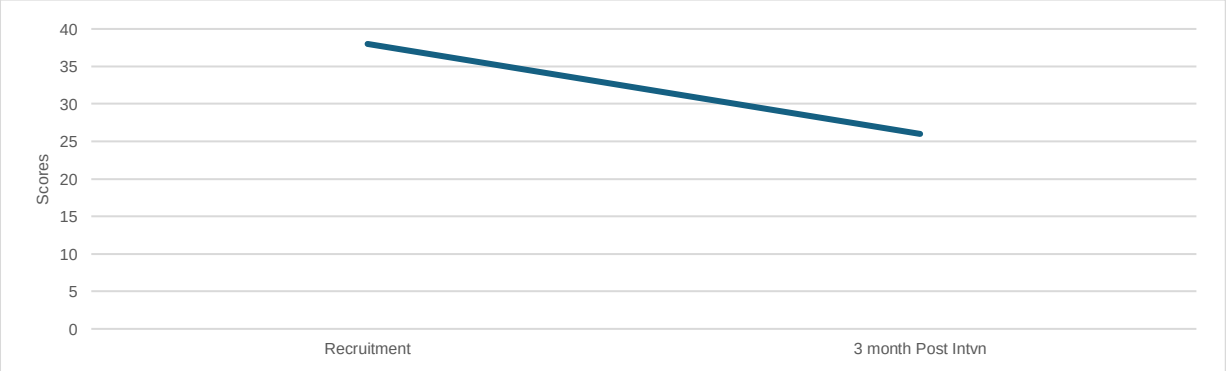
P9-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P9-General Wellbeing Schedule



P9- Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Mary was a 26-year-old postgraduate psychology student who presented with elevated stress at baseline (PSS-14 = 38). Her stress was associated with academic demands, parenting responsibilities, health concerns, wedding planning and COVID-19-related disruptions. Despite these challenges, she remained highly engaged throughout the intervention, consistently attending sessions and actively participating in therapeutic activities.

Mary's Brief-COPE scores showed some decline during the baseline phase. Coping scores improved during the intervention phase before showing a slight decline toward Intervention Week 16. During the follow-up phase, coping scores increased at one-month follow-up, although a slight decline was observed at the three-month follow-up. Overall, the pattern indicated generally stable coping across the study period, despite ongoing life stressors and COVID-19-related uncertainty.

Mary's HSCL-21 total distress scores showed a reduction during the baseline phase prior to intervention. During the intervention phase, distress scores remained lower than baseline levels, although some fluctuation was observed across the intervention period. During the follow-up phase, distress scores remained relatively stable and continued to remain low. Overall, the findings show generally reduced psychological distress across the study period despite ongoing personal and COVID-19-related stressors.

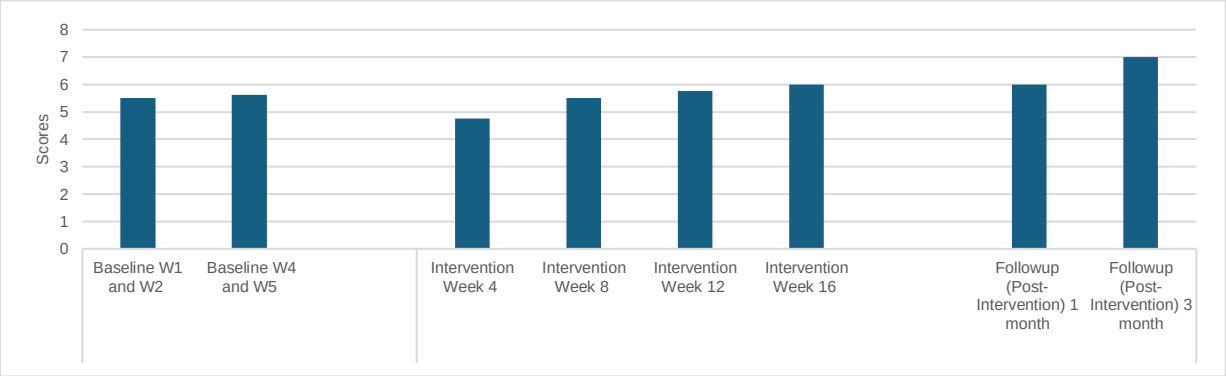
Mary's General Wellbeing Schedule scores remained relatively stable during the baseline phase and improved during the intervention period. However, these gains were not fully maintained during follow-up, with wellbeing scores declining over time, possibly reflecting the influence of ongoing personal and COVID-19-related stressors.

The PSS-14 was used to assess Mary's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up. Mary's scores showed a reduction from recruitment to the three-month follow-up assessment, indicating lower perceived stress over time.

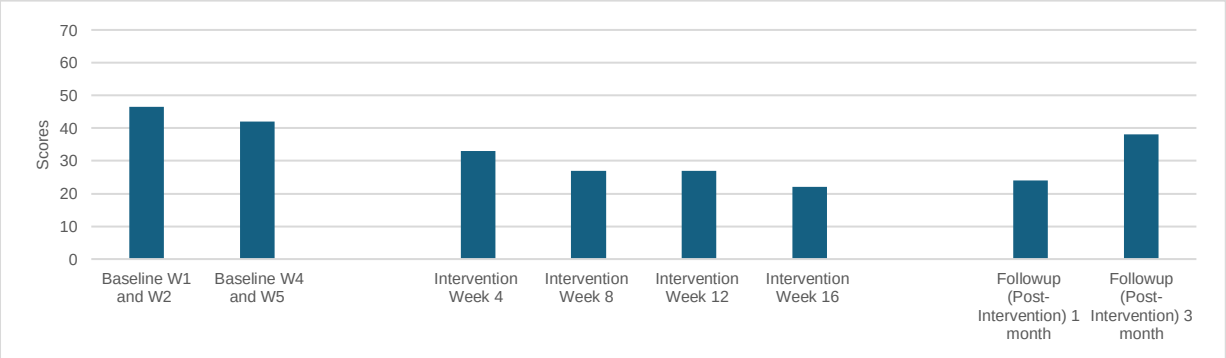
Participant 10: Dorothy

Figure 11

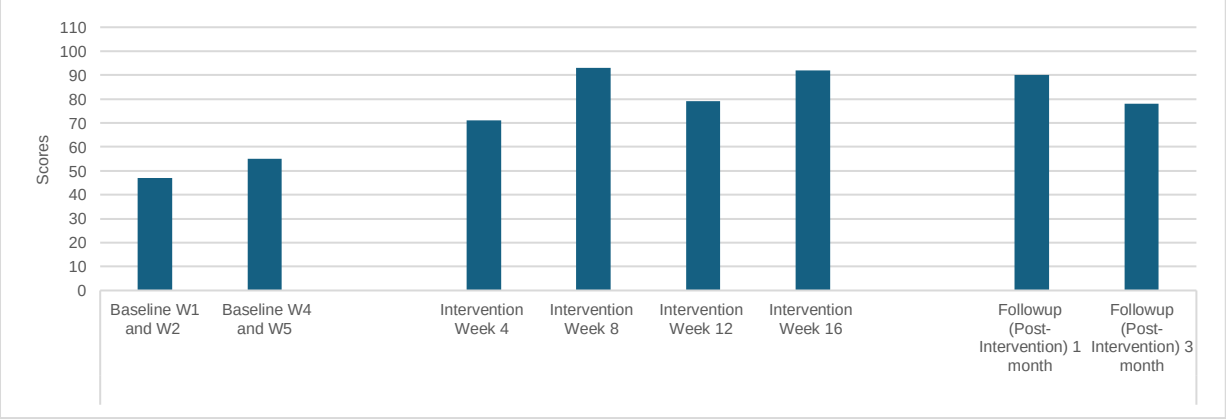
P10-Brief COPE



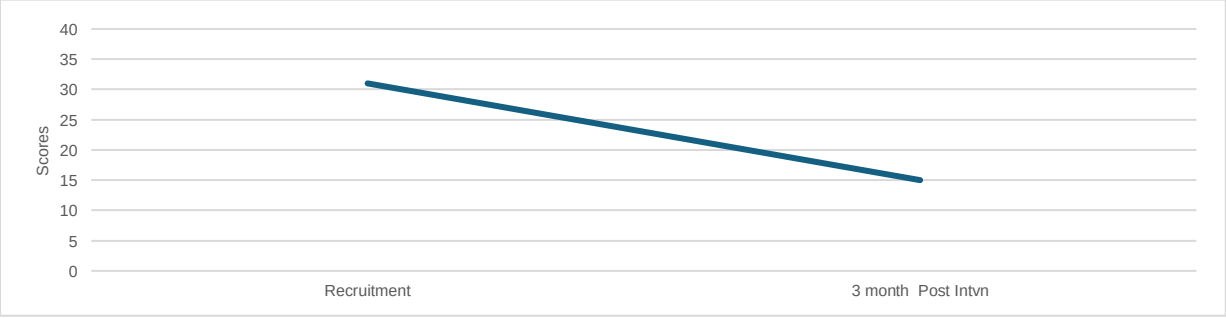
P10- Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P10-General Wellbeing Schedule



P10-Total Perceived Stress Scores-14 at Recruitment and 3-month Follow-up



Dorothy was a 41-year-old mother of three and extramural Bachelor of Arts student who presented with elevated stress at baseline (PSS-14 = 31). Her stress was primarily related to balancing family, caregiving and academic responsibilities. Despite these demands, she remained highly engaged throughout the intervention and actively applied the strategies learned in her daily life.

Dorothy's Brief-COPE scores remained relatively stable during the baseline phase. Following a slight decline during the early stages of the intervention, likely reflecting COVID-19-related restrictions and competing family and academic demands, coping scores gradually improved across the remainder of the study. These gains were maintained during follow-up, with further improvement observed at the three-month follow-up.

Dorothy's HSCL-21 total distress scores decreased during the baseline phase prior to intervention, During the intervention phase, distress scores decreased overall and remained relatively low at the one-month follow-up, before increasing at the three-month follow-up. Overall, the pattern indicated reduced distress across much of the study period, although some increase in distress was observed over time, possibly related to ongoing family, academic and pandemic-related stressors.

Dorothy's General Wellbeing Schedule scores showed improvement during the baseline phase prior to intervention. During the intervention phase, wellbeing scores increased. During the follow-up phase, wellbeing scores remained elevated, although a slight decline was observed at the three-month follow-up. Overall, the pattern reflected improved wellbeing across the study period, with most gains maintained over time even though family, academic and pandemic-related stressors remained ongoing.

The PSS-14 was used to assess Dorothy's subjective appraisal of stress at recruitment and at the three-month post-intervention follow-up. Dorothy's scores showed a reduction in perceived stress across the intervention and follow-up phase.

Quantitative Findings Across Participants 1-10

Based on the findings from the ten participants in Phase 1, the intervention was associated with reductions in perceived stress and distress symptoms, alongside improvements in wellbeing, although participants differed in the degree of change achieved and the extent to which these gains were maintained over time.

Across all ten participants, perceived stress (PSS-14) decreased from baseline to the three-month follow-up, showing that participation in the intervention was associated with improved stress appraisal over time.

Similarly, most participants demonstrated reductions in distress symptoms as measured by the HSCL-21, with improvements often emerging during the intervention phase and, for many participants, being maintained at follow-up.

Improvements in general wellbeing were also observed across participants, with General Wellbeing Schedule scores typically increasing following the introduction of the intervention. Participants such as Selina, Jacqueline, Rosalind, Christine and Dorothy showed particularly strong and sustained improvements in wellbeing, whereas Kai Ling, Michael, Siew Ping and Mary demonstrated improvements that were only partially maintained at follow-up.

Changes in coping, as measured by the Brief-COPE, were more variable. Michael, Christine, Dorothy, Eliza and Jacqueline demonstrated clear improvements in coping over time, while Rosalind, Mary, Siew Ping and Selina showed more fluctuating patterns. Kai Ling demonstrated a decline in coping scores following the intervention, which appeared to be influenced by significant COVID-19-related stressors including social isolation, travel restrictions and cultural displacement. Nevertheless, many participants demonstrated improved coping at follow-up, indicating that coping skills continued to develop and consolidate beyond the intervention period.

Several participants experienced temporary increases in distress, reductions in coping, or declines in wellbeing during periods of heightened external stress. For example, Kai Ling, Siew Ping, Rosalind, Mary and Dorothy frequently discussed the impact of COVID-19-related disruptions, while Michael experienced ongoing occupational pressures as a firefighter. Despite these challenges, most participants demonstrated improvements relative to baseline, indicating that the intervention may have provided resilience-building skills that supported adaptation during periods of ongoing stress.

Taken together, the findings from these ten participants in Phase 1 indicate that the PRTM intervention was associated with reductions in perceived stress and psychological distress, alongside improvements in wellbeing for most participants. The findings also provide preliminary evidence that the PRTM intervention may be useful in alleviating mild to moderate everyday stressors experienced across educational, occupational, family and social contexts.

Limitation of Single-Case Experimental Design (SCED) and Multiple Outcome Measures

As discussed earlier (in the Design section in Chapter 3), although the SCED A-B with follow-up design offers several methodological strengths, it also presents important limitations. The A-B design is considered one of the weaker single-case experimental approaches for establishing causality because the intervention is neither withdrawn nor replicated across phases. Unlike reversal designs such as ABAB, changes observed during the intervention phase cannot be confidently attributed solely to the intervention itself, as improvements may also result from external influences such as maturation, history effects and spontaneous recovery (Kratochwill et al., 2010; Tate et al., 2016).

In addition, the absence of experimental control increases vulnerability to threats including placebo effects and contextual factors occurring during the intervention period. Although repeated measurements and follow-up phases provide useful information regarding

trends and maintenance of change, the design does not permit firm causal conclusions regarding intervention effectiveness. Furthermore, the small sample size and highly individualised nature of SCED may limit the generalisability of findings to broader populations.

An additional consideration in interpreting the quantitative findings relates to the use of multiple outcome measures assessing different aspects, coping, distress symptoms, wellbeing and perceived stress. The inclusion of several measures is consistent with standard practice in CBT and psychotherapy outcome research, where clinically relevant domains are commonly assessed using a range of instruments rather than relying on a single indicator of change. However, the findings demonstrated that these measures did not always show identical patterns of improvement across participants or across time. This likely reflects the fact that the instruments assessed related yet distinct constructs rather than a single unified dimension of "clinical improvement."

Therefore, in the following chapter, I extend beyond the quantitative findings presented in Phase 1 by incorporating descriptive analyses derived from detailed therapeutic case notes (see Appendix B) recorded throughout the intervention process. While the psychometric findings provided important indications of participant change over time, they did not fully capture the complexity, individuality and contextual nature of participants lived experiences during treatment.

To address this, I used descriptive reports to provide a more detailed understanding of participant progress, therapeutic responsiveness, and the realities of implementing the intervention within real-world contexts. I also explored how behavioural observations, emotional processes, interpersonal factors and contextual stressors interacted with the intervention over time, allowing for a more comprehensive interpretation of participant outcomes.

CHAPTER FIVE: PHASE 1 STUDY: DESCRIPTIVE FINDINGS

Overview

This chapter incorporates descriptive findings based on case notes written throughout all phases of the therapeutic treatment. These notes were recorded by me during the treatment sessions and then summarized into a comprehensive case report as might typically be the final summary for a participant's status at the time of termination. Thus, they capture behavioural, emotional, and contextual observations that are not fully represented in quantitative measures. These reports for each of the ten participants are included in the Appendix section (see Appendix B).

To augment analytic depth, my reports were further examined using a large language model (LLM), Microsoft Copilot, to identify recurring themes, subtle patterns and consistencies present in my case notes during the treatment sessions. This LLM analysis is used as a supplementary interpretive tool rather than a primary data source. The analysis requested was strictly limited to the specific information provided in the texts of my own case reports. The chapter concludes with an integrative summary of both quantitative and descriptive findings. This synthesis highlights how the different data sources agree or differ, and what these relationships reveal about participant outcomes and intervention effects as well as recognizing the indirect role of the clinician's style in delivering a manualised programme. Finally, the value of clinical insights derived from descriptive findings are emphasized. These insights help explain the behavioural data, improve understanding of participant experiences and resources, and support a more complete evaluation of the intervention outcomes.

Descriptive Analyses of Participants 1-10

My case notes, which were written sequentially over the entire period of this clinical trial, have been listed together as one document in Appendix B. Once work with these ten participants was completed, it was possible to go back over the notes as a whole and look for common themes as well as unique issues that they reveal. This retrospective review enabled the identification of descriptive trends across participants while retaining sensitivity to individual variability in presentation, context, and response to intervention. Below is a brief descriptive summary based on my case notes of the ten participants in this clinical trial.

Participant 1: Kai Ling. Kai Ling, an international Master's student from China, entered with high stress driven by perfectionism, cultural self-criticism and academic pressure. Over the intervention, she shifted from passive coping (self-blame, denial, venting) to active strategies such as planning, reframing, mindfulness, self-compassion and gratitude. Cultural identity was central to her work, particularly balancing humility with self-kindness. She demonstrated strong integration of skills, improved social support use and successfully completed her thesis.

Participant 2: Selina. Selina, an 18-year-old first year undergraduate, struggled with self-blame, guilt, avoidance and difficulty receiving support while adjusting to independence. Treatment focused on acceptance, self-compassion and assertive help seeking. She moved from a "good girl" self-concept toward healthier boundaries, reduced academic anxiety and increased comfort receiving emotional and instrumental support. Humour was explored later and remained less central for her.

Participant 3: Michael. Michael, a 39-year-old firefighter, presented with occupational stress, emotional suppression, and impulsive reactions. He engaged strongly with reframing, restraint coping, self-monitoring, and humour awareness. His progress centred on slowing reactions, improving emotional regulation and strengthening family and workplace relationships.

Self-care was implicit rather than lifestyle focused and humour boundaries were a key area of insight.

Participant 4: Jacqueline. Jacqueline, a 27- year-old essential police services worker, entered with avoidance, emotional suppression, and reluctance to seek help. She developed strong reflective skills through discrete thought tracking, reframing, pacing and acceptance. A major focus was learning to access and tolerate social support across emotional, material and informational domains. She showed significant growth in emotional regulation, help seeking confidence and managing uncertainty.

Participant 5: Siew Ping. Siew Ping, a 27- year-old PhD student from Mainland China, experienced stress from academic load, cultural barriers to support, relationship strain and COVID 19 disruptions. She transitioned from rumination and avoidance to active coping via reframing, thought tracking, behavioural problem solving and self-care adjustments (sleep, environment). Increasing openness to emotional support and redefining success were central gains.

Participant 6: Eliza. Eliza, a 23-year-old postgraduate student with preexisting anxiety and medication use, presented with avoidance, self-blame and overwhelm exacerbated by pandemic uncertainty. She responded strongly to metacognitive strategies, reframing narratives, accountability and soothing tools. Self-care, routine building and gradual acceptance of social support reduced anxiety and avoidance, leading to improved confidence and task initiation.

Participant 7: Rosalind. Rosalind, a 20-year-old undergraduate with health issues and academic stress, initially relied on venting, disengagement and self-blame. Therapy focused on helping her set realistic goals, break tasks into manageable steps, become more aware of unhelpful thinking patterns and practise simple mindfulness exercises.

Overtime, she became more active and compassionate toward herself, improved task engagement and cautiously expanded support seeking. Humour and restraint coping began to emerge but remained developing skills.

Participant 8: Christine. Christine, a 20-year-old undergraduate sport science student, struggled with procrastination, perfectionism, and self-blame. Through accountability, task breakdown, mindfulness, self-compassion and Discrete Thought Tracking (DTT), she reframed success as progress rather than perfection. Social support awareness improved, though help seeking remained somewhat passive. Her coping became more proactive and balanced across academic and sporting contexts.

Participant 9: Mary. Mary, a 26-year-old postgraduate student and parent of a special needs child, faced extremely high stress from multiple life domains. Despite this, she demonstrated strong engagement and rapid uptake of strategies. She shifted from avoidance and self-blame to behavioural action, reframing, self-compassion and consistent self-care. She also applied support and boundary skills effectively during a friend's suicide crisis, reflecting strong integration of strategies into her coping repertoire.

Participant 10: Dorothy. Dorothy, a 41-year-old rural mother of three studying extramurally, entered with perfectionism, overcommitment and self-blame leading to procrastination. She embraced metacognition, acceptance, self-compassion and gratitude, with faith as a key coping resource. She improved self-care routines, communication and receptivity to support. Humour was challenging but acknowledged. Her progress reflected sustainable lifestyle level change.

Descriptive Analysis of General Therapeutic Elements

In order to summarize the intervention effects that were seen overall, I conducted a descriptive analysis of the combined records (Appendix B). This was carried out by assigning formal therapeutic labels to statements of participant changes and responsiveness to the intervention, in conjunction with a second reader, my research supervisor, Prof. Ian Evans to ensure reliability.

Five therapeutic elements were identified in this manner that were common to all cases. Because these elements were extracted from my case notes, they do, naturally, reflect the therapeutic activities that are in the different modules of the manual. However, they do not perfectly match the manual, which implies that once it was being applied to actual clients, additional elements were inevitably introduced.

The five core elements that can be seen across all participants are as follows:

1. As expected, all participants initially relied upon passive coping strategies, and these were identified and reframed in favour of behavioural activities and problem solving.
2. Therapy for every case involved helping participants identify irrational thought patterns and self-blame language, emotional triggers and explanation of the link between thoughts, behaviour and mood. One could summarize these as an emphasis on metacognition.
3. Less grounded explicitly in the manual, but introduced in therapy on account of these specific ten participants, were themes of encouraging self-compassion and reducing self-criticism. It was quite common for these participants to show patterns of perfectionism, cultural self-criticism (e.g., high family expectations, fear of disappointing others, and concern about bringing shame or “losing face”), guilt, and low self-esteem.

4. The case notes clearly reflected the benefit for these participants of a skills-based, structured approach, with assignments, role-play activities, journaling and translating session content into real life situations.
5. Finally, the case notes confirmed the importance placed in therapy sessions of both emotional and material social support and the importance of reframing help-seeking from being seen as a weakness to being valued as a resource.

In addition to shared therapeutic elements, several contextual and individual factors influenced intervention focus and delivery. The individual needs and personalities of the participant, meant that the focus, pacing, and emphases of my therapeutic interventions differed for different participants. Again, five themes were easily identified from the case notes:

1. The cultural context mattered in different ways. Kai Ling and Siew Ping both revealed culturally relevant tendencies towards humility, self-criticism and emotional restraint. In Dorothy's case, culturally relevant factors were more closely linked to her rural New Zealand lifestyle, strong faith and family-oriented values. Living on a rural farm involved high physical workload demands, strong expectations around "pushing through" difficulties and significant family responsibilities, all of which shaped her coping behaviours and attitudes toward stress. Her strong faith also appeared to play an important role in reliance on community and relational support during times of distress. Although these influences may be considered contextual rather than cultural in a traditional sense, they nevertheless contributed meaningfully to her values, coping style and help-seeking behaviour.
2. The participants obviously differed in terms of their life stage and the demands of the roles they had. Those who were students focused on procrastination, grades, and doubts about competence. The working professionals (Michael, Jacqueline) were more focused on emotional regulation and respecting boundaries, while those who were parents

(Dorothy, Mary) were concerned with time demands and the need to consider self-kindness.

3. The use of humour in therapy varied according to my understanding of their interpersonal style; it was used considerably with Michael and Kai Ling, much less so for Selina and Dorothy.
4. The general level of mental health complexity for each participants influenced the design of the intervention: Eliza and Mary entered therapy with high levels of complex anxiety and use of medication, whereas most of the others were dealing largely with situational stressors.
5. The component in the manual concerning self-care was applied differently for individual participants. For example, it was more oriented towards lifestyle for Dorothy, Eliza and Siew Ping; it was more cognitive for Michael and Jacqueline.

In summary, my participant session notes made it possible to confirm retrospectively that the basic elements of the manual were included in each case, with some topics really standing out as emphasis. At the same time, the intervention plans were individualized according to the unique characteristics of individual participants. This is most certainly the reality of real-life therapeutic interventions reported by clinicians, even when they are carefully following the procedures of a well-developed, empirically derived structured manualised intervention manual. These features of actual clinical practice in cognitive-behavioural therapy have been noted by a number of scholars over the years (Beck, 2021; Evans, 1996; Evans, 2026; Lazarus & Folkman,1987; Lazarus & Folkman,1984; Rosen & Davidson, 2003; Truijens et al., 2019; Wilson, 1997).

AI-Assisted Summarisation

Following manual descriptive case analysis, I used a large language model (LLM) based summarisation tool (Microsoft Copilot) to generate a consolidated narrative description of participant progress. Note that the output provided a high-level synthesis of patterns, coping transitions and generalised outcomes across participants. This output is treated as a descriptive summarisation aid and not as independent evidence of clinical effectiveness[1].

It is included to illustrate how LLM may compress descriptive clinical data into cumulative narrative form. Below are the results:

I asked: "Summarize the case studies and the overall benefits for the clients, using only the language and principles of the therapist who wrote these case progress notes."

Copilot's response:

"Across the ten participants, engagement with the 16-session intervention was consistently high, with all participants attending sessions reliably, completing weekly assignments, and demonstrating openness to reflecting on their coping patterns. Participants entered the programme with moderate to high perceived stress levels, typically characterized by passive coping responses such as venting, avoidance, self-blame, emotional suppression, procrastination, or over-reliance on internal coping. No participants presented with acute risk and, the intervention was well tolerated across diverse academic, occupational, cultural, and family contexts. These 10 cases provide convergent qualitative evidence that this therapy manual can produce meaningful, sustained improvement in stress-related functioning when delivered competently. Outcomes were consistent, theoretically coherent, and generalized across domains.

[1]. The use of Microsoft Copilot in this study was undertaken in accordance with published guidance on the responsible use of large language models (LLMs) in research from several major universities, including King's College London, Northeastern University, the University of Utah, Northwestern University, and the State University of New York at Binghamton. Consistent with these recommendations, Microsoft Copilot was used only as a supplementary analytical tool to support the exploration of qualitative data. All coding decisions, interpretation of findings, verification of AI-generated outputs, and the final analysis remained the responsibility of the researcher. AI-generated outputs were critically reviewed against the original diary entries, were not accepted without independent verification, and are reported transparently within this thesis.

While conclusions are limited by sample size and lack of controls, the findings justify continued use, further evaluation, and cautious confidence in the manual's clinical value." (Microsoft Copilot, May 12, 2026).

I then asked Copilot to: "Provide an overall descriptive perspective based on my case notes" Copilot's response: "Overall, participants demonstrated a clear trajectory of growth from reactive, stress-driven coping patterns toward more adaptive, intentional, and self-compassionate ways of managing stress. Increased self-awareness, emotional regulation, behavioural activation, and effective use of social support contributed to improved functioning and wellbeing. Despite ongoing stressors, participants reported feeling more capable, balanced, and resilient. Collectively, these cases illustrate the value of a structured, skills-based intervention in supporting individuals to strengthen coping resources, enhance self-regulation, and sustain long-term wellbeing across diverse personal and situational contexts". (Microsoft Copilot, May 12, 2026).

It is quite interesting that Copilot also provided cautionary statements when asked about the scientific strength of the findings, in the form of a question: "How confident can a clinician be that the therapy manual is effective?" The answer was that "a clinician could be moderately confident that the manual constitutes an effective, plausible, and clinically useful intervention for stress-related difficulties, with similar populations and contexts. This conclusion was based on consistent positive trajectories across all 10 clients, with no deterioration or dropout, and on convergent processes of change rather than idiosyncratic improvements, which aligned closely with the manual's theoretical targets." The caveats provided were sound: "However, confidence must be qualified. Based on 10 uncontrolled cases: you cannot claim efficacy in the strict research sense; you cannot isolate manual effects from therapist effects; and you cannot generalize broadly beyond the participating populations." (Microsoft Copilot, May 12, 2026).

The descriptive analyses presented here highlighted overall trends of improvement across participants, while also revealing the highly individualised and context-dependent nature of the therapeutic process. Although psychometric measures and structured intervention modules provided useful indications of change, retrospective review of the case notes indicated that participant progress was often shaped by moment-to-moment experiences, differing personal needs, and varying levels of readiness for specific therapeutic components. These observations raised important questions regarding flexibility in intervention delivery, the importance of beginning with participant strengths and immediate concerns, and the value of capturing coping processes as they occur in everyday life. Such reflections provided the rationale for the more reflective and process-oriented focus of Phase 2, which is explored in the following chapter.

Reflections on Phase 1 and Rationale for Phase 2

Quantitative data obtained from psychometric trends and descriptive case analyses presented in Chapters 4 and 5 provided useful indications of participant progress across the intervention period. Overall, the findings showed that the PRTM was associated with reductions in perceived stress and distress symptoms, alongside improvements in wellbeing, supporting its potential usefulness for addressing mild to moderate everyday stressors experienced in educational, occupational, family and social contexts.

However, retrospective review of the case notes highlighted that the lived therapeutic process was often much more complex and individualised than could be captured by standardised outcome graphs alone. Although the scores showed general patterns of change, they did not fully reflect moment-to-moment shifts, contextual influences, or the unique ways participants applied coping strategies in everyday life.

The case notes (see Appendix B) revealed considerable differences in participant presentation, responsiveness and therapeutic focus. Factors such as cultural background, life

stage, work demands, parenting responsibilities, pre-existing mental health difficulties as well as the broader context of the COVID-19 pandemic all appeared to influence how participants engaged with therapy and which intervention components became most meaningful for them. In practice, therapy rarely progressed in a perfectly linear way despite the structured nature of the manual. Instead, intervention delivery often required flexibility in timing, pacing, emphasis and therapeutic focus depending on individual participant needs.

These observations reflect broader limitations commonly noted in formal treatment outcome studies and manualised intervention research. Quantitative outcome measures may identify whether change occurred, but they often provide limited insight into how change developed, why particular strategies became meaningful for individual clients, or how contextual variables shaped therapeutic progress. Similarly, highly structured manual approaches may risk overlooking the dynamic and adaptive nature of real-world clinical practice, particularly when used by less experienced practitioners who may rely too rigidly on pre-determined sequencing rather than responding flexibly to client presentation. This issue aligns with Chorpita's modular approach to psychotherapy, which argues that interventions may be more effective when therapeutic components are flexibly selected and sequenced according to presenting needs rather than delivered in a fixed order (Chorpita et al., 2005).

Collectively, these reflections led directly to the development of Phase 2 of the current study. Specifically, the findings raised questions regarding whether interventions may be strengthened by beginning with participants' immediate needs rather than relying primarily on predetermined sequencing. Starting from client's personally immediate needs or area that they would like to focus on meaningfully may enhance empowerment, engagement, therapeutic alliance and the perceived relevance of intervention strategies.

A further consideration emerging from Phase 1 was that psychometric measures, while useful indicators of progress, provided limited insight into how coping, social support and self-care fluctuated within participants' daily lives. Consequently, Phase 2 incorporated daily diary entries to examine the *process* of change as it unfolded in real time in participants' everyday lives. Could such sampling of emotionally relevant thoughts and feelings provide deeper insight into the experiences underlying observed patterns of improvement?

CHAPTER SIX: PHASE 2 STUDY: QUANTITATIVE FINDINGS

Overview

Chapter 6 presents the second phase of the research process and provides a comprehensive analysis of the quantitative findings across the two participants selected for this phase. Building on the findings from Phase 1, this phase aimed to explore in greater depth the nature of how enhanced resilience emerges from applications of my manual. Rather than relying solely on aggregated outcome scores, Phase 2 examined changes across specific coping strategies, the pace of intervention delivery, and individual participant responses.

Informed by observations from Phase 1, a flexible and participant-centred intervention approach was adopted in Phase 2. Participants were given the opportunity to begin with the therapeutic strategy they perceived as most relevant to their immediate needs, rather than following a standardised sequence of modules. This approach was intended to explore whether different entry points into the intervention might influence engagement and therapeutic outcomes. For some participants, beginning with active coping strategies and small achievable tasks may increase self-awareness, engagement, and behavioural activation (selecting new activities that are reinforcing). Others may benefit more from earlier focus on emotional support, self-compassion, cognitive reframing, or strengthening social support systems before more structured behavioural work is introduced.

Phase 2 also sought to further examine coping processes as they occurred within participants' everyday lives through the incorporation of structured diary-based reflection and ongoing monitoring of experiences across the intervention period. This approach aimed to capture more dynamic fluctuations in stress, coping, social support utilization, and self-care practices that may not be fully reflected in psychometric self-ratings alone. Contemporary psychotherapy research increasingly emphasises the value of ecological and moment-to-moment

methods for understanding psychological functioning within naturalistic settings (Herron et al., 2018). Although technological approaches such as ecological momentary assessment (EMA), experience sampling methods (ESM) and smartphone-based monitoring have demonstrated value in capturing dynamic behavioural and emotional processes in real time (Verhagen et al., 2016), such technologies are not always practical or accessible within routine clinical settings. Importantly, a clinically accessible analogue already exists within psychotherapy practice: structured diary keeping and reflective journaling.

Diary-based methods have long been used within cognitive-behavioural therapies to monitor thoughts, emotions, behaviours, triggers, coping responses and patterns of change over time (Bartlett, 2012; Herron et al., 2018). Diary-based methods enable clinicians to gather concrete information, rich descriptions and explanations of everyday life in ways unavailable through other methods (Evans & Robinson, 1978; Keleher & Verrinder, 2003). Such approaches provide clinicians with richer insight into daily functioning while simultaneously increasing client self-awareness and metacognitive reflection (Herron et al., 2018). Accordingly, Phase 2 was designed to investigate both the value of allowing participants to begin with intervention components most relevant to their immediate needs, in addition to the utility of capturing coping processes as they unfolded in daily life through structured diary-based reflection and monitoring.

In this chapter, I outline the methodology employed in Phase 2, including the study design, ethical procedures, participant recruitment process, and data collection strategy. The psychometric measures utilised were identical to those used in Phase 1 and therefore are not described again in detail within this chapter. The chapter also briefly outlines the procedures followed with each participant and then presents those psychometric quantitative findings associated with the intervention and follow-up phases. Findings derived from these data for both participants are then discussed. Descriptive findings obtained from participant diaries, therapeutic observations and case analyses are presented separately in Chapter 7.

Second Evaluation of the Manual

Study Design

In Phase 2, I again used a single-case (n = 1) experimental design (SCED), applying an A-B design with follow-up series across two participants to evaluate changes over time associated with the intervention. Data from the self-report questionnaires were collected on a single occasion one week prior to treatment. This served as a comparison point for changes observed during the intervention phase, while follow-up phase examined the durability and maintenance of improvements post-intervention. For this phase, intervention was carried out over a shorter period of 4-weeks to examine whether it could produce meaningful therapeutic change within a more intensive and time-efficient format that may be more feasible in routine clinical practice. Although the intervention was delivered within a condensed timeframe, the content, sequence and therapeutic objectives of the manual were preserved. Each of the eight modules was delivered across two sessions per week, maintaining the integrity of the original treatment programme while increasing the intensity of delivery. The post-intervention follow-up assessment was conducted two weeks after the final intervention session. Across all phases, participants were assessed exclusively using repeated self-report measures to track changes in coping behaviours, psychological distress, and subjective wellbeing over time.

In Phase 2, participants received the intervention according to a non-standardised sequential modular structure. Participants were asked which module they would like to begin with after a brief description was provided. They were encouraged to start with a module which they perceived as most needed, rather than following a strictly predetermined sequence of modules. This is in keeping with the recommendations made by Chorpita et al. (2005) regarding modular treatment packages.

Measures: Formal

In Phase 2, the psychometric instruments used were identical to those in Phase 1 and

were administered in a similar manner, with the exception of the Brief-COPE and Perceived Stress Scale-14 (PSS-14).

An important methodological difference concerned the analysis of the Brief-COPE measure. In Phase 1, Brief-COPE scores were examined primarily as aggregated coping outcomes. Although this approach provided an overall indication of change across the intervention period, it was difficult to determine which specific coping components were responsible for observed improvements or declines. As multiple coping strategies were combined into broader overall scores, changes within individual coping components could potentially be masked by improvements or regressions occurring in other areas.

To address this limitation, in Phase 2, I examined Brief-COPE components at a more specific level. Baseline scores were obtained one week prior to the commencement of the intervention. Subsequent scores were then compared following completion of the intervention module corresponding to the specific coping domain being measured. For example, Active Coping (Active coping module) was measured using Brief-COPE items 2 and 7, Self-Blame (Passive coping module) using items 13 and 26, Acceptance (Self-care module) using items 20 and 24 and Use of Emotional Support (Social-Support module) using items 5 and 15. This approach allowed changes in specific coping strategies to be examined following the completion of the corresponding intervention module. Rather than relying solely on overall coping scores, it became possible to observe whether improvements occurred in the particular coping domain targeted by a given module. Consequently, the relationship between intervention content and participant outcomes could be evaluated more directly.

Although it remains possible that external factors and life events contributed to observed changes, analysing coping components separately provided a clearer indication of the specific areas in which participants appeared to improve. This approach enhanced the interpretability of the quantitative findings and allowed for a clearer understanding of how different components of

the intervention may have influenced coping behaviour over time.

A further modification concerned the administration of the PSS-14. In Phase 1, the PSS-14 was administered during participant screening and again at the post-intervention follow-up phase. In contrast, Phase 2 involved weekly administration of the PSS-14 throughout both the intervention and follow-up period. This enabled closer monitoring of fluctuations in perceived stress over time and provided a more detailed understanding of participants' responses to the intervention.

Ethics

Ethical approval was granted by the Massey University Human Ethics Committee: Massey University Ohu Matatika 1 (Application OM1 26/02). Following ethical approval, formal permission was obtained from the Chief Executive Officer (CEO) of a private hospital in Penang, Malaysia, to conduct participant recruitment on the premises. Recruitment was undertaken through the display of a study poster within the hospital, inviting interested individuals experiencing stress to participate in a PhD research study examining coping with stress and the enhancement of psychological resilience.

Phase 2 also provided an opportunity to examine the application of the intervention within a Malaysian cultural context. Whereas Phase 1 was conducted primarily with New Zealand participants, with some participants of Asian ethnicity, Phase 2 extended the evaluation to Malaysian participants, allowing consideration of the intervention's applicability across different cultural settings. This cross-cultural evaluation represents a particular strength of the research, extending the evaluation across culturally diverse populations.

Recruitment of Participants

Inclusion Criteria. Participants in the study were required to be 18 years old by January 2026, a Malaysian citizen, and an employee of the hospital either in a clinical or administrative capacity. Restricting recruitment to employed hospital staff ensured that participants were

experiencing ongoing occupational demands comparable to the work- or education-related stressors experienced by participants in Phase 1, thereby enhancing comparability between the two phases of the research programme.

Exclusion Criteria. Excluded from the study were individuals who reported having clinical diagnoses of schizophrenia, bipolar disorders, having strong suicidal ideations/intent, or were currently on any antipsychotic medications or in psychological treatment

This was a non-randomised intervention study where participants were recruited when inclusion and exclusion criteria were met. Interested participants were required to contact me via email to express their interest. I then provided further details about the study, including the participant information sheet and consent form.

Participants who met all inclusion criteria and achieved a Perceived Stress Scale-14 score above the cut-off of 28 were deemed eligible and included in the study. A total of two participants were recruited and agreed to participate under the study conditions. The participants in Phase 2 represented a Malaysian population and shared a broadly similar cultural background. However, they differed in their demographic characteristics, educational achievement, occupational roles and life experiences. These differences provided an opportunity to evaluate the intervention across varied life circumstances, occupational demands and stress presentations. The participants also varied in age, family responsibilities, work-related pressures and previous experiences of mental health challenges.

Participants received the intervention free of charge and were required to attend one-hour therapy sessions twice weekly over a four-week period. Participants were advised that they needed to complete mandatory daily journalling throughout the 4-week period, reflecting on how they coped daily. Both participants readily agreed to this requirement. Daily journalling is for many individuals a naturalistic and widely familiar activity, which makes it an easily understood and implemented process for gathering experience-sampling data in real time.

Differences in Intervention Administration from Phase 1

Several modifications were made to the intervention procedures in Phase 2. All intervention sessions were conducted at the Psychology Clinic of a local private hospital in Penang, Malaysia, where I am employed. Unlike the delivery formats used with some participants in Phase 1, all sessions in Phase 2 were exclusively administered via face-to-face contact sessions.

A shorter baseline period was adopted in Phase 2. Rather than collecting repeated baseline measurements, a single baseline assessment was conducted one week prior to commencement of the intervention. Questionnaires were subsequently administered following the completion of every two sessions, corresponding to the completion of a specific intervention module. This approach allowed for more frequent monitoring of participant progress and changes across the intervention period.

The intervention was delivered twice weekly over a four-week period, resulting in the completion of all eight intervention modules within a relatively condensed timeframe. This increased pace was intended to maintain participant engagement and to capture coping experiences and behavioural changes closer to the time they occurred.

A key modification in Phase 2 was the introduction of participant choice regarding the sequence of intervention modules. Rather than following a predetermined order, participants were invited to identify the therapeutic strategy that they considered most relevant to their immediate needs and were thus permitted to select the module with which they wished to begin. Following completion of each module, participants were given the opportunity to choose the next module they wished to undertake. This participant-centred approach was intended to enhance engagement, autonomy and the perceived relevance of the intervention.

Participants were asked to complete a brief diary entry each day throughout the four-week intervention period. They were encouraged to record significant events or stressors that

occurred during the day, their emotional reactions to these experiences, how they coped with them, and any reflections they considered important. Participants were informed that there were no right or wrong answers and were encouraged to write openly and honestly about their experiences and feelings. They were also assured that diary entries would remain confidential and would only be reviewed by me and my supervisors for the purposes of therapy and research analysis.

Diary entries were reviewed collaboratively during each therapy session, providing opportunities to discuss coping strategies, reinforce learning, clarify experiences and identify emerging patterns in participants' responses to stress. The diary process also served as a means of capturing participants' experiences in close proximity to everyday events, thereby reducing reliance on retrospective recall and providing a deeper understanding of how all therapeutic suggestions (practices, change recommendations, exercises, et cetera) were applied in real-life situations.

The two participants commenced the intervention one week apart. Both successfully completed all eight intervention modules within the four-week intervention period. Follow-up measures were collected two weeks after completion of the intervention to assess the maintenance of any changes observed during treatment

Supervision

Clinical responsibility, practice, and potential legal responsibility remained with my Malaysian hospital work supervisors. Research and procedural supervision meetings were conducted regularly with research and clinical supervisors Ian Evans, PhD and Kirsty Ross, PhD during the implementation of the intervention; this served to ensure that the study was conducted in an ethical, professional, and methodologically sound manner.

Supervision focused on participant safety, maintaining adherence to ethical standards, and adherence to the intervention protocol. In addition, supervision facilitated ongoing reflection on my dual role as researcher and therapist, helping to ensure that participant welfare remained the primary consideration throughout the intervention process. This regular supervisory support contributed to maintaining professional standards and enhancing the overall quality, credibility and integrity of the research.

My Therapeutic Style in Phase 2

My therapeutic approach in Phase 2 was broadly consistent with that utilised in Phase 1. As in the earlier phase of the study, I maintained a collaborative, supportive and culturally sensitive therapeutic style while adhering to the structure and content of the intervention manual. The key difference in Phase 2 was that participants were given greater autonomy in selecting the sequence of intervention modules according to their perceived needs and priorities. However, the content of each module continued to be delivered as outlined in the manual.

I also incorporated cognitive-behavioural therapy (CBT) principles and therapeutic techniques that were consistent with the aims of the intervention. Throughout the study, I adhered to established therapeutic guidelines and best-practice principles while remaining attentive to timing, cultural considerations and the development of a positive therapeutic relationship.

As a Malaysian clinician of South Asian descent, I am familiar with local cultural values, communication styles and social norms, which helped me remain sensitive to cultural issues throughout the intervention, particularly when working with participants who shared similar cultural backgrounds and values. Similar to Phase 1, I maintained a gentle, collaborative and supportive therapeutic style throughout the study. I encouraged participants to take small, manageable steps towards change and consistently acknowledged and reinforced their progress.

As in Phase 1, participants were informed that they were taking part in a study evaluating a resilience intervention but were not informed that the *Psychological Resilience Treatment Manual* (PRTM) had been developed and authored by me. This approach was maintained to reduce the potential for response bias.

I regularly reminded participants of the importance of maintaining their daily diaries and reviewed their entries during each session. These discussions provided opportunities to explore how participants had applied coping strategies within their daily home, family, social and work environments.

A key focus of my work was the development of metacognitive awareness. I encouraged participants to become more aware of self-critical and self-blaming thought patterns, recognise early signs of cognitive distortions and reflect on the effectiveness of their coping responses. Particular emphasis was placed on helping participants move from passive coping styles towards more active coping strategies.

I also prioritised emotional validation throughout the intervention. Participants' feelings, personal experiences and challenges were acknowledged and normalised, particularly when working with issues related to perfectionism, self-blame, help-seeking and the use of social support. I sought to create a safe and supportive therapeutic environment that encouraged self-compassion, engagement and openness to change.

Psychoeducation was integrated throughout the intervention using both the structured manual and CBT-informed concepts. Topics such as cognitive reframing, active and passive coping, self-care, social support, problem-solving and restraint coping were discussed using accessible language to maximise understanding and engagement.

Overall, my approach remained structured, collaborative, compassionate and culturally responsive, with a strong emphasis on empowering participants to strengthen adaptive ways of thinking, adopt healthy self-care behaviours, and draw on supportive relationships to build

resilience in everyday life.

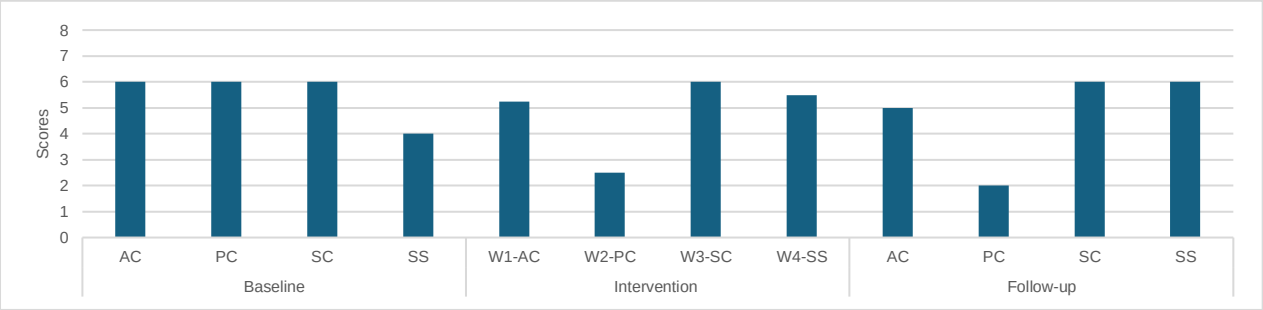
The next section provides a comprehensive analysis of the quantitative findings across the two participants selected for this phase. Consistent with the aims of Phase 2, the analyses examine changes in perceived stress, distress symptoms, wellbeing and coping behaviours across the baseline, intervention and follow-up periods. In addition to evaluating intervention outcomes, the findings are considered in relation to the participants' selected intervention pathways, providing insight into how different therapeutic strategies may contribute to resilience development. Together, these quantitative findings provide the foundation for the subsequent qualitative analyses, which explore participants' day-to-day experiences of the intervention and the processes through which change occurred.

Quantitative Data

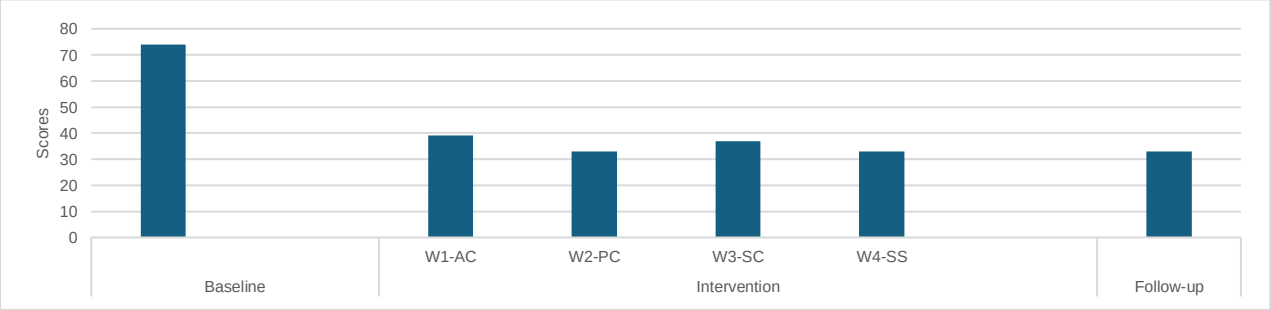
Participant 11-Lily

Figure 12

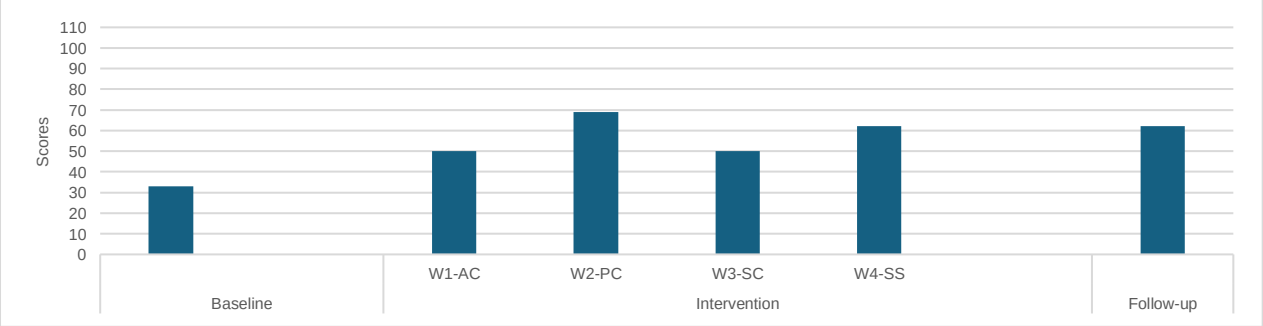
P11-Brief COPE



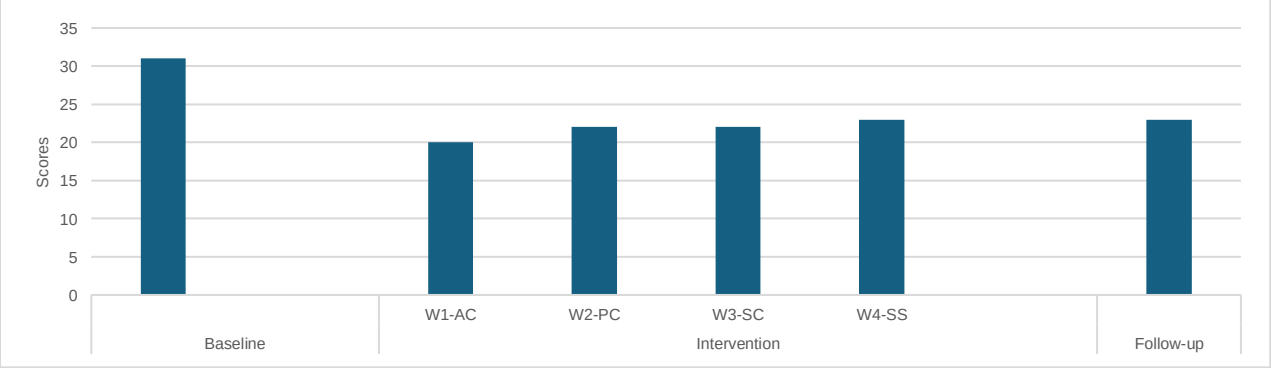
P11-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P11-General Wellbeing Schedule



P11-Total Perceived Stress Scores-14



Lily was a Malaysian healthcare worker of Indian descent in her thirties and a single parent raising two children. She entered the study with elevated perceived stress (PSS-14 = 31) while managing multiple family and occupational responsibilities following the death of her husband approximately 18 months earlier. Lily remained highly engaged throughout the intervention and chose to begin with the active coping module, followed by passive coping, self-care and social support.

Lily's Brief-COPE results indicated high levels of active coping at baseline, which declined slightly over time. However, despite selecting the active coping module as her starting point, active coping scores declined slightly during the intervention and follow-up phases. In contrast, passive coping scores were elevated at baseline but showed a progressive reduction throughout the intervention and follow-up phases. These findings was a positive shift toward more adaptive coping, characterised by reduced passive coping, increased support-seeking and the maintenance of healthy self-care practices.

Lily's HSCL-21 total distress score was high during the baseline phase. During the intervention phase, distress scores decreased following the active coping and passive coping modules. A slight increase was observed following completion of the self-care module (Intervention Week 3); however, distress levels reduced again following the social support module. At follow-up, a small increase in distress was evident. Overall, the psychometric data show a reduction in total distress across the study period, with improvements largely maintained at follow-up.

Lily's General Wellbeing Schedule scores indicated low psychological wellbeing at baseline but showed an overall improvement during the intervention. Psychological wellbeing increased following the Active Coping and Passive Coping modules, declined temporarily after the Self-Care module and increased again following the Social Support module. Although wellbeing decreased slightly at follow-up, it remained relatively high. Overall, the pattern

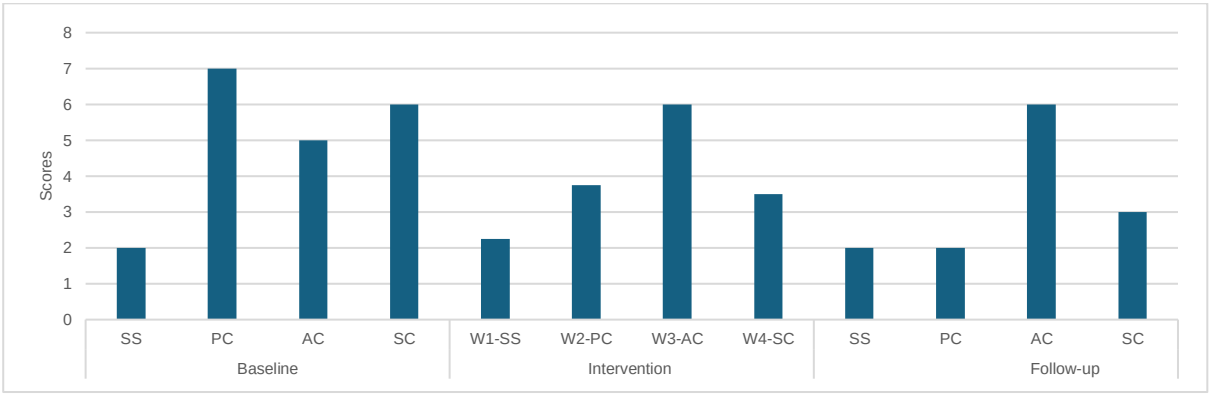
demonstrated an improvement in general wellbeing across the study phases despite some fluctuations during the intervention phase.

Similarly, Lily's PSS-14 scores indicated elevated perceived stress at baseline. Perceived stress decreased following the Active Coping module and remained relatively stable throughout the remainder of the intervention, with only minor fluctuations. At follow-up, stress levels remained considerably lower than baseline, indicating that reductions in perceived stress were largely maintained over time.

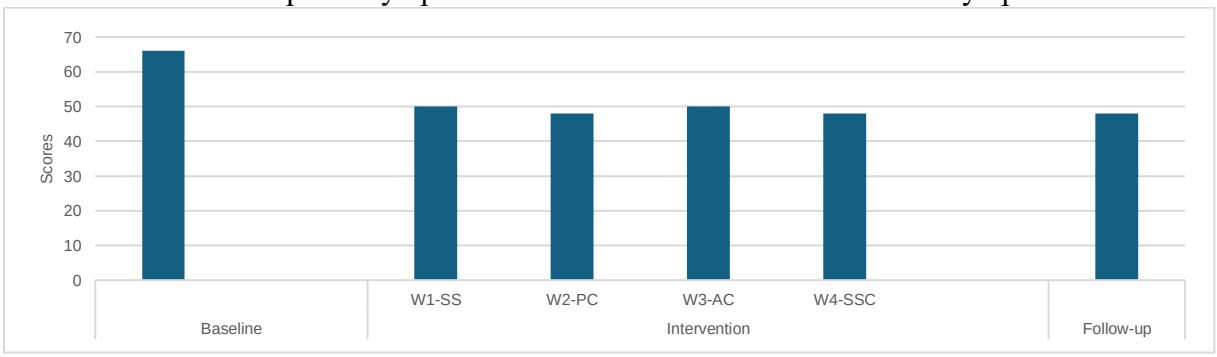
Participant 12-Jennifer

Figure 13

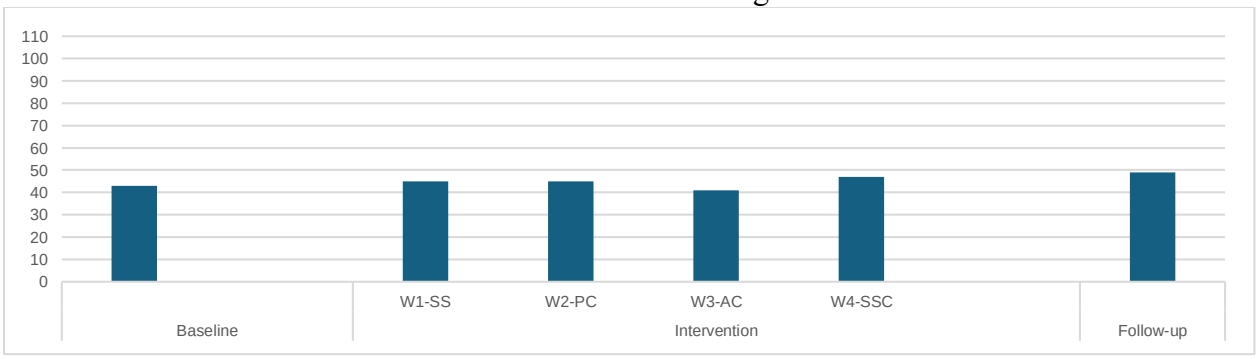
P12-Brief COPE



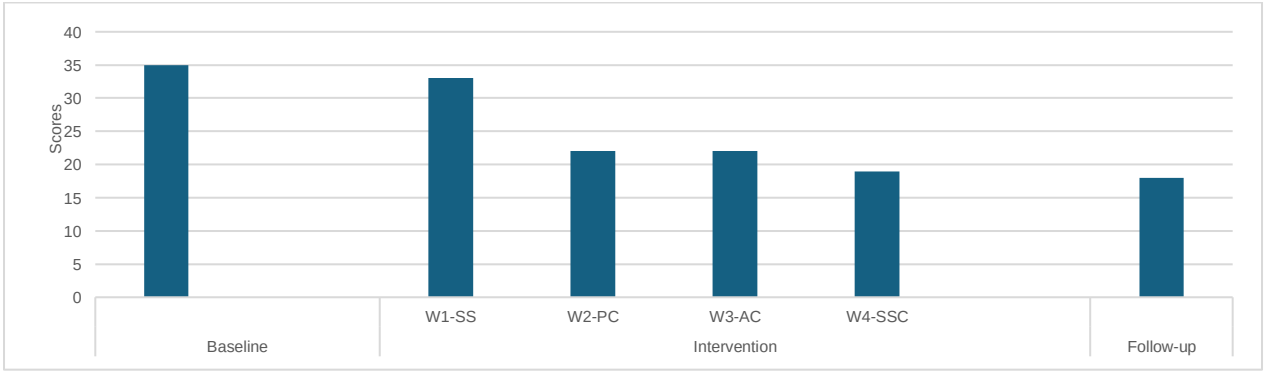
P12-Hopkins Symptoms Checklist-21-General Measure of Symptom Distress



P12-General Wellbeing Schedule



P12-Total Perceived Stress Scores-14



Jennifer was a 23-year-old Malaysian junior nurse who entered the study with elevated perceived stress and demonstrated high engagement, insight and willingness to apply the intervention strategies throughout the programme. She chose to begin with the social support module, followed by passive coping, active coping and self-care.

Jennifer's Brief COPE results indicated relatively low levels of social support seeking at baseline, with mild improvements observed during the intervention phase that were not maintained at follow-up. In contrast, passive coping was elevated at baseline but decreased substantially following the intervention and continued to decline during follow-up, showing s a sustained reduction in less adaptive coping behaviours. Active coping was already relatively high at baseline and increased further following the active coping module, with gains maintained at follow-up. Although self-care scores were initially high, they declined during the intervention phase and showed only a slight increase at follow-up. Overall, the intervention appeared most effective in reducing passive coping and strengthening active coping, while having limited impact on social support seeking and self-care behaviours.

Jennifer’s HSCL-21 scores indicated elevated levels of total distress during the baseline phase. Following the introduction of the intervention, distress levels decreased substantially and remained consistently low throughout the intervention and follow-up phases. Overall, the findings indicated that the intervention was associated with a marked and sustained reduction in psychological distress, with improvements occurring early and being maintained over time.

Jennifer’s General Wellbeing Schedule score was moderately low during the baseline phase prior to intervention. During the intervention phase, wellbeing scores increased slightly after the social support and passive coping modules. A brief decline was observed following the active coping module; however, wellbeing subsequently improved following the self-care module. At follow-up, Jennifer’s wellbeing score increased further. Overall, the pattern demonstrated only a mild improvement in general wellbeing across the study phases despite

some fluctuations during the intervention phase.

Jennifer's PSS-14 scores indicated elevated perceived stress at baseline. Following the introduction of the intervention, perceived stress decreased progressively throughout the intervention and follow-up phases, with the greatest reduction occurring after the passive coping module. Overall, the findings indicate a substantial and sustained reduction in perceived stress over the course of the study.

Quantitative Findings from Participants 11 and 12- Different Pathways to Resilience Development

Taken together, the self-report psychometric data showed that both participants benefited from the intervention, particularly through reductions in passive coping, total distress and perceived stress. However, the pathways through which these improvements occurred differed substantially. Participant 11's (Lily) improvements were more closely associated with increased utilisation of social support, sustained self-care practices, and reduced passive coping behaviours. In contrast, Participant 12's (Jennifer) progress was characterised by strengthening active coping strategies while simultaneously reducing passive coping behaviours.

These findings are consistent with one of the key observations emerging from Phase 1, namely that participants often demonstrated different patterns of response to the intervention despite receiving the same core content. Consequently, Phase 2 was designed not only to evaluate intervention outcomes but also to explore whether participants might benefit from different components of the programme depending on their individual circumstances, strengths and coping needs. To facilitate this investigation, participants were permitted to select the intervention module they perceived to be most relevant at the outset of treatment rather than following a predetermined sequence.

The experiences of Lily and Jennifer support the value of this participant-centred approach. Although both participants achieved broadly similar outcomes in terms of reduced passive coping, distress and perceived stress, the mechanisms through which these improvements occurred appeared to differ. These findings show that there is more than one way to build resilience and that participants will potentially benefit from different intervention components depending on their individual needs.

Importantly, the psychometric measures provided evidence that change had occurred but offered limited insight into how those changes developed. The inclusion of daily diary methodology was therefore intended to complement the quantitative findings by capturing participants' ongoing experiences, application of skills and responses to everyday stressors. This process-oriented approach allowed for examination of the mechanisms underlying change and provided a deeper understanding of how participants integrated resilience skills into their daily lives.

Accordingly, the primary contribution of Phase 2 was not simply the replication of beneficial outcomes observed in Phase 1, but the identification of different mechanisms through which participants achieved those outcomes. The findings highlight the importance of individualising intervention delivery and indicate that allowing participants to begin with therapeutic strategies most relevant to their immediate concerns may enhance engagement and facilitate therapeutic progress.

Chapter 7 therefore turns to the qualitative diary findings, which provide a more detailed examination of the processes through which resilience skills were developed, practised and incorporated into participants' everyday lives. Through these analyses, it becomes possible to better understand not only whether change occurred, but how and why different participants followed distinct pathways towards similar therapeutic outcomes.

CHAPTER SEVEN: PHASE 2 STUDY: QUALITATIVE (DAILY DIARY) FINDINGS

Overview

In this chapter, I present the qualitative findings obtained from Phase 2 of the study. While Chapter 6 focused on quantitative changes observed across psychometric measurements and coping components, this chapter explores the participants' experiences of the intervention as reflected in their daily diary entries collected over approximately 30 days and across eight intervention sessions.

The primary source of data for this chapter consists of the diary entries completed by Participants 11 (see Appendix D) and 12 (see Appendix E). These entries were analysed using qualitative content analysis. The analysis followed a systematic process whereby diary entries were examined and organised into meaning units, condensed meaning units, codes, categories and themes (Erlingsson & Brysiewicz, 2017). This approach enabled me to identify recurring patterns and experiences within the participants' accounts while remaining grounded in the participants' own descriptions of their experiences.

The qualitative findings presented in this chapter complement the quantitative findings reported in Chapter 6. While psychometric measures provide valuable information regarding changes in distress, wellbeing, perceived stress and coping behaviours, diary entries offer insight into how these changes were experienced in participants' everyday lives. Examining both forms of data allows for an in depth understanding of the therapeutic process and the mechanisms through which change may have occurred.

As the sole researcher conducting this study, I completed the content analysis independently. In qualitative research, it is common for coding and thematic development to be reviewed by additional researchers to enhance reliability and validity. As an independent coder was not available for this study, I employed a Large Language Model (Microsoft Copilot), as a

supplementary analytic tool to provide an additional layer of interpretive exploration. The purpose of this process was not to replace the primary content analysis but rather to examine whether similar or additional themes, patterns and observations could be identified from the same source material.

All prompts provided to Microsoft Copilot, together with the resulting outputs, are documented and reported within this chapter to ensure methodological transparency. The findings generated by Copilot are presented as a secondary interpretive layer and are considered alongside the themes developed through the formal content analysis. Areas of convergence and divergence between the two approaches are discussed where relevant.

Prior to submission to Copilot, all identifying information was removed, including names, workplaces, locations and other personal details that could directly identify participants. Although these diary entries inevitably contained contextual information relating to participants' life circumstances, occupations, relationships, cultural backgrounds and significant events, such information may have allowed Copilot to interpret certain characteristics of the participants and their experiences based on the information they had provided.

Accordingly, this chapter presents a two-layered qualitative examination of participant experiences. The first layer consists of a systematic content analysis of participant diary entries, while the second layer explores supplementary interpretations generated through Microsoft Copilot. Together, these analyses provide a deeper understanding of the participants lived experiences and offer additional context for interpreting the quantitative findings presented in Chapter 6.

Content Analysis of Diary Entries

Content analysis was used to examine participants' daily diary entries and identify recurring patterns, meanings, categories and themes within their experiences. The analysis followed the procedures described by Erlingsson and Brysiewicz (2017), involving familiarisation with the data, identification of meaning units, coding, categorisation and the development of broader themes.

In the present study, the diary entries completed by Participants 11 and 12 throughout the intervention period were analysed to explore how they experienced the intervention in their everyday lives, including changes in perceived stress, coping behaviours (active and passive), use of social support, engagement in self-care activities, emotional responses and behavioural changes over time. The qualitative findings complemented the quantitative outcomes presented in Chapter 6 by providing a deeper understanding of participants' experiences.

As the sole researcher, I completed the analysis independently. Although content analysis relies on researcher interpretation, my familiarity with the participants' cultural backgrounds and therapeutic contexts assisted in interpreting the meanings embedded within their diary narratives.

Following the framework proposed by Erlingsson and Brysiewicz (2017), the analysis progressed through the stages of Diary Entry → Meaning Unit → Condensation → Code → Category → Theme. Meaning units were first identified within each diary entry and subsequently condensed while preserving their essential meaning. The condensed meaning units were then assigned codes (e.g., labels), with similar codes grouped into categories representing shared concepts and experiences. Finally, broader themes were developed to capture the underlying patterns and meanings reflected across participants' diary narratives.

The findings are presented separately for Participant 11 (Lily) and Participant 12 (Jennifer) to maintain the individuality of their experiences and to enable comparison with the quantitative findings reported in Chapter 6. Each participant completed eight diary submissions

corresponding to the eight intervention sessions. To enhance readability and reduce repetition within the main body of the thesis, content analysis tables for Sessions 1 and 2 are presented in this chapter as samples while the remaining analyses are provided in the appendices (see Appendices D and E).

The text excerpts selected as meaning units are presented in bold and italics to distinguish them from the subsequent stages of analysis.

Participant 11: Lily's diary entries

Session 1- Active Coping

"Work was exhausting today. Too many outpatients and walk-in cases. I am still learning how to work as a receptionist at my department. On this particular day, I had to do something that is new for me as /I have not learned it before. So, I turned to my friend who works beside me to ask some advice from her ***but she glared at me and gave me a cold shoulder. When I saw what she did, my temperature and stress level started to rise because I did not disturb her purposely but to merely ask some advice. For a moment I thought that I could show face back to her but then I took a deep breath and look back at the situation. I saw that my friend was talking on the phone probably to some annoying patient who is asking to much question. At that moment I understood why my friend glared at me to avoid delaying my work or getting myself upset, I told myself that I could ask someone else to help me. I went to my manager and asked her help, informing about the situation that we are facing at the front counter. My manager was glad to offer a hand and I manage to do my work.*** What I applied —>Active coping strategy:

During this situation, I applied the active coping and tried not to stress too much.
My son came down with flu and running nose last night and was having difficulty sleeping due to nose block. I used a nose spray to clear the block in his nose while my mother-in-law was holding him. When I came home after work today, ***my mother-in-law told me that the medicine (nose spray) that I used in the morning is not suitable for kids as she was told by a pharmacist. This instantly made me think that I did something wrong even though deep down I know I did what is right. I went to my room and started to think why my mil told me that and I realise she was only thinking of the best for my son. I went back to her and explained that the medicine that I used was actually given to him at the hospital when he was admitted***. She understood what I said and I explain that we can use the medicine that she bought because the ingredients are same. I learned from my sessions with Dr.S that sometimes is best for us to think why the other person said or do that. I learned that thinking from another perspective is always good.

My daughter always shows tantrum every morning when I wake her up. Today, she did the same and I was not in the mood to get myself agitated. So what I did was, I woke her up as usual and when she started to act up, I just left the room. My daughter felt something wasn't right so she got up quietly and when to take her shower".

Session 2

"Today was a very hectic day. There were a lot of outpatient and inpatient walk-ins today. I almost lost my cool and patience few times today. ***The most significant or event that really pissed me off is when one of this patient came to me to change appointment. She wanted to change for the whole month and I got so stress because the computer system suddenly malfunction. I took a minute for myself, took a deep breath, I told the patient to have a seat and explained to her that it is going to take some time since the system malfunction.*** I was glad that the patient did not ask anything further and took a seat. I was glad after 10 min I manage to book her appointment and she left gladly. I told my friends what happened and they made fun of me as I manage to handle that particular patient who is actually very fussy.
My family is to attend a wedding tomorrow and I particularly told my daughter to bring everything that she needs for the wedding tomorrow from my in-laws place. As usual, she left her shoes back home and she innocently told me about it. I did not yell at her as I usually would do but I told her nicely that next time I would like her to obey whatever I told her. So, that night, I had to drive back to my in-laws house to get her shoes.

I told my daughter to sweep the house so that I can start mopping the house. She said 'No' directly to me. I really got angry and I scolded her. A few moments later l spoke to her softly and I explained why I told her to help me. She agreed to sweep half-heartedly and I managed to get my household chores done.

Today was a very hectic day. As usual, too many patients. My hands was full with a lot of work and ***I noticed that my partner is not in for work yet. She came in late 5 minutes and did not even apologize or explained why she was late. This is not the first time she had done this. I was unhappy and I confronted her nicely, quietly when there was no patient. She explained that she was in the toilet and lost track of time. I told her frankly that this was not the first time she did that. Then, she apologize to me. I told her to inform me if she is going to be late so that I can explain to anyone who asks"***

Table 1: Content Analysis for Participant 11-Lily

Meaning Unit	Condensation	Code	Category	Themes
Session 1 Friend glared at her when she asked for help at work; she reflected on the situation and sought assistance from her manager instead.	Reflected before reacting and sought alternative help.	Cognitive reframing; problem-solving, and help-seeking.	Adaptive workplace coping	Developing active coping skills
Mother-in-law criticised the medication used for her son; participant considered another perspective and explained calmly	Consideration of other person's intentions before responding.	Cognitive reframing; Perspective taking;	Cognitive reframing	Developing active coping skills
Daughter showed tantrums; participant walked away instead of becoming agitated.	Avoided conflict	Problem-solving	Managing emotional reactions	Developing active coping skills
Session 2 Patient appointment issue and computer malfunction increased stress; participant paused, breathed deeply and explained situation calmly.	Used breathing and communication to manage stress.	Self-care	Stress management	Developing active coping skills and self-care techniques
Confronted colleague about repeated lateness respectfully and privately.	Addressed problem directly and calmly.	Social skills-Assertive communication	Problem-solving skills	Developing active coping skills and social skills
Session 3 A student who asks a lot of questions which left her feeling exhausted. She used the active coping strategy and used self-care techniques to reduce frustrations	Addressed problem calmly.	Social skills-Assertive communication	Problem-solving skills	Developing active coping skills and social skills
Planned ahead for son's therapy appointment anticipating possible difficulties.	Prepared in advance for expected challenges.	Problem-solving	Active coping	Developing active coping skills and self-care techniques
Managed	Used coping skills	Self-care	Stress management	Developing active

overwhelming workload by calming herself and prioritising tasks.	during work pressure.			coping skills and self-care techniques
Session 4 Bought washing machine for mother and experienced relief and satisfaction.	Felt fulfilled through helping family.	Social skills; gratitude	Positive emotional experiences	Increase of social support skills (Strengthening interpersonal relationships)
Explained family plans to daughter and negotiated expectations calmly.	Communicated openly and managed expectations.	Social skills-Calm communication	Positive emotional experiences	Increase of social support skills (Strengthening interpersonal relationships)
Session 5 Asked colleagues for help rather than continuing to vent internally.	Sought practical assistance from others.	Social support seeking	Social and workplace support	Increase of social support skills
Enjoyed dinner with friends and shared problems and solutions.	Felt relieved through sharing experiences.	Social support seeking	Social connectedness	Increase of social support skills
Session 6 Spent quality time walking with son and reported feeling relaxed.	Engaged in enjoyable activity with child.	Social support-Quality family time	Self-care and wellbeing	Developing self-care techniques and increase of social support skills
Session 7 Used STOP technique during busy workday and prioritised urgent tasks.	Applied learned strategy to manage demands.	Self-care-STOP technique	Problem-solving skills	Developing active coping skills and self-care techniques
Used STOP technique during son's meltdown and remained calm. Appreciated her neighbours who came to provide support her in calming her son.	Regulated emotions during parenting challenge.	Social support	Managing emotional reactions	Developing active coping skills and increase of appreciation of social support skills.
Session 8 Reflected on personal growth and ability to ask for help.	Recognised positive personal changes.	Self-care; Self-awareness	Personal growth	Increase of social support skills
Expressed gratitude for daughter's support and son's progress.	Appreciated support and positive outcomes.	Social skills; gratitude	Positive appraisal	Increase of social support skills (Strengthening interpersonal relationships)

Summary of Content Analysis Findings for Participant 11-Lily

The content analysis of Participant 11's, Lily's diary entries was undertaken to summarise the intervention effects observed across the eight intervention sessions. Content analysis of the diary entries identified four interrelated themes that reflected Lily's experiences and responses to the intervention.

The four core themes that emerged are as follows:

1. **Development of active coping skills.** Throughout the intervention, Lily increasingly demonstrated the use of active coping strategies at workplace, with parenting and family-related stressors. Rather than responding through avoidance and rumination (which are more characteristic of passive coping behaviours), she reported reflecting on situations, considering alternative perspectives, engaging in problem-solving and communicating calmly with others. These experiences indicate increasing cognitive reframing in managing challenges through active coping approaches.
2. **Development of self-care techniques.** As the intervention progressed, Lily increasingly incorporated self-care practices into her daily life. She utilised breathing exercises, planning strategies, self-calming techniques and the STOP technique to manage stress and emotional demands. She also reported engaging in activities that promoted relaxation and wellbeing, such as spending quality time with her son and prioritising tasks during periods of high workload. These findings show greater awareness of her emotional needs and increased ability to manage stress.
3. **Increased utilisation of social support.** Across the intervention, an increase in Lily's willingness to seek and accept support from others was observed. Initially, she appeared to rely mostly on her own coping resources; however, later sessions reflected greater help-seeking behaviours from colleagues, friends, family members and neighbours. Helpful experiences associated with sharing concerns, requesting assistance and

accepting support appeared to strengthen her perception of available resources and reduce feelings of isolation and shame.

4. **Strengthening of interpersonal relationships.** The diary entries also reflected improvements in Lily's interpersonal functioning. She described communicating more openly with family members, negotiating expectations calmly with her daughter, expressing gratitude towards her mother and appreciating positive developments within family relationships; particularly with her children. These experiences indicate improved communication skills and stronger social skills and connectedness.

In addition to these themes, the diary records demonstrated considerable overlap between the intervention modules. Active coping skills frequently occurred alongside self-care practices and social support utilisation, suggesting that these components were mutually reinforcing rather than operating independently. For example, Lily often managed stress with support seeking behaviours and self-care techniques.

By the final session, Lily demonstrated increased self-awareness regarding her personal growth and recognised meaningful improvements in her ability to cope with stress, express gratitude, seek support when needed and maintain improved relationships. Overall, the diary findings show that the intervention contributed to enhanced psychological resilience through the development of active coping strategies, increased self-care practices, stronger engagement with social support networks and improved interpersonal functioning.

AI-Assisted Summarisation

To explore whether similar patterns would emerge using a large language model (LLM) based approach, the diary materials were also analysed using Microsoft Copilot. The findings from this supplementary analysis are presented below. All prompts and outputs generated through Microsoft Copilot are reported to ensure transparency. The prompt was intentionally structured around the four intervention modules of the *Psychological Resilience Treatment Manual* (PRTM): active coping, passive coping, self-care and social support, to determine whether Microsoft Copilot would independently identify changes in these domains based solely on the participant's diary entries.

I asked: “Summarise the diary entries of Participant 11 and explore how the participant experienced the intervention in her everyday life. Consider any changes in perceived stress, coping behaviours (active and passive), utilisation of social support, engagement in self-care activities, and behavioural changes over time. Base the summary solely on the content of the diary entries and use language and interpretations that are grounded in the participant's own descriptions and experiences based on these diary entries.”

Copilot’s response:

“Participant 11’s diary entries show a clear and progressive shift in how she experiences and manages stress in everyday life. Across sessions, she describes becoming more reflective, intentional, and calm in handling work demands, parenting challenges, and interpersonal situations. She frequently links these changes to what she ‘learned with Dr. S’ and describes herself as ‘changing bit by bit’ and becoming “more mature” in how she manages situations.”

Analysis of the Themes From the Copilot-Generated Summaries.

1.**Perceived Stress and Emotional Experience.** "At the outset, stress is described as frequent and situational, especially in work and parenting contexts: Work is 'exhausting,' "very hectic," and overwhelming with many patients and tasks. She experiences moments where her 'temperature and stress level started to rise' or she "almost lost cool and patience". Parenting situations also trigger stress, frustration, and embarrassment (e.g., dealing with children's tantrums or incidents in public). Over time, there is a noticeable shift, she increasingly describes feeling calm, in control, and less reactive (e.g., "I was not worked up like I usually do," "very calm day"). She begins to express positive emotional states, such as feeling "happy," "grateful," "relieved," and "pleased" after handling situations effectively. By the final sessions, stress is still present (e.g., busy days, children's behaviour), but she experiences it as manageable rather than overwhelming."

2. **Coping Behaviours.** "Active coping-dominant and increasing: Active coping is evident from early entries and becomes more consistent and refined, pausing and regulating emotions, taking deep breaths, stepping away briefly, or giving herself 'a minute' before responding. Perspective-taking: trying to understand others' behaviour (e.g., colleague on the phone, mother-in-law's concern). Problem-solving: seeking help from her manager, planning ahead for appointments, prioritising urgent tasks. Communication and assertiveness: addressing issues calmly (e.g., confronting a colleague about lateness, explaining situations to her children). Use of specific techniques such as S.T.O.P to manage reactions in stressful moments. She explicitly recognises applying these strategies (e.g., 'I applied the active coping strategy,' "I used the S.T.O.P technique")."

"Passive coping (reduced over time): Passive responses appear less dominant but still present in earlier or transitional entries. Initial tendencies toward anger, blaming, or internal frustration (e.g., snapping at others, venting to herself), feelings of self-doubt or negative self-

evaluation (“I felt like a useless mother”). However, these are increasingly followed by active correction, where she reflects on her reactions (“I shouldn’t have blamed…”), reframes the situation and continues calmly. This indicates a shift from passive to more adaptive, active coping patterns.”

3. **Utilisation of Social Support.** “Participant 11 progressively engages more with social support:

Early and Mid-Stages: Seeks practical support at work (e.g., asking manager for help). Begins to communicate more openly with family members (e.g., explaining situations to her daughter, discussing with mother-in-law).

Later Stages: Actively values and uses emotional support. Sharing experiences with friends, which helped her feel ‘good, relieved, and relaxed’ and led to “solutions to the problems”. Recognising the importance of teamwork (“we are a team”). Receives and acknowledges support from others; family members (daughter helping with son, neighbours cheering her child). Also provides support to others, especially her children, by applying learned strategies to calm and guide them. By the end, she explicitly states she is ‘able to ask for help’ and values shared coping.”

4. **Engagement in Self-Care.** “Self-care becomes more explicit and integrated over time: Early Phase: Limited direct mention of self-care, though she begins to regulate stress through small actions (e.g., breathing, stepping away).

Middle Phase: Introduction of structured self-reflection (identifying obstacles and solutions). Efforts to reduce stress through cognitive reframing and pacing work.

Later Phase: More consistent engagement in restorative and enjoyable activities; walking with her son; socialising with friends. Recognition of physical and emotional benefits: Feeling energetic after good sleep and activity; Experiencing calmer, smoother days after rest. Attention to gratitude and positive experiences, which she describes explicitly. Self-care is not framed as

separate from daily life but becomes embedded within routines and relationships."

5. **Behavioural Changes Over Time.** "Several clear behavioural changes emerge: Emotional and Cognitive Behaviour; from reactive and easily agitated to reflective and composed. Increased ability to pause, reframe, and respond thoughtfully. Interpersonal Behaviour; from occasional confrontation or frustration to calm communication and problem-solving. Improved parenting approach; explaining rather than scolding; adapting to children's emotional needs and more collaborative and assertive at work. Task Management and Daily Functioning; more organised and proactive (planning ahead, prioritising tasks); better ability to handle busy environments without feeling overwhelmed. Overall Self-Perception; shift toward seeing herself as capable and improving; 'I am surprised and glad that I can see changes in me' and feeling more mature and effective in managing situations."

Overall Interpretation

"Participant 11 experienced the intervention as practical and immediately applicable to daily life. She consistently integrates learned techniques into real situations at work and at home. Over time, she describes:

- Reduced intensity of stress and greater emotional stability
- A shift from reactive or self-critical responses to intentional, active coping
- Increased use of social support and collaborative problem-solving
- Greater engagement in self-care through rest, activity, and positive reflection

Her narrative reflects a gradual but consistent transformation, where she not only manages stress more effectively but also applies these skills to support others, particularly her children." (Microsoft Copilot, May 31, 2026).

Participant 12: Jennifer's diary entries

Session 1- Social Support

"I'm at work, nothing big matters happened, but i had tried to socialise with my colleagues, smiled, laughed, share the works, everyone asked me why you're so happy, I just answered like ahh? really?, and ***I have accompanied one of my malay colleague for her sahur, I mean it's a new experience for me and glad I tried to mingle up with people, I guess something Is better than nothing right!!! I've been to work, smiling through all to my colleagues, this time I started conversation first instead of waiting for them to talk with me. I guess it's a good change".***

Session 2

" I've been to work (night shift), with one of my Malay seniors, all went well.
The same night shift @ 04:00 am we need to update census and look forward to cancelling staff due to low census***. I've called my sister (manager) and she talked with me like normal at first but then she started to shout due to poor connection, I couldn't hear her properly. She said "every time I want to talk with you and each time also you mentioning couldn't hear you properly, go and wash your ears and then come and listen, ba bla bla". But I managed to end the conversation nicely, I had tried to think "Alright, She have two little kids, she needs to cook early morning, making breakfast, prepare them to school". I had tried but I felt still I'm hurt, and I couldn't take it in a positive way.***

I've come to my boyfriend's home and talked with my bf through all the things out. I've been trying too hard to understand him about the smoke thing and I've opened up all the things that matters to me. He had listened until the end and he said "I'll try to change myself a little by little".
I'm glad that at least he listened to me when no one could but I'm still scared to trust him.
I've been to work, it was my double shift, but ***I've been experiencing this Gastritis symptoms more to vomiting and everything. Try hard myself to work until 10:40 am that morning, end up seeing Medical Office (MO) at A&E and they give MC (medical certificate) with IV medications. My colleagues doesn't like I took MC and I've asked sorry to everyone and left the room.***

Clock in to work, everyone asked me how are you feeling right now? I said I'm fine and reassured everyone that I can work today. ***Seems like everything went good. WHY Im SCROLLING REELS? - To feel accompanied - to avoid something deeper felt.. - Highly engaging platform".***

Table 2: Content Analysis for Participant 12-Jennifer

Meaning Unit	Condensation	Code	Category	Themes
Session 1 Socialised with colleagues, smiled, laughed, shared work and joined a colleague for "sahur" (breaking fast during Ramadan month) despite usually being reserved.	Communicated openly and made effort to engage socially with colleagues.	Social skills	Social connectedness	Increasing social support skills
Initiated conversations with colleagues instead of waiting for them to approach her.	Took initiative in social interactions.	Social skills	Social connectedness	Increasing social support skills
Session 2 Senior nurse Manager became angry during a phone conversation; participant tried to understand her circumstances before reacting.	Considered Senior Manager's perspective despite feeling hurt.	Cognitive reframing; Perspective taking	Active coping; Cognitive reframing	Developing active coping skills
Openly discussed concerns about smoking with boyfriend and expressed personal needs.	Communicated concerns.	Social skills-Assertive communication	Active coping; Problem-solving skills	Developing active coping skills and social skills; strengthening interpersonal relationships
Experienced gastritis symptoms but sought medical treatment when unable to continue working	Prioritised health needs.	Self-care	Physical self-care	Developing self-care techniques
Reflected on scrolling behaviour and recognised it was used to avoid deeper feelings.	Increased awareness of avoidance behaviour.	Cognitive reframing; Self-monitoring	Active coping; Metacognitive awareness	Developing active coping skills
Session 3 Reduced scrolling and completed household responsibilities before returning to social media**.**	Improved control over scrolling habits.	Cognitive reframing	Reducing avoidance behaviours	Developing active coping skills
Enjoyed working	Experienced	Social skills-	Social	Increasing social

with supportive colleagues during a busy shift.	positive workplace interactions.	Workplace connectedness	connectedness	support skills
Session 4 Reframed senior colleague's criticism and reflected on self-blame before returning to work	Challenged self-critical thoughts.	Cognitive reframing-metacognitive	Problem-solving skills	Developing active coping skills
Managed anxiety about boyfriend not replying by pausing, drinking water and considering his perspective	Used coping strategies to manage overthinking.	Cognitive reframing-metacognitive Self-care	Problem-solving skills	Developing active coping and self-care skills
Encouraged unwell colleague to seek treatment and completed additional tasks to help her.	Provided practical and emotional support.	Social-support; and Emotional support	Social and workplace support	Increasing social support skills
Reduced scrolling and became more productive with daily tasks.	Increased productive behaviour.	Cognitive reframing	Individual utility	Developing active coping skills
Reconnected with family members and communicated with father without holding onto anger.	Improved family communication.	Social-support; Emotional support	Social support; Family relationships	Increasing social skills; strengthening interpersonal relationships
Listened to sister's concerns and provided support.	Offered emotional support.	Social-support; Emotional support	Social support; Family support	Increasing social support skills
Session 5 Reflected on relationship expectations and allowed boyfriend greater social freedom	Developed balanced perspective.	Cognitive reframing	Social support; Relationship adjustment	Developing active coping skills
Occupied herself with shopping and household tasks instead of focusing on loneliness.	Used activities to manage emotions.	Problem-solving	Individual utility	Developing active coping skills and self-care techniques
Recognised fewer relationship conflicts after changing her thinking style.	Linked positive thinking with improved relationship outcomes.	Cognitive reframing	Social support; Relationship improvement	Strengthening interpersonal relationships
Session 6 Managed disappointment when boyfriend declined a visit and considered his	Reframed rejection	Cognitive Reframing; Perspective taking	Relationship improvement	Developing active coping skills

perspective.				
Expressed gratitude for a peaceful work shift.	Appreciated positive experiences.	Cognitive Reframing; Gratitude	Active Coping; Positive appraisal	Developing self-care techniques
Session 7 Modified eating habits by making healthier food choices.	Implemented healthier lifestyle behaviours.	Healthy lifestyle changes	Self-care	Developing self-care techniques
Socialised with friends, remained engaged in conversations and avoided phone use.	Increased social participation.	Social skills; Social involvement	Social connectedness	Increasing social support skills
Reflected on walking as a form of exercise despite fatigue.	Recognised everyday physical activity.	Self-awareness	Self-care	Developing self-care techniques
Session 8 Paused during an argument with boyfriend, reflected and communicated concerns calmly.	Used coping skills during interpersonal conflict.	Cognitive Reframing	Conflict management	Developing active coping skills and strengthening interpersonal relationships
Attended gym and swimming activities.	Engaged in health-promoting activities.	Self-care	Physical self-care	Developing self-care techniques
Used portion control when eating with friends.	Applied healthier eating strategies.	Self-care	Health behaviour management	Developing self-care techniques
Reflected on becoming more social and spending less time on her phone.	Recognised positive personal changes.	Self-awareness	Personal growth	Developing active coping skills and increasing social support skills

Summary of Content Analysis Findings for Participant 12-Jennifer

The content analysis of Jennifer's diary entries across the eight intervention sessions revealed similar four interrelated themes that reflected her experiences and responses to the intervention: developing active coping skills, developing self-care techniques, increasing social support skills and strengthening interpersonal relationships. The four core themes that emerged are as follows:

1. **Developing Active Coping Skills**. Throughout the intervention, Jennifer demonstrated increasing use of active coping strategies when managing workplace stressors, relationship concerns and familial challenges. Rather than relying solely on avoidance behaviours, excessive social media scrolling, self-blame, or overthinking, she increasingly engaged in cognitive reframing, perspective taking, problem-solving and metacognitive reflection. She applied cognitive reframing to interpret others' behaviour, challenging self-critical thoughts and utilise coping techniques to reduce distress in stressful situations. These experiences show increasing use of cognitive reframing and problem-focused coping when responding to difficulties.

2. **Developing Self-Care Techniques**. Evidence of self-care development emerged throughout the intervention. Jennifer demonstrated greater awareness of her physical and emotional wellbeing by seeking medical treatment when unwell, reducing excessive scrolling, engaging in productive daily activities and engaging in healthier lifestyle habits. In later sessions, she reported making healthier food choices, attending gym and swimming sessions, monitoring her physical activity levels, and expressing gratitude for positive experiences. These changes reveal increasing awareness of the importance of self-care in maintaining both physical and psychological wellbeing.

3. **Increasing Utilisation of Social Support.** Across the intervention, an increase in Jennifer's willingness to seek, provide and engage in social support was observed. Early diary entries reflected efforts to socialise more actively with colleagues and initiate conversations

rather than remaining passive in social situations. This finding is important, as Jennifer chose the Social Support module as her entry point into the intervention. As the intervention progressed, she reported opening up to her boyfriend regarding relationship concerns, reconnecting with family members, supporting colleagues and her sister during difficult situations, and spending more time engaging with friends. These experiences appeared to strengthen her sense of belonging and social connectedness, while also increasing skills in both seeking and providing support.

4. **Strengthening Interpersonal Relationships**. The diary entries also reflected improvements in Jennifer's interpersonal functioning. She described communicating more openly with her boyfriend regarding relationship concerns, managing disagreements more effectively, demonstrating greater understanding of others' perspectives in workplace relationships and friendships and reconnecting with family members whom she had previously avoided. These experiences show improved communication skills and stronger interpersonal connectedness.

In addition to these themes, the diary records also demonstrated considerable overlap between the intervention modules. Active coping skills frequently occurred alongside self-care practices and social support utilisation, suggesting that these components were mutually reinforcing rather than operating independently. For example, Jennifer often used cognitive reframing to manage distress while simultaneously engaging in healthier behaviours, seeking support from others, or improving her interpersonal communication.

By the final session, Jennifer demonstrated increased self-awareness regarding her personal growth and recognised meaningful improvements in her ability to manage stress. She also reported spending less time on her phone, engaging more socially, and practicing healthier lifestyle. Overall, the diary records indicate that the intervention contributed to enhanced psychological resilience through the development of active coping strategies, increased self-care

practices, stronger engagement with social support networks, and improved interpersonal functioning.

AI-Assisted Summarisation

As with Lily, I also examined Jennifer's diary materials using a large language model (LLM)-based summarisation tool (Microsoft Copilot) as a supplementary interpretive tool. The same prompt structure was used. Below are the results:

I asked: "Summarise the diary entries of Participant 12 and explore how the participant experienced the intervention in her everyday life. Consider any changes in perceived stress, coping behaviours (active and passive), utilisation of social support, engagement in self-care activities, and behavioural changes over time. Base the summary solely on the content of the diary entries and use language and interpretations that are grounded in the participant's own descriptions and experiences based on these diary entries."

Copilot's response: "Overview of Participant 12's Experience Across Sessions: Participant 12's diary entries describe a gradual shift from emotional reactivity, self-doubt, and passive coping towards increased self-awareness, active coping, and more intentional behaviour in daily life. Her reflections are grounded in everyday experiences at work, in relationships, and in personal routines".

1. **Perceived Stress and Emotional Experience.** "At the beginning, stress appears situational and interpersonal, particularly in work and close relationships: She described feeling hurt and unable to reframe experiences positively, especially after conflict with her sister and critical comments from Physical stress responses were also present (e.g., gastritis, vomiting, exhaustion). Over time, there is a shift toward: Greater emotional regulation, where she still feels hurt or irritated but is able to pause, reflect, and manage reactions (e.g., 'felt my chest so heavy… paused… counted numbers… handled the situation in a calmer way'). Increased ability to reframe others' behaviour, such as considering her sister's stress or her boyfriend's workload.

By later sessions, stress is still present but described as more manageable and less overwhelming, with moments of gratitude (‘grateful for this peaceful night’) and acceptance”.

2. **Coping Behaviours**. “Passive Coping (Early to Mid Phase): Initially, the participant relied on more passive or avoidance-based strategies: scrolling social media to ‘feel accompanied’ and avoid deeper; overthinking and rumination, especially in relationships (‘started to overthink… he don’t care about me anymore’) and self-blame, particularly in response to workplace criticism. These behaviours gradually reduce over time.”

“Active Coping (Increasing Across Sessions): The intervention appears to support a shift to more active strategies. Metacognitive techniques: pausing, questioning thoughts, reframing (‘I took 5 min to think through… the metacognitive exercise helped me’); emotional regulation strategies: pausing, breathing, counting, drinking water, behavioural activation: completing chores, maintaining routines, grocery shopping, engaging in tasks instead of scrolling, and problem-solving and assertiveness: raising concerns (e.g., consent error at work), expressing feelings to her boyfriend. By later sessions, she explicitly identifies that she is “adjusting [her] behaviour in a good way” and thinking more positively.”

3. **Social Support and Interpersonal Behaviour**. “Early Stage-there is hesitation and sensitivity to others’ reactions, especially at work and within family. She seeks support primarily from her boyfriend but reports difficulty trusting him fully.

Development Over Time- Increased active engagement with others, such as initiating conversations at work and socialising with colleagues, more open communication (e.g., expressing concerns to her boyfriend, listening to her sister). Greater ability to both seek and provide support, she relied on her boyfriend for emotional support. She provided emotional support to colleagues (encouraging a sick colleague to seek care) and family (listening to her sister). Later Stage; she describes herself as ‘more socialising with my friends’ and she uses social situations more intentionally (e.g., not using her phone, engaging more directly).”

4. **Engagement in Self-Care.** “Self-care emerges gradually and somewhat inconsistently: Early Phase; limited explicit self-care; focus is more on coping with stressors. Physical health issues (gastritis) highlight neglected wellbeing.

Middle Phase; increased attention to rest, routines, and productivity (sleeping, chores, limiting scrolling), recognition that reducing screen time improves productivity (‘more productive… rather than before’). Later Phase- she attempts at dietary changes (portion control, switching to lighter foods), physical activity introduced (gym and swimming). However, self-care is inconsistent due to fatigue, work demands, and social contexts (e.g., overeating with friends, unable to exercise when tired). Overall, self-care becomes more intentional but remains influenced by situational constraints.”

5. **Behavioural Changes Over Time**. “Clear behavioural shifts are evident:

Social Behaviour: From reserved and reactive to more proactive and engaged; initiating conversations, participating in group activities, and reducing phone use in social settings.

Cognitive and Emotional Behaviour: from self-blame and overthinking to reflective thinking and reframing and adoption of metacognitive strategies to manage thoughts and emotions

Daily Habits: Reduced excessive scrolling and increased time spent on tasks and rest; more structured routines (chores, sleep, work preparation).

Relationship Behaviour: From dependency and reassurance-seeking to greater autonomy and understanding and allowing space in relationships and reducing conflict.”

Overall Interpretation

“Across the diary entries, Participant 12 experienced the intervention as practically applicable in daily life, particularly in helping her pause and reflect instead of reacting impulsively; reframe interpersonal situations and gradually replace avoidance (scrolling, overthinking) with more constructive behaviours. Her experiences propose a progressive shift toward emotional regulation, active coping, and social engagement, even though challenges (fatigue, interpersonal

sensitivity, inconsistent self-care) remain. The changes are described in her own terms as ‘good change,’ ‘more productive’, and ‘slowly achieving’, indicating a sense of gradual but meaningful personal development.” (Microsoft Copilot, May 31, 2026).

Implications

The findings presented in Chapter 7 provided valuable insights into how Phase 2 participants experienced the intervention and how resilience developed through different pathways in everyday life. While the quantitative findings demonstrated improvements in perceived stress, wellbeing, and coping, the qualitative findings revealed the processes through which these changes occurred and highlighted the importance of individual differences in resilience development. Taken together, the findings from both phases of the research informed a broader understanding of the PRTM, its underlying mechanisms, and its potential applications. The final chapter draws these findings together and considers their implications for resilience theory, clinical practice, and future research.

CHAPTER EIGHT: GENERAL DISCUSSION AND CONCLUSION

Overview of the Research Programme and the Key Findings

After an extensive review of the resilience literature, I found the closest of the many resilience models to my own clinical experience was one proposed by de Terte and Stephens (2014). The model suggests there are three broad domains of psychological functioning that are valuable in the face of adversity: adaptive cognitive coping, adaptive health and self-care behaviours, and access to supportive social environments. These domains encompass sources of influence in individuals' lives that contribute significantly to psychological wellbeing and resilient outcomes when stressed. Based on this framework, I utilised these three domains to structure an intervention programme designed to reinforce cognitive coping skills, promote adaptive behavioural practices, and improve social support resources.

I recognized that there were large differences in the needs of those individuals experiencing highly traumatic catastrophic circumstances and those facing everyday stresses in pressured situations and occupations. I therefore conducted a focused literature review of research focused on the latter group. This helped me operationalised the three domains by specifying relevant therapeutic exercises, activities, and intervention strategies that participants could apply in their daily lives.

To influence participants who were experiencing relatively mild daily stress and to enhance their resilience, I identified what might be called therapeutic targets such as rational thinking, emotion regulation, health-supporting activities and social connections. I then incorporated several well-established CBT principles of change to help client achieve them. These CBT techniques included cognitive restructuring, self-monitoring, metacognitive awareness, behavioural activation, problem-solving training, relaxation training, goal setting,

psychoeducation and relapse prevention. It should be noted that in most CBT practice manuals treatment goals and processes of change are usually intermingled.

The three domains helped establish a balanced grouping of intervention strategies. Within adaptive coping, participants were encouraged to identify and challenge unhelpful thinking patterns such as self-blame, catastrophising, and avoidance, while developing more balanced and adaptive appraisals of stressful situations. Self-monitoring techniques, including Discrete Thought Tracking (DTT), were used to increase awareness of the relationship between thoughts, emotions and behaviours and to facilitate metacognitive awareness. Within health and self-care, behavioural strategies focused on increasing involvement in self-care activities, useful routines and goal-directed actions that increased wellbeing and resilience. Relaxation and mindfulness-based exercises were incorporated to reduce physiological stress responses. Within the domain of supportive social environments, participants were encouraged to utilise social support networks. Staying true to CBT principles, social support-seeking behaviours were conceptualised as behavioural responses to stress that decreases avoidance. Through guided reflections and communication skills practice, participants identified supportive individuals, challenged behaviours that might prevent help-seeking and developed strategies for accessing structural, functional, emotional and cognitive or informational social support when required.

Problem-solving and restraint coping techniques were also introduced to encourage reflective responses to stress rather than avoidant reactions. Relapse prevention principles were integrated throughout the intervention to support the maintenance of coping skills and resilience beyond intervention period. Psychoeducation was fused throughout all modules of the intervention. Participants were taught about the psychology of stress, passive and active coping styles, self-care behaviours and the buffering role of social support.

This cluster of topics is commonly included in clinical applications of any complex CBT intervention plan. Such components are intended to increase self-awareness, normalise stress responses and improve participant's view in their ability to manage stress effectively.

I then organised these procedures into a structured 16-session intervention therapy sessions. To facilitate consistent delivery that could be used by other therapists, the intervention was developed into a treatment manual comprising a series of sequential modules. The resulting manual was later professionally published as the *Psychological Resilience Treatment Manual* (Chettiar & de Terte, 2022). As can be seen, such a manual has multiple elements of both focus and intervention (treatment) strategy, as is now common with any of the evidence-based treatment programmes in CBT, which not only have different modes of treatment but are also typically arranged as a series of modules.

My next activity involved evaluating the manual with ten participants who met the study inclusion criteria and were considered likely to benefit from an intervention focused on psychological resilience. The original plan was to deliver the intervention individually in a face-to-face format. However, the COVID-19 pandemic interfered with both delivery method and research procedures. Consequently, while some participants were seen in person, others completed the intervention through online sessions. Despite these adaptations, the intervention content and therapeutic procedures remained consistent across delivery formats.

To evaluate the effectiveness of delivering the intervention according to the sequence of modules presented in the manual, I administered a range of psychometric measures relevant to the constructs of the original model. These measures were administered at multiple time points, including a pre-treatment baseline, throughout the 16-session intervention and at two follow-up assessments following treatment termination.

The data from this series of individual case studies were then summarised and evaluated. While the overall results indicated that the intervention produced desirable results for all ten participants, data also revealed that individual participants responded to the intervention in different ways. These variations suggested that the key mechanisms underlying resilience development were more complex than anticipated. While the original model provided a useful framework for organising the intervention, the model did not identify the likely interactions between the three domains as well as the effect of the therapeutic relationship and other well-known non-specific influences on participants living complex lives.

These observations prompted me to look beyond outcome measures alone and consider process issues: how resilience was developing throughout the intervention process. This became an important motivation for the second phase of the research, which sought to examine participants' lived experiences and the means through which change occurred. This was achieved by recruiting two new participants who were asked to maintain a daily diary in which to record their feelings, their activities, thoughts and life events throughout intervention period. These diary entries provided an important source of information regarding how participants experienced the intervention, applied resilience strategies in their daily lives and adapted to ongoing stressors over time.

The diary data were subsequently analysed in detail using content analysis. This revealed how participants tracked different pathways towards reaching similar outcomes, specifically reduced stress, improved coping with daily stress and improved psychological resilience. Although both participants showed constructive changes, the mechanisms through which these changes occurred differed according to their individual circumstances, coping styles and use of intervention strategies. These findings emphasized the dynamic and individualised nature of resilience development and suggested that multiple pathways may lead to similar resilience outcomes. These findings also highlighted the value of incorporating structured daily diaries into

the intervention. Lambert and colleagues (Lambert & Shimokawa, 2011; Lambert et al., 2018; Miller et al., 2005) pioneered the routine use of brief, standardised self-report measures throughout therapy to monitor client progress and identify individuals who were not responding to treatment.

I used a similar strategy to obtain indices of change in relevant self-report questionnaires in Phase 1. More recently, technological advances have facilitated the use of Ecological Momentary Assessment (EMA) to capture intensive real-time data on clients' daily experiences and behaviours (Mink et al., 2025). However, EMA seems more valuable as a research tool than for routine, evidence-based, clinical practice. As shown by Lily and Jennifer, diary keeping, on the other hand, provides a mid-point between these two approaches, affording a CBT therapist rich information regarding both compliance with therapy-derived strategies and actual situations in which they were needed and when successful, provide evidence of general progress, as well as insight into the client's subjective experiences.

Strengths and Limitations of the Research

Like all clinical research, the present investigation has both strengths and limitations that should be considered when interpreting the findings. Although the small number of participants may limit the generalisability of the findings, the study was not designed to produce statistically generalisable conclusions. Instead, it adopted an idiographic cognitive behavioural approach that sought to provide a detailed understanding of resilience development and the processes through which therapeutic change occurred in individual participants. Across both phases of the research, participants represented the type of individuals for whom the Psychological Resilience Treatment Manual (PRTM) was developed: adults experiencing the cumulative effects of everyday occupational and life stress rather than major traumatic events. Furthermore, participants varied in ethnicity, cultural background and geographical locations, providing the

opportunity to examine the intervention across a range of real-world contexts. These characteristics strengthen the ecological validity of the findings while remaining consistent with the personalised nature of contemporary CBT.

A further strength of the research lies in its idiographic methodology. Cognitive behavioural therapy has traditionally recognised the importance of understanding individual patterns of change through detailed case formulation rather than relying exclusively on group averages. The use of repeated psychometric measures throughout Phase One, combined with the detailed daily diary methodology employed in Phase Two, provided complementary sources of evidence regarding both therapeutic outcomes and the processes through which change occurred. While quantitative measures demonstrated improvements in stress, wellbeing and resilience, the qualitative diary data offered valuable insight into how participants integrated intervention strategies into their everyday lives. This combination enabled the research to move beyond the question of whether the intervention appeared effective and to examine how resilience developed over time.

A further methodological consideration concerns the condensed four-week delivery schedule adopted in Phase Two. Although the intervention was delivered over a shorter period, the content, sequence and therapeutic objectives of the manual were preserved. The more intensive format may have enhanced participant engagement by reducing the interval between sessions and allowing participants to apply newly acquired coping strategies while therapeutic material remained salient. It may also have strengthened the relationship between therapy sessions and the daily diary recordings by enabling participants to document coping experiences and behavioural changes closer to the time they occurred. Conversely, the condensed timeframe may have provided less opportunity for participants to consolidate newly acquired skills between sessions or for behavioural changes to emerge more gradually. As the present study was not designed to compare different intervention schedules, it is not possible to determine whether the

intensity of delivery influenced therapeutic outcomes. Future research should therefore compare the original and condensed delivery formats to examine their relative effects on participant engagement, resilience development and the maintenance of therapeutic gains over time.

The study was not designed as a randomised controlled trial and consequently direct comparisons with other resilience interventions or treatment manuals cannot be made. Similarly, because participants received the intervention within an ongoing therapeutic relationship, it is not possible to determine the relative contribution of specific intervention components, non-specific therapeutic factors, therapist characteristics, or spontaneous improvement over time. However, the primary purpose of this research was not to isolate individual treatment effects in the manner of a medical trial. Rather, the objective was to understand resilience as a complex psychological process and to explore how the integrated components of the PRTM functioned together to facilitate resilience development. From this perspective, the study provides evidence regarding therapeutic processes that may not be readily captured through highly controlled experimental designs.

It should also be recognised that the intervention incorporated cognitive behavioural strategies that have individually been supported by a substantial body of previous research. Cognitive restructuring, behavioural activation, problem-solving, psychoeducation, self-monitoring, relaxation and social support interventions have each demonstrated effectiveness across a wide range of clinical populations. The present study therefore did not seek to establish the efficacy of these individual techniques in isolation. Instead, its contribution lies in examining how these established components could be integrated into a comprehensible resilience intervention and how different individuals engaged with the intervention as a whole.

Another consideration relates to the role of the therapist. Throughout this research, I served as both therapist and researcher. Although this dual role enabled detailed observation of participants' progress and facilitated detailed qualitative analysis, it also raises questions

regarding therapist effects and the influence of my own clinical style on treatment outcomes. It remains unclear to what extent similar outcomes would be achieved by therapists with different levels of experience, different therapeutic styles, or different cultural backgrounds. Future research should therefore examine the implementation of the PRTM by multiple therapists across a broader range of clinical settings to better understand the contribution of therapist factors to resilience development.

Despite these limitations, the research provides a valuable foundation for future investigation. Rather than proposing a fixed protocol that operates independently of the therapist or client, the findings suggest that resilience interventions are likely to be most effective when delivered flexibly within a collaborative therapeutic relationship and adapted to individual strengths, preferences and life circumstances. This has important implications for the continued refinement of the PRTM. The long-term goal is to develop a manual that retains its cognitive behavioural foundations while remaining sufficiently practical and accessible for dissemination beyond specialist psychological services.

Implications for Clinical Practice and the Value of Treatment Manuals

The findings of this research have several important implications for clinical practice and the development of resilience interventions. Collectively, the two phases of the research demonstrated that resilience can be strengthened through a structured cognitive behavioural intervention while highlighting the importance of maintaining flexibility in how the intervention is delivered. Although the PRTM was developed as a sequential 16-session intervention, the findings suggest that treatment manuals should be viewed as flexible clinical frameworks rather than rigid protocols. Their value lies not in prescribing a fixed sequence of intervention techniques but in providing an evidence-based framework that allows therapists to adapt the

pacing, emphasis and sequencing of intervention components according to individual clients' needs, strengths and circumstances.

One of the most important clinical observations to emerge from this research was that participants entered therapy with different coping resources, life experiences, learning styles and preferred ways of responding to stress. While some participants responded well to structured problem-solving, behavioural activation and goal-directed strategies, others benefited more from emotional reflection and increased self-awareness. These observations suggest that resilience interventions are most effective when therapists remain responsive to individual differences rather than assuming that all clients benefit from the same sequence or emphasis of intervention components. The PRTM therefore provides both a structured framework and sufficient flexibility to allow therapists to tailor intervention according to the client's presentation while remaining grounded within cognitive behavioural principles.

The study also highlights the importance of collaborative treatment planning. Although the PRTM provides a recommended sequence of intervention modules, I found that both the order and emphasis of these components should remain responsive to individual client needs and circumstances. Across Phase One, participants demonstrated different patterns and rates of therapeutic improvement despite receiving the same intervention: resilience did not develop through a single uniform pathway. Phase Two extended these observations, since participants appeared to engage more fully when intervention strategies built upon their existing strengths, reflected their personal priorities and addressed issues that were meaningful within their everyday lives. The diary data provided examples of enhanced engagement by clients when they identified therapeutic priorities and selected personally meaningful outcomes.

Rather than viewing treatment manuals as prescriptive programmes or clients as passive recipients of treatment, the findings support a collaborative approach in which therapists and clients work together to tailor intervention within an evidence-based framework. This approach

is consistent with the principle of collaborative empiricism (Tee & Kazantzis, 2011) that underpins contemporary cognitive behavioural therapy and reinforces the importance of adapting treatment to the individual rather than expecting individuals to adapt to the treatment.

Another important implication concerns the role of treatment manuals themselves. Manuals are sometimes criticised for encouraging overly standardised therapy. However, the findings from the present research suggest that manuals can instead provide a valuable clinical framework that supports consistency while allowing considerable professional judgement in their implementation. The PRTM was designed to integrate established cognitive behavioural strategies into a comprehensible resilience intervention. These components need not be delivered with equal emphasis for every client. Rather, therapists should be encouraged to consider which components are most relevant to each individual while maintaining the overall therapeutic objectives of enhancing adaptive coping, self-care and supportive social environments (Chorpita et al., 2020; Chorpita & Daleiden, 2013).

Another important implication concerns the evaluation of therapeutic change. Throughout this research, repeated psychometric measures provided a practical and systematic method of monitoring changes in perceived stress, wellbeing, coping and resilience across pretreatment, intervention and follow-up periods. Routine outcome monitoring is increasingly recognised within cognitive behavioural therapy as valuable methods for informing clinical decision-making, evaluating treatment progress and identifying when intervention strategies require modification. Within the present research, repeated measurement enabled changes to be monitored objectively while supporting collaborative discussions regarding participants' progress throughout therapy.

However, quantitative measures alone could not fully explain how resilience developed. The daily diary methodology employed during Phase Two provided an additional level of clinically meaningful information by capturing participants' experiences within the context of

their everyday lives. The diary entries illustrated how intervention strategies were applied outside therapy sessions, how participants interpreted stressful experiences and how resilience developed through enduring behavioural adaptation and interpersonal interactions. Thanks to recent advances in Large Language Models (AI), we now also have a convenient way of summarizing detailed written narratives from clients, as themes, consistencies and novel elements can be quickly accessed by clinicians and researchers when only veridical information direct from clients is inputted. Together, the integration of quantitative and qualitative methods produced a more detailed understanding of resilience development than either approach could provide independently.

Overall, the findings suggest that effective resilience interventions require a balance between evidence-based structure and clinical flexibility. Treatment manuals such as the PRTM should not be viewed as fixed protocols but as practical clinical frameworks that support therapists in delivering interventions that are both systematic and responsive to individual needs. By combining structured cognitive behavioural principles with collaborative treatment planning, routine outcome monitoring and process-oriented qualitative evaluation, resilience interventions can be adapted to clients' unique strengths and life circumstances while maintaining fidelity to evidence-based practice.

Implications for the Topic of Resilience and Where the Manual Can Be Applied

The findings of the present research provide further support for resilience as a dynamic and multifaceted process that develops through the interaction of cognitive, behavioural and social influences, rather than as a static psychological construct. At the outset of this research, the resilience model proposed by de Terte and Stephens (2014) provided the conceptual framework for developing the Psychological Resilience Treatment Manual (PRTM). The model proposed that resilience is strengthened through the interaction of three broad domains: adaptive

cognitive coping, adaptive health and self-care behaviours and supportive social environments. The findings from both phases of the present research suggest that these domains remain highly relevant and provide a useful framework for understanding how resilience develops in response to the challenges of everyday life.

However, this research also suggests that resilience cannot be understood solely as the presence of these three domains. Rather, resilience appears to emerge through the dynamic interaction of cognitive, behavioural, interpersonal and contextual processes, with different individuals drawing upon these resources in different ways. While all participants received the same intervention, they differed in the ways they engaged with therapeutic strategies and in the pathways through which resilience developed. Consequently, resilience should be viewed less as a single outcome or set of skills and more as an adaptive process that is influenced by individual strengths, life circumstances, therapeutic experiences and available social resources. These findings suggest that resilience is better understood as an adaptive process that emerges through the interaction of individual strengths, life experiences, interpersonal relationships and contextual influences, rather than simply the acquisition of a fixed set of coping skills. Consequently, the three domains proposed by de Terte and Stephens remain central to resilience development, but their influence appears to vary according to the individual's circumstances, preferences and way of engaging with change.

A further implication concerns the contexts in which resilience interventions are most needed. Much of the resilience literature has focused on catastrophic events, military settings, natural disasters and severe early childhood trauma. While these remain important areas of application, the investigation supports the perspective that the cumulative effects of occupational demands, family responsibilities, interpersonal difficulties and the everyday challenges of modern life represent an equally important focus for resilience training. For many individuals, resilience is required not in response to a single traumatic event but in managing the ongoing

pressures of daily living. This broader conceptualisation has implications for prevention and early intervention by promoting resilience before more significant psychological difficulties emerge.

The findings provide pointers for the future application of the PRTM. Although the manual was originally developed for adults experiencing occupational and everyday stress, its underlying cognitive behavioural principles have potential application across a broad range of settings, including healthcare, education, workplace wellbeing programmes and community mental health services. Because the intervention focuses on fundamental psychological processes rather than diagnosis-specific techniques, it offers a flexible framework that can be adapted to different populations while maintaining its theoretical foundations. In keeping with contemporary developments in personalised and process-based approaches to CBT, the PRTM is intended to serve as a structured guide rather than a rigid protocol, allowing therapists and other trained practitioners to tailor intervention to the needs of individuals and the contexts in which they work.

Reflecting on this research programme has also influenced my own understanding of resilience. At the beginning of this thesis, I viewed resilience primarily as a collection of psychological resources that could be strengthened through a structured intervention. While I continue to believe this is true, I now see resilience as a highly individual process that develops through multiple pathways. Effective resilience interventions are therefore not simply about teaching coping skills, but about recognising people's existing strengths, understanding the contexts in which they live and helping them integrate evidence-based strategies into their own ways of responding to life's challenges. From this perspective, resilience is not something that therapists create, but something they facilitate by helping individuals recognise, strengthen and sustain the resources they already possess.

Implications for the Future of Cognitive Behavioural Therapy in Professional Practice

The present research has broader implications for the future dissemination of cognitive behavioural therapy beyond specialist psychological services. Throughout the development of the Psychological Resilience Treatment Manual (PRTM), the primary aim was not simply to produce another CBT manual, but to develop a practical, evidence-informed intervention that could be adapted to the diverse needs of individuals experiencing everyday stress. As this research progressed, it became increasingly apparent that resilience interventions need not be restricted to delivery by highly specialised clinicians.

This perspective was reinforced during the 7th Sarawak Mental Health Conference, July 2026 where Dr. Abdul Kadir bin Abdul Bakar, in his keynote address Bridge to Healing: Connecting Minds, Hearts and Care Across Generations, described community-based initiatives in Sarawak, Nepal, Afghanistan, Africa and other regions that equipped village leaders, midwives, family members and other trusted community members with practical psychological knowledge and basic coping strategies. His message emphasised that psychological support should not be confined to psychologists and psychiatrists but should be shared with those who are often the first point of contact for individuals experiencing distress. Although these initiatives differed substantially from the present research, they reflected a common principle: evidence-based psychological knowledge has the greatest public benefit when it is translated into practical approaches that are accessible within everyday communities.

A similar argument has been advanced by Clark (2018), who described the United Kingdom's Improving Access to Psychological Therapies (IAPT) programme as an example of how evidence-based CBT can be successfully disseminated through structured therapist training, routine outcome monitoring and the implementation of practical treatment frameworks across routine healthcare services. Clark argued that effective psychological interventions should be made available to substantially larger sections of the population by extending delivery beyond a

relatively small number of specialist clinicians while maintaining fidelity to evidence-based practice.

These developments closely align with the long-term vision for the PRTM. The present findings suggest that resilience training may be particularly well suited to dissemination because it addresses the cumulative stresses encountered in everyday life rather than highly specialised psychiatric disorders. Many individuals experiencing life challenges may never require specialist psychological treatment, yet could benefit from structured resilience-building strategies delivered by appropriately trained healthcare professionals, educators, counsellors or community workers. The PRTM therefore has the potential to function not only as a therapist's guide but also as a practical educational resource that supports the wider dissemination of evidence-based cognitive behavioural principles.

A future edition of the PRTM will build on the findings of this research by placing greater emphasis on flexible implementation rather than rigid adherence to session sequences. It will provide clearer guidance on adapting the order of intervention modules, recognising different pathways to resilience, incorporating collaborative treatment planning and monitoring therapeutic progress using both routine psychometric measures and practical qualitative methods such as reflective diaries. Additional case examples illustrating different resilience pathways, together with guidance for non-specialist practitioners, will further enhance the manual's accessibility while maintaining its cognitive behavioural foundations. These refinements reflect contemporary developments towards personalised, process-based and idiographic approaches to CBT (Dobson & Kazantzis, 2017; Hayes et al., 2022; Ong et al., 2022).

Ultimately, the broader contribution of this research extends beyond the development of a resilience intervention. It supports an emerging direction within contemporary CBT that seeks not only to develop effective psychological treatments but also to make them accessible to the wider community. In this way, the PRTM represents one possible contribution to the ongoing

dissemination of evidence-based psychological practice, helping to extend the benefits of CBT beyond specialist mental health services while remaining grounded in established psychological theory and research.

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APPENDIX A: COMPREHENSIVE SUMMARY OF EMPIRICAL CONTRIBUTIONS TO THE TREATMENT MANUAL

1.Akhtar, M., & Kroener-Herwig, B. (2019)

Germany

Quantitative

A total of 533 university students Asian (235), European (204) and Latin American (94) were included in this study. Age range: 20- 35 years.

Problem-focused Styles of Coping Inventory.

Suppressive coping (i.e., avoidance) significantly associated with lower levels of psychological wellbeing among all groups of students. Reflective coping (a functional problem-solving strategy) significantly associated with a higher level of psychological wellbeing among all groups of students. Reactive Coping (strong emotional reactions) style was associated with lower levels of psychological wellbeing, as it misrepresents the problem, reducing the ability for a more adaptable solution. The scope of counselling services should be widened to address the needs of international students. International students are less likely than domestic students to use counselling services.

2. Bland, H., Melton, B., Welle, P., & Bigham, L. (2012).

USA

Quantitative

A total of 248 millennial college students were included in this study.

Stress Tolerance Questionnaire. This questionnaire encompasses checklists for stressors, symptoms, and coping strategies.

This research identified lifestyle habits and coping strategies are significantly associated with high or low stress tolerance among millennial college students. Problem solving and patience were identified as two qualities lacking in the millennials. This research indicated that approach-oriented coping resources such (i.e., as social support or the perception that an individual is cared for) offered the basis for the millennial college students to develop high stress tolerance in addressing adversities. Avoidant coping (i.e., internet usage, substance usage) strategies were largely observed to be used by low tolerance student groups.

3.Chao, R. (2012)

USA

Quantitative

Total students: 459 college students. Age range: 18- 35 years.

COPE (60 items)

This study examined how low social support deteriorated the association between stress and well-being. The results indicate that college students who reported low social support and frequent use of dysfunctional coping were most vulnerable to stress.

4.Coiro, M.J., Bettis, A., & Compas, B. (2017)

USA

Quantitative

Total students :135 undergraduate students from two different universities. Age range: 18- 22 years

The Responses to Stress Questionnaire

Current study explained coping strategies correlated with stress and mental health. Students experiencing high levels of interpersonal stress reported using reduced adaptive coping strategies (i.e., problem solving, emotion modulation and secondary control). This resulted in increased symptoms of depression, anxiety, and somatization. Disengagement coping strategies (i.e., rumination, denial or avoidance) were apparent among students experiencing more interpersonal stress.

5.Deasy, C., Coughlan, B., Pironom, J., Jourdan, D., &McNamara, P. (2014)

Ireland

Quantitative

Total students :1577 undergraduate nursing/ midwifery and teacher education university students Age range: 17- 26 years

Ways of Coping Questionnaire.

The use of passive coping strategies (i.e., escape avoidance behaviours) with high levels of psychological distress, physical inactivity and poor diet in this study indicated the importance of replacing these maladaptive coping strategies with adaptive coping to reduce psychological distress.

6. Denovan, A., & Macaskill, A. (2013)

UK

Qualitative

Ten first year social science undergraduate from UK university studying criminology, sociology, psychology or politics. Age range: 18- 21 years

N/A

Findings from this study suggested: 1. Students who used forms of problem-focused coping adjusted better with the transition. 2.Students coped better when they kept regular contact with family and friends. Acceptance strategy was used best to cope with homesickness. 3.Students

with positive coping adapted better than students with Passive Coping. Students who executed behaviours such as keeping a diary and organising their time, fared better. 4.Students who had goals felt a sense of achievement and self-respect. 5.Cultivating adaptive Social Support is a form of constructive coping strategy to reduce stress. 6.Reframing negative events contributed to improved psychological wellbeing. 7.Having a part- time job eased financial stress and increase adaptation. 8.Problem- focused coping responses to stress benefited these students.

8. Enrique, A., Mooney, O., Salamanca-Sanabria, A., Lee, C. T., Farrell, S., & Richards, D. (2019)

Ireland

Quantitative

Total students: 75 college students (undergraduate and graduate) who were randomised to one of the three groups: (1) an intervention group with human support; (2) an intervention group with automated support; or (3) a waiting list control group. Age requirement: 18 years and above.

Brief Resilience Scale

The study indicated that Internet-delivered interventions have the potential to navigate beyond psychopathology to emphasise human coping and resilience and stress prevention. On a macro scale, internet-based intervention can be utilised to reduce stress and increase wellbeing (i.e., happiness) in college students.

9.Freire, C., Ferradas, M. D. M., Nunez, J. C., & Valle A. (2018)

Spain

Quantitative

Total students: 1,402 university students. Median age of students- 21.11 years.

Coping Scale of Academic Stress Questionnaire

This study established a positive relationship between a combined approach of coping strategies and eudaimonic well-being in university students. Results indicated higher levels of coping flexibility (i.e., positive reappraisal, planning, and support seeking strategies) were better able to manage academic stress, which increases the eudaimonic wellbeing. The study indicated positive correlation between the use of the three coping strategies (i.e., positive reappraisal, support seeking and planning) and the four dimensions of eudaimonic wellbeing (i.e., self-acceptance, perception of mastery, sense of purpose in life, and personal growth).

10. Giamos, D., Lee, Y. S., Suleiman, A., Stuart, H., & Chen, S.P. (2017)

Canada

Qualitative

Total students: 41 participants (students, professors and staff members) from 5 Canadian Universities in Ontario and Quebec.

N/A

This study provided a qualitative view into how campus culture related to mental health stigma and related issues. International students reported feeling uncomfortable when seeking mental health assistance. Students also commented that accessibility to mental health services can be promoted more effectively by reducing the waiting time and increasing access to on-campus counsellors. This study also reported that student mental health coping strategies were predominantly focused on social support, regular exercise, seeing a counsellor, humour, and reframing situations which contributed to better mental health.

11. Gloria, C. T., & Steinhardt, M.A. (2016)

USA

Quantitative

Total students: 200 post-doctoral fellows. Age range: 26 to 52 years.

The Brief Coping Orientations to Problems Experienced Scale and Brief Resilience Scale
This study measured six adaptive coping subscales, including active coping, planning, positive reframing, acceptance, emotional support, and instrumental support, and six maladaptive coping subscales including self-distraction, denial, venting, substance use, behavioural disengagement and self-blame. The study suggests implementing programmes that would aim to increase individual use of adaptive coping strategies, decrease use of maladaptive coping strategies, and increase experiences of positive emotions. In turn, improved levels of resilience would allow postdocs to adapt more effectively when dealing with adversities.

12. Gonzales- Torres, M. C., & Artuc-Garde, R. (2014)

Spain

Quantitative

Total students: 117 university students. Age range:18- 60 years, although most students (56.4%) were 19- and 20- year-olds. Mean age:20.55 years.

Escala de Estrategias de Coping, EEC [Coping Strategies Scale] and Connor-Davidson Resilience Scale (CD-RISC) Results from this study indicated that university students that utilised problem- focused coping strategies, developed solution-focused skills and were more resilient. The study recommended that more interventions that focused on active coping strategies which build resilience be introduced in a university context.

13. Gustems-Carnicer, J., Claderon, C., & Calderon-Garrido, D. (2019)

Spain

Quantitative

Total students: 334 undergraduate university students. Mean age: 23.6 years old

The Coping Responses Inventory—adult form (CRI-A) and Perceived Stress Scale (PSS)

This study indicated that perceived stress and cognitive avoidance negatively correlated with academic achievement. Approach coping (i.e., seeking guidance & problem-solving) and support seeking both correlated positively with academic achievement.

14. Heffer, T., & Willoughby, T. (2017)

USA

Quantitative

Total students: 1132 first year undergrad students, median age 19-years-old.
Shortened version of Brief COPE (15 items)
This study explained that positive coping strategies were associated with better adjustment. Findings also suggested that using a greater number of positive coping strategies as well as using less negative coping strategies may be beneficial for people with either high or low stress. Using less negative coping strategies was associated with better emotion regulation. There was also a bidirectional association between the number of positive coping strategies used and emotion regulation.

15. Herrero, R., et al., (2019)

Spain

Quantitative

Total students: 464 university students assigned to two conditions: (1) an unguided, Internet-based intervention to enhance resilience (N = 232); (2) a care-as-usual condition (CAU) (N = 232).

Connor-Davidson Resilience Scale is a 25-item self- report questionnaire that assesses the ability to cope with stress. Wellbeing: The Ryff Scales of Psychological Wellbeing- 29 items, and The Perceived Stress Scale (this questionnaire measures various aspects of psychological wellbeing.

They include (i.e., autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self- Acceptance). This study aspires to be a forerunner in implementing Internet-based resilience enhancing interventions in university students in the European region. Palma-Gomez et al. (2020) indicated the study yielded good results and it became accepted as a prevention procedure with beneficial components to increase wellbeing in university students.

16. Houston, J.B. et al. (2017)

USA

Quantitative

Total students: 129 College students (N= 65 intervention; 64 control). Age range:18- 23 years.

Connor-Davidson Resilience Scale; The Brief Coping Orientations to Problems Experience scale (Brief COPE). Perceived Stress Scale-14 (PERCEIVED STRESS SCALE-14)

This study indicated that a Resilience Coping Intervention (RCI) was an effective resilience intervention for use with college students when increase time for support, and taking action were observed. Mixed-effects models indicated that intervention participants reported significantly less stress from pre-to post-assessment compared with control participants.

17. Julal, F. S. (2013)

UK

Quantitative

Total students: 131 undergraduate Psychology students, median age: 19 years.

Problem-focused coping styles (PF-SOC)

The study explained that students who apply reflective problem-coping style were more likely to access student support services and are less likely to experience psychological distress. However, students who use more reactive and suppressive and less reflective coping styles, reported higher psychological distress. This study proposed that future interventions should be tailored to increase reflective problem-focused coping skills, to encourage adaptive support seeking behaviour, and to reduce maladaptive problem-focused coping styles that cause psychological distress.

18. Kato, T. (2020)

Japan

Quantitative

Study 1: Total students: 1,468 Japanese college students

(longitudinal); Study 2: 281 Japanese college students (cross

-sectional). Age range: 18 to 24 years.

Interpersonal Stress Coping Scale (ISCS); Evaluation Coping Scale (ECS)

The study showed that higher levels of reassessing coping (i.e., restrain coping), and higher levels of coping flexibility are significantly associated with lower levels of depressive symptoms. This indicated that interventions that aids in increasing reassessing coping techniques and coping flexibility are important to reduce stress in students.

19. Khawaja, N., & Stallman, H. (2011)

Australia

Qualitative

Total students: 22 international students from an Australian University in four focus groups, age range: 20-40 years.

N/A

In this study students were recommended to use the internet for gathering information before leaving their home country and following arrival in the new country. Similarly, electronic devices such as mobile-phones, emails, Facebook, Skype, and GPSs were considered very useful to maintain contact with family and friends. They managed their social isolation by pushing themselves to join a range of social organisations and activities. Good organisational management and prioritisation of tasks were strategies that helped the participants cope with their academic workload. International students found themselves managing their stress by sharing and discussing their problems with fellow students from their own country. They found others in the same circumstances could empathise and offer advice.

20. Korbmarcer, M., & Wright, L. (2020)

UK

Mixed method

Total students: 64 final year undergraduate students were encouraged, during undergraduate dissertation projects, to participate in all three phases of the study.

Brief COPE

Perceived Stress Scale

Results from this study revealed while CA (cognitive appraisal), and CS's (coping strategies) generally predicted perceived stress, no single CA or CS could predict perceived stress. Stress was predicted by the CS's emotion venting and denial (i.e., emotion focussed coping) as well as CA's.

21.Krypel, M., & Henderson-King, D. (2010)

USA

Quantitative

Total students: 309 undergraduate students with a mean age of 19 years.

COPE (53 item) 53-items (four per scale except for alcohol-drug disengagement with only one item) and Perceived Stress Scale (PSS)

This research focused on three coping styles: (1) students who used more emotion-focused coping had practical views of education such as viewing education for obtaining a career, knowledge building, and impacting the world. (2) Students who utilised problem-focused coping viewed education as a way for self- development, and as a way to utilise their education to change the world; they also viewed challenges as opportunities. (3) Students who used disengagement coping styles had more negative perceptions of education. They viewed education as an escape strategy from fulfilling expectations as an adult. The researchers recommended that universities assist students to select adaptive coping (i.e., problem-focused coping style) which would benefit them by making a positive meaning of education and adapting positively.

22. Li, M., Eschenauer, R., & Persaud, V. (2018)

USA

Quantitative

Total students: 220 American undergraduate college students. International students were excluded.) Mean age of the male students was 19.9 years and the mean age of the females students was 20.2 years.

Coping Strategy Indicator; 25-item Resilience Scale; Student-Life Stress Inventory

This study revealed that mediators such as resilience, social support seeking, and self- efficacy positively correlated with problem solving. Future intervention should focus on using social support seeking as an avenue for problem solving.

23. Lin, C. (2016)

Taiwan

Quantitative

Total students: 750 undergraduates from 10 universities in Taiwan; age range:18- 22 years

Coping Style (Lin, 2011); Inventory of Undergraduates Gratitude (IUG)

The study identified that gratitude increases social support which affects coping styles and wellbeing. Results from the study also indicated undergraduates who were grateful accessed a more active problem-focused coping style (i.e., perceived social support) to reduce stress which positively influence their wellbeing. The study recommended that gratitude-focused educational programmes and initiatives to increase social support in undergraduates be considered in universities.

24. McCarthy, B., et al. (2018)

Ireland

Quantitative

Total students: 197 first year undergraduate nursing and midwifery students who were taking a communication or psychology module.166 completed the pre-test and 138 students completed the post test.

COPE Inventory Questionnaire

The study established that the psychoeducation intervention significantly improved the student's coping strategies. The results indicated that post intervention students scored higher on social support indexes specifically in using both emotional social support and instrumental social support. Improvement in coping strategies were also indicated when a decrease in the avoidant coping category was noted. The results implied that post intervention, students were able to better address their stressors instead of avoiding them. In summary, this study established that psychoeducational intervention on the coping strategies of the undergraduate students was

significantly beneficial.

25. Meneghel, I., Martinez, I., Salanova, M., & de Witte, H. (2019) (Study 2 only reviewed)

Spain

Quantitative

Study 2: Total students: 780 university students, age range 18-61 years .

Brief COPE inventory (Spanish version)

The results from Study 2 indicated that students who utilised emotion-focused coping strategies (i.e., social, venting and avoidance coping) showed less academic resilience. Students who sought social support to vent about their stressors and utilised avoidance coping to manage difficult situations often led to increased stress. However, students who utilised higher problem-focused and acceptance, and addressed their stressor, were able to problem-solve and have better acceptance. The study recommended that resilience capacity and coping strategies can be developed via resilience-focussed interventions.

26. Moeller, R., et al. (2020)

USA

Quantitative

Total students: 1185 under-graduate college students, classified as First Years, Sophomores, Juniors, and Seniors .

The Brief COPE Scale

This study revealed that the students in this study were highly stressed and had adjustment issues. Further analysis demonstrated that factors such as coping, physical activity, and mindfulness, decreases stress and increases adaptation in students. Components of mindfulness proved to be a significant predictor in all domains (i.e., stress anxiety, depression, loneliness, and self-esteem). This study recommended that preventative interventions focusing on increasing physical activity, cultivating adaptive coping behaviours, and the promotion of components of mindfulness will be beneficial to these students.

27. Moret-Tatay, C., et al. (2016)

Spain

Quantitative

Total students: 131 university students, age range: 18-

32 years.

Questionnaire adapted from Brief COPE Inventory; General Health Questionnaire-28(Spanish version)

The Bayesian network model in this study established that emotion-focused coping exacerbated

mental health problems and lowered levels of wellbeing. Hence, problem-focused coping was recommended to be utilised to reduce stress symptoms and increase wellbeing.

28. Niegocki, K.L., & Ægisdóttir, S. (2019)

USA

Quantitative

Total students: 719 university students, age range:18-60 years.

The Brief COPE Scale

The study found that students with previous counselling experience, coped by seeking coping techniques and less avoidant coping strategies. This resulted in better stigma tolerance. Meanwhile, students without previous counselling experience, were found to cope better if more support seeking, problem-focused coping, and less use of avoidant coping strategies were utilised. These combinations of coping strategies were also found to be related to higher stigma tolerance and greater belief in psychologists' expertness. Avoidant coping was found to be inversely correlated with stigma tolerance in both samples. This study further recommended that mental health professionals need to focus on psychoeducational intervention in reducing help-seeking stigma and be vigilant about participants' use of avoidance coping.

29. Palma-Gomez, A., et al. (2020)

Spain

Quantitative

Total students: 324 university students randomly assigned to three conditions: (1)CORE, a 6-week unguided training program to improve resilience; (2)HLP, a 6- week unguided training to promote a healthy lifestyle; and (3)WL, waiting list control condition

Connor-Davidson Resilience Scale

This study is an extension of the study from Herrero, R. et al. (2019). Participants will be evaluated at pre-treatment, after each module, 6 weeks after allocation, and at 3-month follow-up. It is an on-going preventative trial to address high prevalence of psychological disorders among university students. This study theorised that Internet-based interventions focused on psychoeducation, autonomy, mindfulness and self-compassion, overcoming obstacles, connecting to others, and having a purpose in life and personal growth can advance resilience and coping skills, increase psychological wellbeing, and prevent depression and anxiety disorders in university students.

30. Ra, Y., & Trusty, J. (2015)

USA

Quantitative

Total students: 220 Asian International students in USA, age range: 18-39 years/

Coping Inventory of Stressful Situations

Findings indicated that international students who use task-oriented coping strategies may minimise acculturative stress, whereas emotion-oriented coping efforts are largely maladaptive. The use of using emotion-oriented coping strategies can be recognized and monitored giving individuals' opportunity to regulate the distress. Practising avoidance-oriented coping strategies (i.e., visiting a friend, watching TV, and going for walks) may help these students engage in purposeful activities and experience less acculturative stress. In summary, the study claimed that a focus on finding solutions to the stressors (e.g., using task- oriented strategies) is considered a better overall strategy.

31. Shermeyer, L., Morrow, M.T., & Mediate, N. (2018)

USA

Quantitative

Total students: 74 college students, the range: 18-52 years

Coping Strategies Inventory

Results from this study revealed that problem-focused engagement was associated with lower negative mood and higher positive mood and quality of daily life. The other three types of coping were negatively related or unrelated to daily functioning. This study suggested that college students would benefit from interventions that increase problem-focused engagement (i.e., problem-solving, and cognitive restructuring) in addressing mood and quality of life.

32. Smeets, E., Neff, K., Alberts, H., & Madelon, P. (2014)

Netherlands

Quantitative

Total students: 49 females first or second year psychology students, mean age: 19.9 years.

Self-Compassion Scale

Participants were randomly assigned to either a brief intervention on self-compassion, or an active control group intervention in which general time management skills were taught. Interventions were similar as they both encompassed of 3 group meetings held over 3 weeks. The study theorised that self- compassion enhances resilience by influencing an individual's responses to negative events. Self-compassion intervention proved to increase self-compassion skills, mindfulness skills (informal skills), optimism and reduce rumination. The study demonstrated that short self-compassion interventions are useful in increasing resilience and wellbeing among female college students.

33. Stallman, H. M., Ohan, J. L., & Chiera, B. (2019)

Australia

Quantitative

Total students: 70 university students with self-reported elevated levels of psychological distress randomly assigned to one of the two programmes. Ages ranged from 18 to 56 years.

The Coping Self-Efficacy Scale

This study suggested that functional online interventions can be an effective way to reduce students' distress. Two different interventions were administered to the university students. (1) "The Care, Collaborate, Connect: Student Success" consisted of three modules: self-care, problem- solving, and self- management. (2) "The Desk" focused on general daily coping such as getting things done, staying calm, staying connected, and feeling good. Strategies included: problem-solving techniques, using feedback, challenging unhelpful thoughts, and mindfulness. Findings from this study indicated that while both interventions reduced stress in university students, the intervention that targeted specific coping techniques reported more behavioural changes. In summary the study recommended brief online coping specific intervention may be warranted to reduce stress in students especially during exam season.

34.Straud, C. L., & McNaughton-Cassill, M. (2019)

USA

Quantitative

Total students: 261 undergraduate college Psychology students, mean age19.9 years.

Brief COPE Scale

This study reviewed the mediating role of proactive coping between self- blame and stress. Results indicated that higher levels of Self-Blame were predictive of higher levels of stress and lower levels of Proactive Coping, and vice versa. This study also suggests Proactive Coping strategies tends to act as a buffer toward self- blame cognitions and stress.

35. Tilley J.L., Farver, J.M., & Huey, S. J. Jr., (2020)

USA

Quantitative

Total students were 96 Chinese undergraduate college students, age range 18-23. Fifty-four participants were randomly assigned to individualistic priming condition (IND-PRIME) and 42 participants were randomly assigned to a collectivistic priming condition (COL-PRIME)

Brief COPE inventory

This study primed the participants to answer questions which were either collective or

individualistic by nature. Students who were primed with individualistic values appeared to use Active Coping to reduce hypothetical stressors. However, the study revealed that while collectivistic oriented individuals use less Active Coping strategies, the tendency was not to avoid stressful circumstances but instead to engage in Acceptance and meaning-making coping strategies to cope with adversities. Recommendation from this study was to be vigilant about student's individual cultural orientation, coping styles, and their causal attributions, which may influence their coping styles and choices.

36. Vally, Z., Cody, B. L., Alsheraifi, S. N. M., & Albloshi, M. A. (2017)

UAE

Quantitative

Total students: 114 female undergrad psychology & general education course students, age range: 18-26 years

BRIEF COPE; only used items 2, 7, 10, 14, 23, and 25 as problem-based coping strategies and the remaining items were classified as emotion-based coping strategies. And the Perceived Stress Scale (PSS).

Results from this study indicated students were more inclined to seek support from family and friends rather than from professional psychological assistance due to mental health stigma. Findings also observed that college students in UAE predominantly used emotion-based coping strategies instead of problem-based coping strategies. This is probably largely due the social and cultural context. Results revealed that psychology students who had more information on mental health information were able to utilise problem-focused coping skills and were more willing to seek professional help than their counterparts from non-psychology faculty. Finally, this study recommended that campuses should provide evidence- based psychological services to address the range of mental health issues in college students.

37. Vasileiou, K., et al. (2019)

UK

Qualitative

Total students: 15 university students who have moved away from home, age range 18-29.

N/A

This study was a theoretically-informed investigation of coping with loneliness in university students. The results showed that the types of coping themes and strategies these students most applied to address loneliness were: support-seeking, self-reliance, social isolation, problem-solving, and accommodation. Less common forms of coping themes and strategies used were helplessness, escape, submission, and opposition. Coping was judged as contextual to the prospects and constraints of the environment. Students sometimes chose coping skills that appeared counterproductive to manage loneliness in university students.

38. Wilson, J. T. (2016)

USA

Quantitative

Total students: 110 college students, 50 in the Intervention group, and 60 in the control group. Student classification: Upper class (80%); Second- year (20%)

The Gratitude Questionnaire-Six Item Form. This questionnaire was modified to include a resilience in learning component.

Findings from this study revealed that practising gratitude as an intentional activity, increased ability to focus and resilience in college students.

39. Wu, Y., et al. (2020)

China

Quantitative

Total students: 1743 undergraduate students from 6 Chinese universities.

Simplified Coping Style Questionnaire (SCSQ) modified, and The Asian Resilience Scale (ARS) modified.

This study revealed that undergraduates with better mood control, self- plasticity, and coping flexibility (i.e., components of psychological resilience) adopted more positive coping styles and experienced higher resilience. Psychological resilience was also noted to be correlated with positive coping styles.

APPENDIX B: CLINICAL SUMMARIES OF PARTICIPANTS 1-10

Participant 1 (Kai Ling)

Background and Stress Profile

Kai Ling, a 29-year-old international postgraduate student from Mainland China, entered the study with a moderate-to-high baseline stress level (PSS-14 score of 32). She noted the advertisement for participants via the Massey student Facebook page and responded with a clear interest in exploring ways to better manage her stress. Her demographic context is significant: as a single, Chinese international student managing academic demands in a culturally unfamiliar environment, she was at risk of heightened stress and social isolation. Notably, she reported no prior use of anxiety medication or antidepressants, suggesting her coping resources were primarily behavioural and cognitive rather than pharmacological.

Engagement and Responsiveness to Intervention

Across the 16-session PRTM intervention, Kai Ling demonstrated consistent engagement and openness to therapeutic strategies. An important part of our therapeutic relationship was her acknowledgment that she felt more comfortable being "open" with me because I was not Caucasian. She not only attended all sessions but also completed her weekly assignments with reflective depth. Her responses suggest a strong capacity for self-awareness, willingness to experiment with new coping tools and a gradual internalisation of adaptive behaviours. Importantly, she often linked session activities to her daily life (e.g., applying mindfulness while writing her research, using humour with friends, or tracking thoughts in stressful academic moments), highlighting her ability to translate theory into practice.

Passive Coping to Active Coping Transition

Initially, Kai Ling acknowledged tendencies toward venting, distraction, denial and self-blame, often rooted in her feelings of inadequacy and perfectionism. An important moment in our sessions was her reflection that, in her culture, being self-critical was seen as a positive way of staying humble and avoiding arrogance. While this perspective helped her maintain modesty, she also began to see how excessive self-criticism could become maladaptive, fuelling denial, avoidance and stress. Together, we worked on striking a balance: honouring her cultural value of humility while cultivating self-compassion and more supportive self-talk. She resonated with role-play exercises and compassion-focused techniques, which allowed her to observe and reframe these patterns. Over time, she developed more adaptive strategies, including planning, acceptance and metacognitive awareness. This transition marked an important shift from reactive to proactive stress management, particularly evident in her ability to identify red flags in her behaviour and re-direct her actions.

Self-Care and Mindfulness

The self-care module highlighted her recognition of practical barriers such as poor time management, academic workload and lack of exercise. Despite these obstacles, she demonstrated insight into the value of nutrition, mindfulness and relaxation. She described mindfulness as novel but quickly adopted it, applying it in everyday contexts to manage anxiety about grades and supervision. Through self-compassion practices (e.g., writing compassionate notes, positive self-talk), she reported noticeable reductions in anxiety and improvements in wellbeing, showing growth in emotional regulation and self-kindness.

Social Support Development
Kai Ling initially perceived deficits in both giving and receiving social support, attributing them partly to cultural norms and family dynamics. However, she progressed toward greater openness, intentionally increasing her engagement with friends, peers and family. She became more comfortable in accepting both emotional and instrumental support, including meals, transport and advice. Notably, she reframed support-seeking from a weakness to a valuable resource, which improved her confidence and sense of belonging. Her reflection that she "allowed herself to receive this support" demonstrates a cognitive shift towards relational reciprocity and reduced self-isolation.

Active Coping and Integration
In the final phase, Kai Ling consolidated her learning by applying active coping strategies such as problem-solving, thought tracking, positive reframing and gratitude journaling. These tools were directly linked to tangible outcomes, most notably her successful submission of her Master's thesis. Humour emerged as a significant coping style, with her recognition of both adaptive (affiliative, self-enhancing) and maladaptive (self-defeating) uses showing advanced metacognitive insight. She expressed gratitude for the intervention, suggesting a deep recognition of its role in sustaining her academic and personal wellbeing.

Overall Perspective
Kai Ling's journey reflects a trajectory from self-critical, stress-reactive patterns to adaptive, self-compassionate and resource-seeking coping behaviours. She demonstrated resilience, strong reflective capacity and behavioural flexibility, which enabled her to benefit fully from the intervention. While initial barriers (cultural expectations, perfectionism and time management difficulties) were evident, she consistently engaged with therapeutic techniques to transform these challenges into growth opportunities.
Her case illustrates the function of structured, skills-based interventions in supporting international students navigating stress in academic settings. More importantly, it underscores the interplay between personal coping resources, cultural background and the development of adaptive strategies that can sustain long-term wellbeing.

Participant 2 (Selina)

Background and Stress Profile
Selina is an 18-year-old undergraduate student, entered the study with a moderate-to-high baseline stress level (PSS-14 score of 35). She learned about this study through the advertisement for participants via the Massey student Facebook page and responded with a clear interest in exploring strategies to better manage her stress. Her demographic and situational context is typical of many first-year university students. She is single, student managing undergraduate academic demands while living away from her family. And navigating the challenges of academic demands, social adjustment and financial independence She was at risk of average level stress especially dealing with living on her own, making friend and managing finances. These factors collectively place her at risk for experiencing an average to elevated level of stress. Selina reported no prior use of anxiety medication or antidepressants, suggesting that her coping mechanisms to date have been primarily behavioural and cognitive. This makes her a suitable candidate for interventions focused on self-care activities, social support access and adaptive coping strategies, aimed at enhancing her overall resilience and stress management capacity.

Engagement and Responsiveness to Intervention

Across the 16-session PRTM intervention, Selina demonstrated consistent engagement and openness to therapeutic strategies. Selina was cooperative, attentive and completed her weekly assignments with enthusiasm. Her responses suggest a strong capacity for self-awareness, willingness to experiment with new coping tools and a gradual internalisation of adaptive behaviours. Importantly, Selina indicated an ability to generalise and apply session content and teaching to her daily life. For example, she noted that she reduced self-blame tendencies when navigating the stress of relocating and informing these changes to her flatmate. She mentioned that she practised acceptance when managing financial vigilance (e.g., reducing self-blame when she needed to shift accommodation and informed her flatmate, highlighting her developing ability to translate session insights into real-life coping and self-regulation.

Passive Coping to Active Coping Transition

At the beginning of therapy, Selina acknowledged tendencies toward venting, self-blame, reduced access to emotional social support which hindered her ability to cope adaptively. She described feeling compelled to be the "good girl" or the "good friend," a role that often left her feeling guilty and inadequate whenever she prioritised her own needs.

A pivotal moment occurred when Selina reflected that being selfless functioned as a way to "stay under the radar" and avoid conflict. It is also a great way to stay likable with everyone. While this perspective helped her avoid confrontations, she also began to see how excessive avoidance could become maladaptive, fuelling guilt, frustration and stress. These sessions therefore focused on enhancing her ability to sought out access to social support, practice acceptance, cultivate self-compassion and more supportive self-talk. Selina particularly liked the role-play exercises and compassion-focused techniques, which allowed her to observe and reframe her schemas and ingrained patterns. Over time, she developed more adaptive strategies, including reducing self-blame, acceptance and metacognitive awareness. This transition marked an important shift from passive to active coping, particularly evident in her ability to identify early warning signs in her behaviour and re-direct her actions.

Self-Care and Mindfulness

The self-care module highlighted Selina's attention to several practical barriers affecting her wellbeing, including poor time management, academic workload and limited physical activity. Despite these challenges, she demonstrated strong insight into the importance of balanced nutrition, mindfulness and relaxation in managing stress. Selina initially found practical mindfulness to be a novel concept but quickly applied it into her daily routine to moments of anxiety related to academic performance and social interactions. Through self-compassion practices (e.g., positive self-talk), she reported noticeable reductions in anxiety and improvements in wellbeing, showing growth in emotional regulation and self-kindness.

Social Support Development

Selina initially perceived deficits in receiving social support, attributing them to her personal tendencies and discomfort with seeking emotional support. Over the weeks, she demonstrated progress in increasing her engagement with friends and peers. She became more comfortable in accepting both emotional and instrumental support, including transportation, small treats and advice, without experiencing excessive guilt or self-criticism. Notably, she reframed support-seeking from being a "burden" to a reciprocal resource, which improved her confidence and sense of belonging. Her insight that she was now "allowing herself to receive this support" demonstrates her progress towards relational reciprocity and reducing guilt and self-blame.

Active Coping and Integration
In the final phase of the intervention, Selina consolidated her learning by applying active coping strategies such as problem-solving, thought tracking, positive reframing and gratitude journaling. These tools were directly linked to tangible outcomes, most notably a reduction in academic anxiety. Although, she initially struggled to engage with humour as adaptive coping mechanism. She found it particularly insightful to explore the therapeutic use of humour and its distinct categories, recognising the difference between adaptive forms (affiliative, self-enhancing) and maladaptive forms (self-defeating). By the conclusion of the intervention, Selina expressed sincere gratitude for the intervention, demonstrating an awareness of its positive influence on both her social support and general wellbeing.

Overall Perspective
Selina's therapeutic journey reflects a trajectory of growth, from self-blame and difficulty receiving emotional and other social support to developing self-compassionate and self-care practices. As the sessions progressed, her attentiveness, insight and willingness to apply these strategies were the main factors in her progress. She demonstrated resilience, strong reflective capacity and behavioural flexibility, which enabled her to engage fully with the intervention and Selina's case highlights the effectiveness of structured, skills-based interventions in supporting undergraduate students managing academic and personal stress. More importantly, it underscores the dynamic interplay between personal coping resources and the cultivation of adaptive strategies that promote long-term psychological wellbeing

Participant 3 (Micheal)

Background and Stress Profile
Michael is a 39-year-old European male working as a firefighter with Fire and Emergency New Zealand. His role exposes him to high-intensity environments, frequent emergency response demands and unpredictable work schedules. He is separated from his wife and lives with his partner, balancing co-parenting responsibilities with his children. His baseline Perceived Stress Scale–14 score was 29, indicating elevated stress prior to intervention. He was not taking anxiety or antidepressant medication. Across the COVID-19 outbreak he remained an essential worker, contributing to additional operational pressure and fatigue. Despite these demands, he consistently engaged in sessions with openness, humour and a willingness to examine and refine his coping strategies.

Engagement and Responsiveness to Intervention
Throughout the programme, Michael demonstrated strong engagement with the intervention processes. He attended sessions reliably, was comfortable with face to face and zoom delivery and consistently reflected on how he was applying strategies in real-life contexts. He frequently described putting techniques into practice particularly reframing, mindful monitoring of thoughts and reactions and enhancing his interactions with his children. His openness to examining both emotional and behavioural responses allowed him to explore patterns related to impulsivity, humour use and emotional expression at work and home. His responsiveness was evident in his willingness to track weekly incidents, evaluate what strategies worked and identify areas requiring adjustment. Overall, he showed a high degree of commitment and behavioural follow-through.

Passive Coping to Active Coping Transition
Michael entered the programme with a tendency to react swiftly in challenging situations, often relying on humour or internal suppression to navigate emotional discomfort. Through the

intervention, he increasingly adopted active coping strategies grounded in awareness, cognitive reframing and restraint.
He demonstrated progress by monitoring thoughts, emotions and behavioural impulses to reduce reactive patterns, adopting positive reframing, particularly in work situations and parenting challenges and recognising moments where restraint coping was needed and planning how to apply it. Micheal also able to explore intentional and reflective responses rather than defaulting to impulsive or avoidance-based tendencies. These shifts reflect a clear movement from automatic, emotionally driven reactions toward more deliberate, adaptive coping.

Self-Care and Mindfulness
Although self-care was not a primary focus early in the intervention, Michael showed increasing awareness of how physiological demands, emotional load and occupational stress affect him. He acknowledged the value of reflective pauses, self-monitoring and prioritising calm appraisal during high-pressure situations. He integrated grounding strategies through humour awareness and reframing, using them to stabilise mood and maintain more consistent emotional responses. He also demonstrated improved attentiveness to the impact of his work routines on family relationships and overall wellbeing, applying strategies intentionally to support balance in these domains.

Social Support Development
Social support was woven into Michael's process primarily through his interactions with family, children, partner and colleagues. Although the modules provided formal structure, he naturally referenced support patterns as part of his day-to-day functioning.
Michael increasingly expressed the importance of connectedness with his children and partner. He recognised how positive interactions and open communication enhanced relational quality and reduced stress. Through reframing and shared problem-solving, he became more intentional about how he sought and used support, particularly in workplace contexts where teamwork and communication are essential.
Overall, he strengthened his capacity to use relational connections as a resource rather than defaulting to self-reliance.

Active Coping and Integration
By the later stages of the intervention, Michael displayed strong integration of active coping strategies. He applied reframing effectively, improved emotional restraint and used weekly monitoring to evaluate progress. He incorporated grateful journaling and preventative strategies into his routine and consistently connected the content to real-world stressors. His understanding of humour as both a coping tool and potential risk factor further demonstrated cognitive integration. Across sessions, he increasingly demonstrated the ability to slow down, assess and intentionally shape his responses reflecting significant cognitive and behavioural maturation. Michael identified limits around humour use for example, recognising when humour becomes inappropriate or discomforting and understanding his own "inside voice" tendencies. This awareness allowed him to adjust behaviour and maintain healthier relational boundaries.

Overall Perspective
Michael's engagement and integration of learned strategies highlight a clear strengthening of resilience, cognitive flexibility and emotional awareness. He moved from reactive, stress-driven responses toward more mindful, considered coping patterns. His recognition of reframing, restraint coping, humour boundaries and self-monitoring reflects sustained psychological growth and capacity for long-term wellbeing.
By the conclusion of the intervention, Michael demonstrated improved relational functioning,

enhanced emotional regulation and greater confidence in navigating personal and occupational challenges.

Participant 4 (Jacqueline)

Background and Stress Profile
Jacqueline is a 27-year-old female of European origin working as an authorised officer in an operational support role within police services. Her work involves collecting and processing evidence and liaising with district officers during emergencies, inherently carries high levels of responsibility, rapid decision-making and exposure to stress. Her baseline Perceived Stress Scale–14 score was 29, indicating elevated stress prior to intervention. She previously used Escitalopram and Lorazepam while an undergraduate student but is currently not on any medication. Throughout the intervention period, she continued working as an essential staff member during the COVID-19 pandemic, navigating rapidly evolving protocols and inconsistent information from authorities. These conditions contributed to situational stress, emotional fatigue and occasional self-doubt. However, she consistently displayed insight, reflective capacity and willingness to modify long-standing patterns around help-seeking and coping.

Engagement and Responsiveness to Intervention
Jacqueline engaged well with all 16 sessions, attended consistently and expressed comfort with online delivery. She demonstrated strong reflective abilities and was open about her difficulties, particularly around emotional expression, help-seeking and feeling judged when receiving support. As the modules progressed, she showed increasing willingness to experiment with new strategies, incorporate weekly practices and evaluate the impact of her behaviours. She regularly articulated how she applied previously learned techniques particularly around structuring support, reframing stressors and managing emotional triggers at work. Her responsiveness was evident in both behavioural application and her deepening understanding of the role that cognitive, emotional and social resources play in resilience.

Passive Coping to Active Coping Transition
Jacqueline began the programme with a tendency toward avoidance, emotional suppression and over-reliance on internalising stress patterns reinforced by family modelling and workplace culture. She often felt reluctant to ask for what she needed, viewing help-seeking as burdensome to others and anticipating rejection.
Across sessions, she gradually transitioned into more active coping. She practiced thought reframing (e.g., shifting from “here we go again” to “what can I offer for you to…”). She utilised the Discrete Thought Tracking (DTT) tool to map and intercept unhelpful patterns. She applied behavioural pacing and reflective pauses to reduce reactive responses. She redefined control, differentiating between what she can influence versus what she must accept. This transition strengthened her sense of autonomy, increased emotional regulation and improved her capacity to handle workplace and interpersonal stressors.

Self-Care and Mindfulness
While initially struggling to prioritise her own needs, Jacqueline progressively incorporated self-care practices throughout the intervention. She engaged in reflection, grounding strategies and pacing methods to help manage stress. As her sleep improved after receiving new glasses and reducing headaches, she reported feeling physiologically better equipped to maintain balance. She also demonstrated greater acceptance of, acknowledging that calm, reflective engagement often yields better outcomes than emotional reactivity. Her awareness of the need for restorative activities particularly given her essential worker status became more integrated across sessions.

Social Support Development
Jacqueline made notable progress in understanding and engaging with all four dimensions of social support. With structural and functional Support, she identified robust structural support from her partner, parents and close friends, though she initially desired more consistency from work authorities. She recognised the importance of perceiving support as beneficial and worked actively to enhance her ability to receive it without self-judgment.
With accessing Emotional support, Jacqueline initially viewed emotional help-seeking as burdensome and feared negative evaluation. Through exploration, she recognised the value of emotional support and recalled specific instances where support from colleagues and family was protective. Her capacity to accept emotional support improved markedly.
With accessing Material Support, she recognised that discomfort with asking for assistance often resulted in avoidance and frustration. By increasing reflection, planning and patience, she began to view material support as a resource rather than an imposition, especially during COVID-19.
Finally with Cognitive/Informational Support, Jacqueline showed strong insight into how access to information influences her emotional state. She recognised that uncertainty communication can trigger restlessness and she applied assertiveness and reflective strategies to manage this. She also appreciated macro-level informational support from transparent public updates during the pandemic. Collectively, Jacqueline's progress demonstrated an expanding ability to both seek and accept support across multiple domains; an important shift from her earlier reluctance.

Overall Perspective
Jacqueline's engagement, insight and capacity to integrate psychological strategies reflect substantial personal and emotional development across the intervention. She demonstrated strengthened resilience, increased emotional awareness and a more confident approach to seeking and using social support. Her transition from avoidance-based coping to intentional, reflective action was clear and she embraced tools such as DTT, reframing and active coping to navigate interpersonal challenges and workplace stressors.
By the conclusion of the programme, Jacqueline showed enhanced stability, improved perspective-taking and greater self-trust in her ability to manage uncertainty. She expressed viewing her experiences "through a different filter," indicating meaningful cognitive and emotional change. Overall, she leaves the intervention with a more robust coping framework, increased adaptive functioning and the confidence to sustain these strategies moving forward.

Participant 5 (Siew Ping)

Background and Stress Profile
Siew Ping is a 27-year-old single female PhD postgraduate student of Chinese Mainland descent with no history of anxiety medication or antidepressant use. On the Perceived Stress Scale-14 her score during the recruitment phase was 33. Her stress profile during the intervention was influenced by multiple factors, including academic workload, interpersonal difficulties with flatmates, cultural barriers to seeking emotional support, long-distance relationship stress, global uncertainty related to the COVID-19 pandemic and the challenges of maintaining wellbeing while living in shared accommodation during lockdown. She experienced occasional sleep disturbances, skin irritation exacerbated by stress and frequent handwashing, relationship tension and anxiety associated with perceived lack of control. Despite these challenges, she showed stable mood, no self-harm risk and a consistent willingness to improve her coping skills.

Engagement and Responsiveness to Intervention
Siew Ping was consistently cooperative, punctual and engaged in all Zoom sessions. She submitted assignments and questionnaires on time, demonstrated thoughtful reflection and openly discussed personal challenges. She responded positively to relaxation strategies, time-management recommendations, reframing exercises and prevention planning. She actively integrated learning into her daily routines such as moving rooms to improve sleep, seeking advice for her skin condition and adjusting expectations in her relationship. Her engagement remained strong throughout all 16 sessions and she frequently reported feeling better as she applied new skills.

Passive Coping to Active Coping Transition
In early sessions, Siew Ping displayed passive coping tendencies such as avoidance, rumination, cultural hesitancy to seek emotional support and sensitivity to interpersonal conflict. She also experienced self-blame, disrupted sleep and difficulty managing outcomes she could not control. Over time, she practiced shifting her internal narratives, identifying behavioural solutions and recognising the importance of accountability. Through discrete thought tracking and cognitive reframing, she learned to tell herself "A different story," reducing emotional reactivity and increasing behavioural agency. She also became more willing to confront stressors, tolerate discomfort and implement small daily goals to prevent overwhelm.

Self-Care and Mindfulness
Throughout the intervention, Siew Ping experimented with and adopted multiple self-care approaches. She used walking, music, cooking, baking and online movies as relaxation strategies and expressed interest in breathing exercises and reading for additional stress relief. Moving to a quieter room improved her sleep and skin condition markedly. She engaged with meaning-making activities to view stress as an opportunity for growth and she incorporated relapse-prevention plans into her routines. She also demonstrated increasing awareness of her internal dialogue and the importance of self-soothing behaviours in maintaining wellbeing.

Social Support Development
Social support became an important focus for Siew Ping, particularly due to her cultural background where emotional help-seeking is uncommon. She recognised structural and functional support from her university peers, international friends and her friend Alex. Over time, she identified her boyfriend as a key emotional support figure and acknowledged the difficulty but also the benefit of being vulnerable. She practiced expanding her support network by listing potential contacts and accepting support when offered. She also accessed material support through her own funds and logistical resources and sought cognitive/informational support for health-related issues. Her progression demonstrated a growing openness to using all four forms of social support.

Active Coping and Integration
By later sessions, Siew Ping showed increasingly active coping. She used reframing to manage conflict with her brother, applied restraint coping and gratitude journaling and embraced behavioural strategies to reduce avoidance and anxiety. She recognised that success includes happiness, personal acceptance and noticing improvement, while redefining failure as a lack of progress rather than a personal flaw. She integrated skills from discrete thought tracking, relapse prevention, cognitive support and humour modules becoming more adaptive in her responses to both academic and interpersonal stressors. Her improved sleep, reduced comparison with others and enhanced emotional stability reflected strong skill consolidation.

Overall Perspective
Siew Ping demonstrated substantial growth across cognitive, emotional and behavioural domains. Her willingness to engage deeply with each module, challenge cultural barriers and apply new coping strategies contributed to meaningful improvements in wellbeing. She strengthened her ability to seek and use social support, reframed stressful situations more effectively, improved her environmental and emotional regulation and utilised self-care consistently. Her integration of active coping strategies combined with increased confidence and reduced self-comparison indicates sustained psychological growth, enhanced resilience and a solid foundation for continued wellbeing.

Participant 6 (Eliza)

Background and Stress Profile:
Eliza, 23-year-old, postgraduate Diploma student from the Faculty of Environmental Studies. She entered the intervention during global uncertainty due to the pandemic. Her Perceived Stress Scale-14 score during the recruitment phase was 37. She presented as forthcoming, cooperative and reflective throughout all zoom sessions. She reported taking anti-anxiety medication, suggesting pre-existing anxiety symptoms which influenced her stress responses, especially when routines were disrupted or when she felt disconnected from familiar environments.

Her primary stressors included the postponement of her long-planned Europe trip, academic pressures, fear of separation from safe environments and uncertainty about employment. These factors often triggered frustration, anxiety and tendencies toward venting, self-blame, or avoidance. Eliza's stress responses were compounded by her high personal expectations and a pronounced sense of responsibility, which sometimes made initiating tasks overwhelming. Despite this, she demonstrated strong psychological insight and readiness to engage with coping strategies aimed at improving accountability, reducing avoidance and managing emotional distress.
Given her academic workload, uncertainty during lockdown and underlying anxiety vulnerabilities, Eliza was well-suited for an intervention that emphasized cognitive reframing, self-compassion, metacognitive strategies and the development of both emotional and practical support networks.

Engagement and Responsiveness to Intervention
Eliza exhibited high engagement from the outset. She consistently submitted assignments, actively participated in role-plays and openly discussed her emotional experiences, daily stressors and behavioural patterns. Each week, she demonstrated thoughtful reflection on her progress, often noting specific changes in her language, attention and coping strategies.
She frequently described the sessions as eye-opening, reporting that concepts such as accountability, behavioural awareness and metacognition were "things she never thought of" but found highly applicable. Throughout the program, she maintained consistent attendance, displayed strong follow-through with homework tasks and showed appreciation for the structure and clarity of the intervention. Her cooperation and receptiveness allowed her to make steady gains in self-awareness, emotional regulation and adaptive coping.

Passive Coping to Active Coping Transition
At baseline, Eliza tended to rely on venting, self-blame, avoidance ("I put off important things because I am lazy and when I feel overwhelmed") and denial which are common passive coping responses associated with anxiety. She expressed frustration toward disrupted plans and feelings

of inadequacy when faced with demanding tasks. High expectations of herself contributed to procrastination and increased stress.

Through cognitive reframing and accountability exercises, she became increasingly aware of her "blame language" and how self-directed frustration intensified her anxiety. She recognised self-blame as a passive strategy through role plays activities that "spirals her down further." Learning to replace these patterns with active coping small goals which she mentioned could be a "may be a game changer" in decreasing avoidance. Additionally, mood monitoring and narrative reframing was particularly impactful for her.
She also responded well to using a "soothing object" (her locket) as an emotional anchor, especially when feeling overwhelmed or unsafe. Over time, Eliza began redefining success, adopting new internal narratives such as "moving on to the next thing," which helped reduce anxiety, avoidance and self-criticism. She was very appreciative of the sessions and said she is very excited about using the metacognitive strategy to reduce residual stress. She mentioned she has never seen the way challenges the way she has noticed and solve them right now.

Self-Care and Mindfulness
Eliza demonstrated strong motivation to improve her well-being through exercise, routine management and reflective practices. She experienced noticeable improvements such as better skin and overall mood which reinforced her engagement with self-care strategies. Eliza responded positively to discussions on fitness, nutrition and establishing realistic routines. She reported that she felt better especially when the lockdown went down to level 2, as she had the chance to return to gym and meet a few of her friends. She also commented that she feels the sessions has "blown her mind" in the way she catches herself responding to difficult stress events.
Mindfulness resonated with her, particularly informal activities like cooking and colouring, which she felt were accessible and grounding. The slower pace of the post-lockdown environment allowed her to be more introspective, helping her integrate mindfulness more naturally into daily life.
Self-compassion was an area she initially struggled with, acknowledging difficulty in being kind to herself during stressful periods. However, she approached this consciously, recognising how self-judgment contributed to anxiety. Small mindful practices, emotional checking-in and daily grounding exercises supported her progress toward a more balanced and compassionate self-view.

Social Support Development
Eliza's relationship with social support evolved meaningfully over these sessions. Although naturally more giving than receiving, she acknowledged feelings of guilt when seeking help. She initially relied heavily on family and her partner while feeling anxious about appearing burdensome. She reported after many zoom calls during lockdown it was such relief that she was able to see her family in person. She related that spending time with her brothers were very fruitful for their sibling relationship.
The social support modules challenged her to broaden her understanding of structural, emotional, material and cognitive support. Although she admitted in feeling mildly anxious, Eliza became more comfortable seeking practical assistance (e.g., job interviews, CV updating), emotional reassurance and informational resources. She also reported that reconnecting with friends and returning to the gym after lockdown significantly enhanced her emotional well-being. Importantly, she recognised that avoidance, anxiety and making excuses often prevented her from accessing support and she began actively addressing these barriers. Gradually, she accepted that seeking help was a sign of resilience rather than inadequacy.

Active Coping and Integration
By the later sessions, Eliza demonstrated a strong ability to integrate active coping strategies into her daily routines. She used metacognitive strategies to manage overthinking and found them "hugely helpful." She mentioned that reframing stressful situation by "telling herself another story" helped her control her anxiety levels. She was excited about the opportunity and realized that can now change her narrative such as "moving on to the next thing" would best suit her to reduce current stressor of getting a job. She applied relaxation techniques, planned weekly tasks and made conscious efforts to reduce procrastination. She began decluttering her space, practicing execution rather than only planning and experimenting with group study and tutor support. She also engaged thoughtfully with humour as a coping strategy, recognising her patterns of affiliative and self-defeating humour and considering how to shift toward more self-enhancing forms even though she admitted that they were difficulty to apply. Her ability to reframe setbacks, such as not securing temporary work showed increased psychological flexibility, emotional stability and reduced reactivity.

Overall Perspective
Eliza demonstrated growth across emotional awareness, behavioural regulation and coping mechanism flexibility. She transitioned from patterns of venting, avoidance and self-blame toward more active, intentional strategies including planning, metacognitive reflection, mindfulness and self-compassion. She became increasingly comfortable seeking and utilising social support, even in areas where she previously felt guilty or anxious. The combination of consistent engagement, strong insight and openness to change allowed her to develop greater resilience, emotional balance and confidence in managing future stressors.
Eliza's engagement and integration of learned strategies highlight a strengthened capacity for resilience, self-care, accessing social support and adaptive coping were key indicators of sustained psychological growth and well-being.

Participant 7 (Rosalind)

Background and Stress Profile
Rosalind, a 20-year-old student, undergraduate student, entered the study with a high baseline stress level (PSS-14 score of 37). She reported noticing the participant advertisement via the Massey student Facebook page and expressed a clear interest in exploring strategies to better manage her stress. She had no prior use of anxiety medications or antidepressants, indicating that her coping resources were primarily behavioural and cognitive rather than pharmacological. Rosalind presented as a forthcoming and cooperative individual. She initially reported stress related to delayed university communications regarding subjects and scheduling, which often caused frustration, anger and venting to friends, occasionally leading to mild self-blame and disengagement from tasks she found uninteresting. Academic stress was compounded by distractions while at her family home, though she generally takes pride in her work and strives for quality outcomes.
While her demographic profile is typical of many undergraduate students, her situational context was unique: she is single, living away from her family, managing academic demands and coping with health issues including pulmonary difficulties and ongoing breathing problems potentially related to her vocal cords. These factors placed her at risk for high levels of stress, particularly in navigating independent living, forming friendships and managing her health. Consequently, she was well-suited for interventions focused on self-care activities, accessing social support and developing adaptive coping strategies, with the goal of enhancing her overall resilience and stress management capacity.

Engagement and Responsiveness to Intervention:
From the first session, Rosalind indicated high levels of cooperation, preparedness and openness. She consistently submitted assignments, actively participated in Zoom sessions and engaged thoughtfully in discussions. She responded well to strategies aimed at reframing stressors, enhancing personal accountability and applying preventive measures to reduce procrastination and self-blame. Rosalind was also forthcoming about times when she found herself disengaged or lacking motivation, often attributing this to distractions encountered while visiting her family home. Her openness in acknowledging these challenges reflected a strong sense of self-awareness and a genuine willingness to address barriers to her productivity and engagement.

Passive Coping to Active Coping Transition:
Initially, Rosalind relied on venting, disengagement and mild self-blame as coping mechanisms. She was encouraged to examine her blame language and consider ways to take accountability, which she found very useful; she reported that this approach helped her reframe issues and cope more effectively. She was also asked to track her mood and see if changing this behaviour has an impact on her mood.

Over time, she transitioned to active coping strategies, including structured planning, applying metacognitive strategies, practicing self-compassion and gradually confronting tasks she initially avoided. Rosalind described defining success as achieving planned goals and viewing failure as instances of frustration or avoidance. She mentioned that she may change her narratives to "why not try 5 minutes of something that I am avoiding so it is not totally frustrating". She believes that might initiates some work instead of avoidance. She demonstrated growing awareness of how her behaviour affects her mood and academic performance. She did comment that while she occasionally engaged in self-blame, she noted that it was infrequent and typically occurred only when assignments did not meet her standards. She also reported giving herself credit and allowing herself to restart when needed and stated that she does not indulge in self-denial. Acceptance and willingness were strategies she applied in decision-making to reduce stress. She expressed excitement about using metacognitive strategies to manage stress and preventive measures were discussed to further support her progress.

Self-Care and Mindfulness:
Rosalind expressed concerns about her weight and aspired to gain control over her craving by taking up martial arts. It was evident that she valued self-care and was motivated to implement lifestyle changes through exercise, improved nutrition and mindful daily routines. She was particularly receptive to practicing informal mindfulness activities such as cooking and brushing her teeth, identifying these as realistic and enjoyable ways to incorporate mindfulness into her day. She also noted the barriers would be that her mind drifts off and has difficulty sustaining her focus but recognized these practices as useful for stress reduction. Rosalind also engaged in discussions about relaxation techniques and time management strategies, demonstrating an understanding of their relevance to her overall well-being. She reported making progress in practicing self-compassion, acknowledging that while she occasionally gives in to her emotions and procrastinates, she is consciously working on these tendencies. She related well to the concept of self-care and noted that even small, consistent efforts such as maintaining focus on minor tasks helped her stay grounded and productive and reduce procrastination.

Social Support Development
Initially guarded in seeking support, Rosalind gradually learned to access emotional, material and cognitive support from peers, tutors and university resources. She also became comfortable

providing support to others and recognized the benefits of social connection for coping with stress. She reported being a guarded person she often avoided seeking emotional support but has recently tried accessing this support and felt the outcome was positive and is now opened to accessing this type of support. She also commented that she is comfortable in extending this support to others. She identified that material resources such as Study Link and additional university assistance were important forms of practical support and she noted that accessing these services had not posed significant obstacles for her. She mentioned while she is still guarded about seeking social support, she feels like cognitive support will allow her to gain outside perspective. As for obstacles, she mentioned that "nothing bad is there to last" so hence not overthinking is good thinking along with removing self from the situations and taking break scan allow her to seek social support again. Over time, she came to appreciate that seeking and maintaining supportive connections contributed meaningfully to her stress management and overall well-being.

Active Coping and Integration:
Rosalind applied a range of active coping strategies to manage academic and personal responsibilities, including group assignments, small-step approaches to challenging tasks and conscious reframing of frustration. She demonstrated an ability to integrate learned skills into daily routines, enhancing resilience, productivity and overall stress management. and affiliative/self-enhancing humour were incorporated to improve emotional regulation and reduce procrastination.
Rosalind appreciated assignments focused on organization and restraint coping and commented that could help her manage procrastination more effectively and also prepare for new tenant to move in soon to her flat. Although she acknowledged that applying some strategies, such as restraint coping and humour, could be challenging, she demonstrated insight into her habitual use of both affiliative and self-defeating humour. Rosalind expressed willingness to practice more adaptive forms-particularly affiliative and self-enhancing humour-and to observe how others use humour as a coping mechanism. Overall, she showed meaningful integration of learned coping strategies into her daily life and a continued commitment to self-improvement.

Overall Perspective:
Rosalind's progression throughout the intervention indicated a meaningful shift from passive to active coping even through health challenges. Initially characterised by frustration, venting and mild self-blame in response to academic and environmental stressors, she gradually developed more adaptive coping strategies through structured planning, reframing and mindfulness. Her willingness to engage openly, reflect on her challenges and apply newly introduced techniques signalled strong motivation for personal growth. As the sessions progressed, Rosalind demonstrated the capacity to integrate metacognitive and behavioural strategies into her daily routines, translating insight into consistent action.
Notably, she showed enhanced emotional regulation through the use of humour, acceptance and preventive self-care measures, while also learning to access and value social support systems more effectively. Although she maintained a degree of guardedness, her increasing comfort in both seeking and offering support suggested a developing sense of relational trust and social resilience. Rosalind's growing use of self-compassion and mindful awareness contributed to reduced self-blame and improved focus, helping her manage academic and personal stressors with greater balance and flexibility. Rosalind's engagement and integration of learned strategies highlight a strengthened capacity for resilience, self-care, accessing social support and adaptive coping which are all key indicators of sustained psychological growth and well-being.

Participant 8 (Christine)

Background and Stress Profile

Christine, a 20-year-old undergraduate student in the Faculty of Sport Sciences at Palmerston North, entered the programme presenting with stress related to academic pressures, high expectations of herself and tendencies toward procrastination. Her Perceived Stress Scale-14 score during the recruitment phase was 37. She reported a pattern of venting, often toward her best friend, but also inwardly toward herself, which contributed to self-blame and reduced motivation. She did not report any history of self-harm, harm to others, or psychiatric treatment, suggesting her coping strategies were primarily behavioural and cognitive in nature. Christine's context as a young university student balancing study, social commitments and part-time work shaped the stressors she brought into the sessions.

Engagement and Responsiveness to Intervention

Christine was notably forthcoming and cooperative from the first session, consistently attending meetings, submitting assignments and reflecting thoughtfully on weekly tasks. She described early sessions as "effective" and said she felt "better at the end of the session" after practising new strategies. She valued the structure and looked forward to the weekly interventions. Her ability to translate theoretical content into her daily experiences such as managing stress through venting accountability, applying metacognitive strategies and restructuring self-talk demonstrated strong engagement and receptivity.

Passive Coping to Active Coping Transition

At the beginning, Christine displayed reliance on venting, distraction, procrastination and self-blame, often linked to high expectations of herself and stress-induced avoidance (e.g., cleaning instead of academic work). When reflecting on procrastination, she admitted, "I put off important things and distract myself with cleaning," highlighting her awareness of avoidance patterns. Through role plays and reflective activities, she recognised how denial and blame language reinforced these passive coping styles. A pivotal shift occurred when she began to break tasks into smaller target areas, reframing achievement as progress rather than perfection. Over time, she developed more adaptive strategies such as accountability, thought reframing and planned goal execution. Her self-awareness increased and she began to see control not as a rigid standard but as something flexible that enabled learning and growth.

Self-Care and Mindfulness

Christine reported being consistently active and health-conscious, yet she acknowledged that stress sometimes disrupted her routines. She explained that she has "always been active and conscious with my diet," but admitted obstacles could limit exercise in the future. The self-care module encouraged her to anticipate these barriers, while mindfulness training provided practical tools for managing distraction and procrastination. She commented that she was "excited to practice informal mindfulness activities," recognising their potential to help her sustain focus on assignments. Relaxation strategies such as aromatherapy, walks and bike rides also became part of her repertoire, contributing to mood stability during exam periods. Christine initially struggled to extend kindness toward herself, particularly when she felt she had neglected academic tasks or social obligations. During the self-compassion session, she reflected, "I struggle to be kind to myself, but this will be a conscious reminder that will reduce stress." She identified self-compassion as a key reminder for reducing stress and rebalancing after setbacks. Gratitude journaling further enhanced her emotional regulation, allowing her to reframe experiences positively and strengthen resilience.

Social Support Development
Christine's sessions revealed early hesitance in seeking support, especially structural or emotional support. She gradually reframed this perspective, recognising social support as a resource rather than a burden. This was evident when she shared that she was "planning to access more structural support and frequency this coming week." Later, she reported that her partner and mother were her main emotional supports, alongside cousins and sporting friends. She expressed gratitude for these connections, noting, "I am thankful that I have access to this support, even though I don't actively seek it." Informational and cognitive support from tutors and peers further helped reduce academic stress, particularly as a distance student.

Active Coping and Integration
In the later stages, Christine consolidated her learning by applying active coping strategies such as problem-solving, DTT (discrete thought tracking) and restrain coping. She used these tools both in academic contexts (e.g., organising assignments, addressing issues with tutors) and in her sporting life (e.g., regulating reactions on the soccer field). She reflected that "breaking things down to smaller target areas makes achievement possible," showing increased flexibility and realistic self-appraisal. In the humour module, she admitted that humour felt like "something that can be learnt but not necessarily teachable," and acknowledged her use of both affiliative and self-defeating humour, with a tendency toward macabre humour. Despite this, she expressed openness to cultivating more adaptive humour styles. By the final sessions, Christine reported greater organisation, improved communication and a sense that the strategies were "useful" and practical for sustaining wellbeing.

Overall Perspective
Christine's trajectory illustrates a progression from self-blame and procrastination to self-awareness, accountability and proactive coping. She demonstrated resilience, openness and an ability to integrate therapeutic tools into both academic and personal domains. While perfectionism and hesitance to seek support were initial barriers, she grew in self-compassion, strengthened her social connections and developed active coping strategies that enhanced her confidence and balance. Her journey highlights how structured, skills-based interventions can effectively support university students in navigating stress while building sustainable strategies for long-term wellbeing.

Participant 9 (Mary)

Background and Stress Profile
Mary is a 26-year-old, a postgraduate psychology student balancing academic demands, parenting a special-needs child, planning a wedding and managing ongoing health concerns (irritable bladder and congenital heart condition). Her Perceived Stress Scale-14 score during the recruitment phase was 38. Additional stressors during the intervention included a friend's suicide attempt, childcare pressures, assignment stress and COVID-related disruptions. Despite these stressors, Mary maintained stable mood, utilised support effectively and showed insight into how stress impacted her functioning.

Engagement and Responsiveness to Intervention
Mary was consistently forthcoming, cooperative and well-prepared, regularly completing assignments and engaging actively in role-play and reflective tasks. She demonstrated strong motivation to apply strategies, often reporting improvements week-to-week. She showed enthusiasm for new tools such as blame-language reframing, metacognitive strategies, self-compassion notes and gratitude journaling. Her willingness to discuss personal stressors and her

consistent attendance reflect high engagement and therapeutic responsiveness.

Passive Coping to Active Coping Transition
Across sessions, Mary identified several passive coping tendencies including avoidance, self-blame, procrastination and denial. She recognised how high expectations and feelings of inadequacy contributed to disengagement from academic tasks and increased stress. Through cognitive reframing, small-goal setting, accountability strategies, behaviour tracking and narrative restructuring, she gradually shifted toward active coping. She mentioned she realized that "your life isn't in your head" by putting energy in behaviours and action instead of being anxious. Her ability to halt negative spirals, take behavioural action and "restart" rather than pursue perfection illustrated meaningful cognitive and behavioural change.

Self-Care and Mindfulness
Mary actively incorporated self-care strategies including exercise, improved nutrition planning, decluttering her environment and using relaxation breathing. She resonated with informal mindfulness practices mindful eating, gardening and bringing awareness into everyday activities. She also adopted self-compassion techniques to counter perfectionism and self-criticism, particularly around academic performance and parenting. These practices contributed to improved emotional regulation, better sleep and more adaptive daily functioning.

Social Support Development
Throughout the intervention, Mary explored the four domains of social support; structural, functional, emotional and material. She acknowledged early life barriers to seeking support but demonstrated considerable growth in her willingness to access it. She identified her partner, mother, sister and close friends as reliable emotional resources, utilised childcare support to create functional space for academic work and engaged more comfortably in requesting help when needed. Mary also reported that her childhood friend attempted suicide and called her at 6am and then proceeded to call another friend who helped him. While she reported that she felt guilty about not responding to the call. She was surprised that he called her as they "are not that close." She was asked additional specific risk analysis questions. "Since the incident you had any recent mild or intense suicidal ideations and thoughts about hurting herself and others?" She quickly responded that she is no risk to herself and her family, as she has lots of hope for her future and looking forward to her upcoming wedding in October with her partner and enjoying her son. Here Mary applied these principles effectively when supporting a friend in crisis, showing good judgment and boundary management**.**

Active Coping and Integration
Mary increasingly integrated intervention strategies into her daily life. She used reframing during health-related stress, employed restraint coping in emotionally charged situations, applied gratitude journaling and maintained behavioural consistency even during busy periods. She showed clear understanding of how the programme's sessions linked together, especially during the Discrete Thought Tracking (DTT) module, noting that the structure "made sense" and supported her growing psychological flexibility. Her stable mood across significant stressors reflected successful skill consolidation.

Overall Perspective
Mary demonstrated substantial psychological growth across the intervention. Her consistent engagement, willingness to challenge passive coping habits and adoption of active, mindful and self-compassionate strategies contributed to improved functioning and wellbeing. She strengthened her ability to seek and utilise social support, regulate stress and maintain balanced

expectations of herself. Through her integration of learned strategies reframing, behavioural activation, mindfulness, self-care and structured coping. Mary exhibited enhanced resilience and emotional stability. These developments indicate sustained progress and a strong foundation for continued psychological wellbeing.

Participant 10 (Dorothy)

Background and Stress Profile

Dorothy, a mother of three (aged 19, 16 and 11), age 41-year-old who lives on a rural farm in North Island, New Zealand with her husband and family while pursuing a Bachelor of Arts degree extramurally. Her Perceived Stress Scale-14 score during the recruitment phase was 31. Balancing household responsibilities, academic pressures and caregiving roles created a demanding context that heightened her stress and sense of being overextended. She initially presented as slightly shy but quickly became forthcoming and cooperative in sessions. Importantly, she reported no history of self-harm or psychiatric medication, suggesting that her coping resources were behavioural, relational and faith-based. Her stress was shaped by perfectionistic tendencies, overcommitment and disrupted self-care routines, all of which fed into procrastination and self-doubt.

Engagement and Responsiveness to Intervention

Across the 16-session PRTM programme, Dorothy demonstrated steady commitment and reflective engagement. She attended sessions punctually, returned assignments and often remarked that the strategies were "extremely useful" or "hugely helpful." She expressed gratitude for the structure, describing the sessions as "doable and easier than I anticipated," and noted that the weeks "went by fast." She actively experimented with coping strategies in her daily life, applying metacognitive techniques to reduce overthinking and recognising immediate benefits such as improved sleep and energy.

Passive Coping to Active Coping Transition

Initially, Dorothy relied on venting, distraction, procrastination and self-blame, often attributing this to her high expectations and avoidance patterns. She acknowledged that she sometimes put off important tasks, such as weight loss or academic work, admitting to subtle self-sabotaging thoughts (e.g., worrying about "losing too much weight and having to buy new clothes"). Role plays on venting and self-blame were particularly powerful, with Dorothy describing them as "very fruitful." Over time, she embraced accountability and acceptance, reframing her idea of success away from achieving "100%" toward asking herself, "What is the learning in this?" This shift reflected a transition from reactive, blame-based coping to proactive strategies rooted in planning, reframing and resilience.

Self-Care and Mindfulness

Dorothy resonated strongly with the self-care and mindfulness modules. She noted that metacognitive strategies had "hugely helped" reduce overthinking and supported better rest. She committed to exercise, healthy eating and routine maintenance as ways of improving sleep and balance. She was particularly enthusiastic about informal mindfulness activities such as mindful eating and exercising, explaining that they made her feel "more accomplished" and improved how she felt about herself. While she acknowledged that family visits or farm work could sometimes disrupt her routines, she demonstrated growing insight into anticipating obstacles and developing preventive strategies to sustain her progress.

Dorothy initially struggled with self-kindness, especially in response to academic setbacks or farm-related stressors (i.e., a recent exam result and difficulty feeding the cows). She admitted,

"I struggle to be kind to myself," but added that consciously reminding herself of this could reduce stress. The self-compassion session within the self-care module helped her reframe self-critical thoughts, while gratitude journaling reinforced her focus on positive experiences. Faith was also a central grounding resource, as she reflected, "I always rely on my faith and my community when I am troubled." These practices fostered resilience and emotional regulation, enabling her to approach challenges with greater patience and gentleness.

Social Support Development

At the outset, Dorothy described her structural social support as small and admitted discomfort in seeking help. Over time, however, she reframed support-seeking as a resource rather than a weakness, remarking that she was "looking forward to learning how social support can be a resource for me." She identified her husband, children, parents and siblings as key supports, while also recognising the importance of close friendships. She reflected on past experiences, such as the loss of her brother and her family's move to the South Island, as times when emotional support became vital. By the later sessions, she acknowledged a willingness to engage more openly with both emotional and instrumental support, reframing it as an opportunity for relational reciprocity rather than a burden.

Active Coping and Integration

In the later stages, Dorothy consolidated her learning by applying active coping strategies such as problem-solving, restrain coping and gratitude journaling. She noted that learning how to restrain her reactions was important both for addressing academic procrastination and for managing interactions with her children. She reported communicating more effectively with her parents, saying this was "easier than I anticipated." The humour session presented challenges, as she admitted to having few close friends and finding humour "difficult," yet she recognised her use of both affiliative and self-defeating humour and expressed openness to using more affiliative humour with family and friends. By the end of the programme, Dorothy expressed gratitude for the sessions, describing them as practical, helpful and directly applicable to her life.

Overall Perspective

Dorothy's journey reflects a clear transition from stress-reactive, avoidance-based coping to adaptive, proactive and resource-seeking strategies. She consistently engaged with therapeutic tools, reframing perfectionism and blame into learning opportunities and compassion. Despite initial discomfort with support-seeking and humour, she demonstrated resilience, strong reflective capacity and a growing ability to integrate coping strategies into her family, academic and rural life context. Her reflections "hugely helped," "extremely useful," "easier than I anticipated" underscore her perception of meaningful growth. Ultimately, Dorothy's case illustrates how structured, skills-based interventions can support individuals juggling multiple roles in cultivating long-term wellbeing and relational balance.

APPENDIX C: MEASUREMENTS

PERCEIVED STRESS SCALE-14 (Cohen, S., Kamarck, T., & Mermelstein, R., 1983)

The questions in this scale ask about your feelings and thoughts during THE LAST MONTH. In each question, you will be asked HOW OFTEN you felt or thought a certain way. Although some of the questions are similar, there are small differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a seasonable estimate. For each question choose from the following alternatives:

0= Never
1= Almost Never
2= Sometimes
3= Fairly Often
4= Very Often

	Never	Almost Never	Sometimes	Fairly Often	Very Often
1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous or "stressed"?	0	1	2	3	4
4. In the last month, how often have you dealt successfully with irritating life hassles?	0	1	2	3	4
5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?	0	1	2	3	4

6. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
7. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
8. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
9. In the last month, how often have been able to control irritations in your life?	0	1	2	3	4
10. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
11. In the last month, how often have you been angered because of things that happened that were outside of your control?	0	1	2	3	4
12. In the last month, how often have you found yourself thinking about things that you have to accomplish?	0	1	2	3	4
13. In the last month, how often have you been able to control the way you spend your time?	0	1	2	3	4
14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

Brief COPE (Carver, 1997)

There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. Use these response choices.

Make your answers as true FOR YOU as you can.
1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

In the recent past…	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1.I've been turning to work or other activities to take my mind off things.	1	2	3	4
2.I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
3.I've been saying to myself "this isn't real."	1	2	3	4
4.I've been using alcohol or other drugs to make myself feel better.	1	2	3	4
5.I've been getting Emotional Support from others	1	2	3	4
6. I've been giving up trying to deal with it	1	2	3	4
7. I've been taking action to try to make the situation better	1	2	3	4
8. I've been refusing to believe that it has happened	1	2	3	4

9. I've been saying things to let my unpleasant feelings escape	1	2	3	4
10. I've been getting help and advice from other people	1	2	3	4
11. I've been using alcohol or other drugs to help me get through it	1	2	3	4
12. I've been trying to see it in a different light, to make it seem more positive	1	2	3	4
13. I've been criticizing myself	1	2	3	4
14. I've been trying to come up with a strategy about what to do	1	2	3	4
15. I've been getting comfort and understanding from someone	1	2	3	4
16. I've been giving up the attempt to cope	1	2	3	4
17. I've been looking for something good in what is happening	1	2	3	4
18. I've been making jokes about it	1	2	3	4
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping	1	2	3	4
20. I've been accepting the reality of the fact that it has happened	1	2	3	4
21. I've been expressing my negative feelings	1	2	3	4
22. I've been trying to find comfort in my religion or spiritual beliefs	1	2	3	4
23. I've been trying to get advice or help from other people about what to do	1	2	3	4
24. I've been learning to live with it	1	2	3	4
25. I've been thinking hard about what steps to take	1	2	3	4

26. I’ve been blaming myself for things that happened.	1	2	3	4
27. I've been praying or meditating.	1	2	3	4
28. I've been making fun of the situation.	1	2	3	4

Hopkins Symptoms Checklist-21 (Green, D. E., Walkey, F. H., McCormick, I. A., & Taylor, A. J. W., 1988)

The following questions are about general stress symptoms. Please describe how much of each of the symptoms you experienced during the past seven (7) days. Please use the following scale to record your responses.

1= Not at all
2=A little bit
3=Quite a bit
4=Extremely

In the past seven (7) days, how much were you bothered by:	Not at all	A little bit	Quite a bit	Extremely
1. Difficulty in speaking in times of excitement	1	2	3	4
2. Trouble in remembering things	1	2	3	4
3. Concerns about sloppiness or carelessness	1	2	3	4
4. Blaming yourself for things	1	2	3	4
5. Pains in the lower part of your back	1	2	3	4
6. Feeling lonely	1	2	3	4
7. Feeling ‘blue’	1	2	3	4
8. Your feelings being easily hurt	1	2	3	4
9. Feeling that others do not understand you, or are unsympathetic	1	2	3	4

10. Feeling that people are unfriendly, or dislike you	1	2	3	4
11. Having to do things slowly, to ensure that you're doing them properly	1	2	3	4
12. Feeling inferior to others	1	2	3	4
13. Muscle soreness	1	2	3	4
14. Having to check and double check what you do	1	2	3	4
15. Occasional hot or cold spells	1	2	3	4
16. Your mind occasionally going blank	1	2	3	4
17. Either numbness or tingling in your body	1	2	3	4
18. A lump in your throat	1	2	3	4
19. Trouble in concentrating	1	2	3	4
20. Feeling of weakness in parts of your body	1	2	3	4
21. Occasional 'heavy' feelings in your arms and legs	1	2	3	4

The General Wellbeing Scale, (Dupuy H., 1978)

For each question, choose the answer that best describes how you have felt and how things have been going for you during the past month.
First 14 questions use a six-point rating scale that represents either intensity or frequency. The remaining 4 items use a 0- 10 rating scale.

5- In excellent spirit
4 -Very good spirit
3 -In good spirit mostly
2 -I've been up and down in spirit a lot
1 - In low spirit mostly
0 - In very low spirit

In the past month, how much were you bothered by:	In very low spirit	In low spirit mostly	I've been up and down in spirit a lot	In good spirit mostly	Very good spirit
1. How have you been feeling in general?	0	1	2	3	4
2. Have you been bothered by nervousness or your "nerves"?	0	1	2	3	4
3. Have you been in firm control of your behavior, thoughts, emotions, or feelings?	0	1	2	3	4
4. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile?	0	1	2	3	4
5. Have you been under or felt you were under any strain, stress, or pressure?	0	1	2	3	4
6. How happy, satisfied, or pleased have you been with your personal life?	0	1	2	3	4

7. Have you had reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory?	0	1	2	3	4	5
8. Have you been anxious, worried, or upset?	0	1	2	3	4	5
9. Have you been waking up fresh and rested?	0	1	2	3	4	5
10. Have you been bothered by any illness, bodily disorder, pain, or fears about your health?	0	1	2	3	4	5
11. Has your daily life been full of things that are interesting to you?	0	1	2	3	4	5
12. Have you felt downhearted and blue?	0	1	2	3	4	5
13. Have you been feeling emotionally stable and sure of yourself?	0	1	2	3	4	5
14. Have you felt tired, worn out, used up, or exhausted?	0	1	2	3	4	5

From number 15 -18 please circle the number that seems closest to how you have felt generally during the past month.

15. How concerned or worried about your health have you been?

Not concerned at all	10	8	6	4	2	0	Very concerned

16. How relaxed or tense have you been?

Very relaxed	10	8	6	4	2	0	Very tense

17. How much energy, pep, and vitality have you felt?

No energy at all, listless	10	8	6	4	2	0	Very energetic, dynamic

18. How depressed or cheerful have you been?

Very depressed	10	8	6	4	2	0	Very cheerful

APPENDIX D: PARTICIPANT 11- LILY'S DIARY ENTRIES

Session 1- Active Coping

"Work was exhausting today. Too many outpatients and walk-in cases. I am still learning how to work as a receptionist at my department. On this particular day, I had to do something that is new for me as /I have not learned it before. So, I turned to my friend who works beside me to ask some advice from her but ***she glared at me and gave me a cold shoulder. When I saw what she did, my temperature and stress level started to rise because I did not disturb her purposely but to merely ask some advice. For a moment I thought that I could show face back to her but then I took a deep breath and look back at the situation. I saw that my friend was talking on the phone probably to some annoying patient who is asking to much question. At that moment I understood why my friend glared at me to avoid delaying my work or getting myself upset, I told myself that I could ask someone else to help me. I went to my manager and asked her help, informing about the situation that we are facing at the front counter. My manager was glad to offer a hand and I manage to do my work.*** What I applied —>Active coping strategy: During this situation, I applied the active coping and tried not to stress too much.

My son came down with flu and running nose last night and was having difficulty sleeping due to nose block. I used a nose spray to clear the block in his nose while my mother-in-law was holding him. When I came home after work today, ***my mother-in-law told me that the medicine (nose spray) that I used in the morning is not suitable for kids as she was told by a pharmacist. This instantly made me think that I did something wrong even though deep down I know I did what is right. I went to my room and started to think why my mil told me that and I realise she was only thinking of the best for my son. I went back to her and explained that the medicine that I used was actually given to him at the hospital when he was admitted.*** She understood what I said and I explain that we can use the medicine that she bought because the ingredients are same. I learned from my sessions with Dr.S that sometimes is best for us to think why the other person said or do that. I learned that thinking from another perspective is always good.

My daughter always shows tantrum every morning when I wake her up. Today, she did the same and I was not in the mood to get myself agitated. So what I did was, I woke her up as usual and when she started to act up, I just left the room. My daughter felt something wasn't right so she got up quietly and when to take her shower".

Session 2

"Today was a very hectic day. There were a lot of outpatient and inpatient walk-ins today. I almost lost my cool and patience few times today. ***The most significant or event that really pissed me off is when one of this patient came to me to change appointment. She wanted to change for the whole month and I got so stress because the computer system suddenly malfunction. I took a minute for myself, took a deep breath, I told the patient to have a seat and explained to her that it is going to take some time since the system malfunction.*** I was glad that the patient did not ask anything further and took a seat. I was glad after 10 min I manage to book her appointment and she left gladly. I told my friends what happened and they made fun of me as I manage to handle that particular patient who is actually very fussy.

My family is to attend a wedding tomorrow and I particularly told my daughter to bring everything that she needs for the wedding tomorrow from my in-laws place. As usual, she left her shoes back home and she innocently told me about it. I did not yell at her as I usually would do but I told her nicely that next time I would like her to obey whatever I told her. So, that night, I had to drive back to my in-laws house to get her shoes.

I told my daughter to sweep the house so that I can start mopping the house. She said 'No' directly to me. I really got angry and I scolded her. A few moments later l spoke to her softly and I explained why I told her to help me. She agreed to sweep half-heartedly and I managed to get my household chores done.

Today was a very hectic day. As usual, too many patients. My hands was full with a lot of work and I noticed that my partner is not in for work yet. She came in late 5 minutes and did not even apologize or explained why she was late. This is not the first time she had done this. I was unhappy and I confronted her nicely, quietly when there was no patient. She explained that she was in the toilet and lost track of time. I told her frankly that this was not the first time she did that. Then, she apologize to me. I told her to inform me if she is going to be late so that I can explain to anyone who asks"

Session 3- Passive Coping

"***Tuesdays are always a busy days for me. Its Maths day and I won't have rest until I have finish my class. There is one particular student of mine who has difficulty or (sometimes I think) just do not want to study. On this particular day, he asked me so many questions that I had to focus on only him. I used the active coping strategy that I was taught. I left the room for a while to breath, drank a cup of water and went back to class. I told him to do the questions first while I taught the other students.*** He did as he was told and I had time to teach other students. When I got back to him, I saw that he had tried to answer the mathematic question although he made some mistake. I joked with him and the other students saying that it is always good to try and make a mistake because we all learn from our mistakes.. He understood what I was saying.

Today we had a lot of patients. ***I walked in to my department today morning to six patients waiting to be registered and attended to. I did not expect this. I did not manage to sign in to my computer when I was bombarded with questions from the patients. One of the therapist said that I should come a bit early to cope with the registration. To that I replied that since you are already here, why didn't you help with the registration. I was a bit angry and when I think back, I shouldn't have blamed the therapist for not helping me. I turned around took a deep breath, sat on the chair and started my work. I started to recall the active coping, and blame language I learned yesterday.*** I calmed myself down and managed to do my work smoothly.

I was on leave today. ***My son had appointment for speech therapy today. I knew my son would vomit today. (He always does that when he has any hospital appointment). So I planned ahead. I gave him breakfast at home. Like I wrote just now, he did vomit but it was at home that he did it. I managed to clean him up again and leave the houses on time.*** His speech therapy session went well without any episode from him. At the same time, I manage to finish all pending work that needed my attention and my presence at the particular place. Overall, I think today went well because I planned ahead what to do first and where to go first".

Session 4

"I was feeling great, I would say that I was happy. ***I bought a washing machine for my nom and I feel great about that. I have never bought anything expensive for her and it was something that I always thought about. When I see my other siblings getting gifts or buying something expensive for her, I feel bad, very bad as if I am not a good child. So, when I got my bonus a few days ago, I knew what I could get for her. I know it is very hard for her to wash her clothes by hand. I know she bas back pain and knee pain. After completing the purchase, I felt very good, almost like a burden has been lifted.*** I do not know if it is something that I learnt from my sessions with Dr.S, but I clearly felt very good.

I woke up a bit later than the usual time today as it was a holiday. I planned in advance what we were going to do as a family today as I don't want anything to disrupt the mood today. With what I've learned from my sessions with Dr.S, it is always okay if things don't go the way we planned, but how we accept it or how we feel about it is what matters more. ***My daughter was complaining that I didn't bring her out for the weekend. I sat and talked with her. I explained why we can't go out for the day because her brother has an OT session today at 2pm. If we were to go out in the morning, we have to rush back to be on time for the OT session. And if we go after the OT session, we can't enjoy ourselves as there is a limited time. My daughter understood the situation, and she was calm about it. I told her that I would take both of them to the playground tomorrow morning. I was happy with the way I handled the situation with my daughter, and I was more pleased by the way she took the situation into account.***

I kept my word today and brought both of them to the playground. They had a wonderful time today. We spent almost an hour or more at the playground. After that, we decided to buy lunch, and my daughter wanted chicken rice from one particular shop. I went to the place but had a hard time finding a place to park the car. I was a bit stressed and angry by the way other people parked their cars. I was about to give up and go back home, but I thought about my daughter. I took a deep breath, calmed myself, and told my daughter that if we couldn't find any parking nearby, we needed to park abit fo further and walk to the shop. She agreed half-heartedly and made another circle back to the place. Fortunately, we manage to find a parking and I was glad that we did not need to walk very far.

Today, I was supposed to bring the kids out for the day off but had to postpone the plan. I was disappointed because what I had planned did not work out. I had to postpone our day out because the plumber said he was coming over to the house to repair the pipes. We waited until mid-afternoon but he did not turn up. After a few phone calls, the plumber cancelled his appointment. I was very disappointed and angry but most of all I felt like I had let down the kids. I took a few minutes to think and I decided that I would take the kids out tomorrow. The kids were happy about what I had planned for them tomorrow".

Session 5- Self-care

"3 things that are obstacles - Waking up early - To finish a task - To show gratitude to coworkers 3 possible solutions. - To fix an alarm clock - Somehow find a way to finish a task - Saying a simple thank you. Like I mentioned in my entry yesterday, I managed to take my kids out today. I took them to the indoor playground near my mother's place. So many things happened in those 2 hours. Firstly, my son somehow managed to walk into the indoor playground with only his right shoe on. When I saw that, I felt like a useless mother. So many people saw us walk in. What would they have thought about me? I literally had to walk back the way we came to find his shoe and I finally found it in the car. Secondly, halfway through the play, my son vomited in the playground. He was so excited and happy that he was jumping and running about that he vomited. To tell the truth, I was a bit embarrassed by the situation because I had to clean up the whole place and my son could not stand still just for a while. Third and last of all is when we were about to go back. My son did not want to go home. He literally laid down on the floor and started crying. I was angry, tired, and embarrassed all at the same time. I told him we would come again some other time and took him home. He was still crying in the car, but once I put on his favourite song, he calmed down a bit.

Today's work was a bit stressful as most of my Malay co-workers were still on holiday. I had to do a few things at the same time. I was tired and started to vent to myself. I was venting to myself for quite some time and I realised that nothing good was coming out of it. So, I changed the way I was looking at things or my work at that time. I decided that I didn't want to stress myself too much and decided that I would do what I can and ask for help with my

work. After all, we are a team and we must work as a team. I did ask for help, some of them did help me and we managed to finish our work easily.
Today, I went out with two of my friends for dinner. It has been a long long time since I went out with my friends. I felt very good and relaxed. We went for a walk after dinner. We talked about work and family. I felt good, relieved, and relaxed because as we talked, we managed to find some solutions to the problems we were facing individually. We also discussed plans and ways to make certain things possible. I felt that sometimes it is good to share our feelings, thoughts, and burdens with other people".

Session 6
"Today was a fun day. Work was excellent and I was not stressed. ***After work, I took my son out for a walk. We had a good time just both of us. We walked for about 30 minutes or so and then we went back home. He was in a good spirit despite having the flu. I gave him his dinner and cleaned him up. I got him ready for bed. He slept soundly tonight.***
I had a good sleep today. Yesterday's walking and good sleep at night made me energetic this morning. Managed to do my work with ease. Usually, Saturdays are very rushed, but today it was easy going. We finished work happily and I managed to rest for a while before taking my son to his OT session. I was surprised to see my son well-behaved when he went for his OT session. Usually, he would cry not to go in, but today he went in willingly. I was surprised and also proud of him. I can see changes in him in the past few days. I did not bring my kids to the playground today. Both of them woke up late today and I was having stomach issues today. When my son woke up, I gave him breakfast as usual, but he did not make any fuss about going out as if he understood that I was not feeling good. When his big sister got up, had her breakfast, and was ready, all three of us went down to the barber shop to cut my son's hair. My son doesn't like anybody to touch his head, and usually, hair-cutting day is a stressful day for him and also for me. Thank God, he did not throw a lot of tantrums, and we managed to get his hair cut. I thank my daughter for being a huge help for me.
I am very grateful for today. Everything went very smoothly today. No hiccups, no delays, and no interruptions. Everything was great today. Work went smoothly today, and I managed to rest in between working hours today".

Session 7- Social Support
"Compared to yesterday, today was a busy day. Work was ok, it still went smoothly, but tuition was hectic. Although it is only for one and a half hours, it was still hectic. I still feel the stress. It's Maths Day. Of course, it will be a busy day. All the students had one or other questions to ask. I managed to answer and help a few of them during the duration of time. For some, I told them that we would discuss it next week. At the end of the day, when I look back at what happened from morning till now, I was genuinely happy or pleased that I could help some of them.
Today, I used the S. T. O. P technique that I learned with Dr. S. This month, I am back to the normal work, and one of my friends did not turn up to work. It was a hectic day, and all the therapists needed something to be done. So, I applied what I learned. I did what needed to be done which is urgent and did what was not urgent later. I find that this technique really helped me a lot today, and I was not worked up like I usually do.
My son started to have his melt-down. He started to shout and scream because he did not get what he wanted. In just a split moment, I started to feel my head heating up. For a few seconds, I just used the S.T.O.P technique, took a deep breath, and did what I thought was right. I scooped him up, took him out of the house, and made him sit on the car. For a while, he was whimpering, and then he totally stopped whatever he was doing. He became calm and started to smile. My daughter came out to cheer him up, and when my neighbours saw

us out, they too came out to cheer him. At the end, he was more calm, and he was able to sleep better. Actually, all three of us were able to sleep better".

Session 8

"Today was my last session with Dr. S. ***I was sad that the session was ending but very glad that I got this opportunity. I managed to learn a lot about stress coping and find myself changing bit by bit. I am surprised and glad that I can see changes in me.*** Changes not only in me but in how I manage situations around me. I feel more mature and am able to ask for help. I am able to cope with my children's tantrums and most of all am able to go down to their level of thinking, their level of emotions, and their level of expectations.

Today was a very calm day. Events did happen, minor events, but mostly it was a very calm day. Work was good. We worked jovially and went back without any complaint. I was very grateful for the sunny weather, although the temperature was hot, but I am still grateful for the weather. I had a good night's sleep and woke up the next day energetic.

My daughter had to play her violin today for Easter. She was very nervous and was telling me a lot of times that she did not want to play. I can see that she was very agitated. I sat her down and told her calmly that she can do it. It doesn't matter if she does not play well, but she can do it. I was very glad that I could teach her certain things that I learned with Dr. S. Although she did not understand many of it, I saw that she was calm after she took a deep breath for a few times. I took my son to occupational therapy today at the general hospital. I was worried about what they would say. I waited for an hour, and I was relieved when he came out smiling. I can see that he was very happy. The therapist also gave me a good result, and I was relieved. ***I tried to stay positive with all the feedback given, and I am making sure that my daughter and I do the tasks that have been given to help my son. I am very grateful for my daughter. She has been my pillar throughout this 2 years".***

APPENDIX E: PARTICIPANT 12-JENNIFER'S DIARY ENTRIES

Session 1- Social Support

"I'm at work, nothing big matters happened, but i had tried to socialise with my colleagues, smiled, laughed, share the works, everyone asked me why you're so happy, I just answered like ahh? really?, and ***I have accompanied one of my malay colleague for her sahur, I mean it's a new experience for me and glad I tried to mingle up with people, I guess something Is better than nothing right!!! I've been to work, smiling through all to my colleagues, this time I started conversation first instead of walting for them to talk with me. I guess it's a good change".***

Session 2

" I've been to work (night shift), with one of my Malay seniors, all went well.
The same night shift @ 04:00 am we need to update census and look forward to cancelling staff due to low census. ***I've called my sister (manager) and she talked with me like normal at first but then she started to shout due to poor connection, I couldn't hear her properly. She said "every time I want to talk with you and each time also you mentioning couldn't hear you properly, go and wash your ears and then come and listen, ba bla bla". But I managed to end the conversation nicely, I had tried to think "Alright, She have two little kids, she needs to cook early morning, making breakfast, prepare them to school". I had tried but I felt still I'm hurt, and I couldn't take it in a positive way.***
I've come to my boyfriend's home and talked with my bf through all the things out. I've been trying to hard to understand him about the smoke thing and I've opened up all the things that matters to me. He had listened until the end and he said "I'll try to change myself a little by little". I'm glad that at least he listened to me when no one could but I'm still scared to trust him.
I've been to work, it was my double shift, but ***I've been experiencing this Gastritis symptoms more to vomiting and everything. Try hard myself to work until 10:40 am that morning, end up seeing Medical Office (MO) at A&E and they give MC (medical certificate) with IV medications. My colleagues doesn't like I took MC and I've asked sorry to everyone and left the room.***
Clock in to work, everyone asked me how are you feeling right now? I said I'm fine and reassured everyone that I can work today. ***Seems like everything went good. WHY Im SCROLLING REELS? - To feel accompanied - to avoid something deeper felt.. - Highly engaging platform".***

Session 3: Passive Coping

"After come back room, instead of scrolling a lot, I did called my boyfriend. ***I did scrolled but for like less than 1 hour, then I took a nap. I did set alarm to woke up and after woke up I did laundry, washed hair, ironing uniform, ate dinner and after I settled, I started to Scroll back. I think when it comes to scrolling for me if I make it less than 30 mins,*** even it's a good moment. Bye!!!!!!
I have been to work, seems like everything normal and for the whole day even we have busy shift. ***I think it's because I have worked with all of my beloved staffs like me. Enjoyed the day even when it's busy.***
Nothing big matters, all fine with work as I'm getting used to my routines, paeds (pediatrics) cases and more interested in paeds cases actually. I have to learn alot more on medication, blood IV for paeds and I'm look forward to it. I've handled a paeds case and I have allowed myself to learn when my senior staff taught me how to read the blood test, how to carry

doctor's order, and etc, I felt a lot improved on myself".

Session 4

"***I was into work, I'm having period pain and I was leaned down a bit and my senior noticed it, said "okay, you are gonna took another MC today?", I was shocked and hurted why she's so mean....*** Actually the other day due to Gastritis, I took MC, that day this senior was worked without me, I was thinking maybe the other day she might be go through alot at working place without manpower, so she might get irritated whenever she sees me, instead of "Oh she say like that ah? She never took MC before is it?" Actually in deep down, I did self blame, whatever, it is like everyone says, I cannot take MC, don't make them to take care of everything alone***. I took 5 min to think through what I am self doubting/blaming is right? I have came up with an idea where to take care of myself first in that case I won't fall sick instead of wasting my time the whole day. Within 5 minutes I settled my mind and got back to work afterwards. The metacognitive exercise helped me through.***

I have noticed my boyfriend haven't text me/replied to my messages for few hours. I know that today he's busy he's doing auditing and work stress, but I cannot accept it. I want him to text me at least "Hey I cannot text you right now, I'll text you once I'm free. Love you". I started to overthink like he don't care about me anymore. ***Started to scrolling and felt my chest so heavy, so I paused scrolling, drink water, counted numbers, and felt myself become lighter, even I'm hurted, but I started to understand his side and handled the situation in a calmer way. I think I used metacognitive technique.***

I came to night shift and saw my other colleague is not well, struggling to walk like normal speed. I asked her what happened and she said she's going through some sick thing and dont want to take MC ete etc. After takeover shift I forced her to see MO and get medicine, meanwhile I did her work included mines. She said sorry cannot help you etc, I said it's fine and you can get rest as well since night shift we have plenty of time to finish our work. I think I used Emotional support.

All goes fine and I didn't encounter any much of issues, my day went fine.

Post night shift I noticed I didn't scrolled for hours instead I can finish my chores, getting sleep, I'm more productive rather than before in a way where I keep myself occupied. I'm slowly achieving Individual Utility.

I went back for my cousin's birthday and in that case went to my parent's home first. I had my sister who welcomes me always and talked with my mom for a while ***I felt like connected a bit with family, in front of many of family members. My father came and talked with me and I also talked back with him instead of holding my anger and thoughts back.*** He asked me how is your work all going so far and I have replied all fine with me. Just 2 words and I didn't embarass anyone in that big day.

After enjoyed the big day ***I talked with my sister and I think I relieved her hard feelings just by listening to her. I think in that time she just needed someone to listen and support her decisions are also correct, and I guess I did the right thing. Emotional support has been helping me out!!!*** Said my goodbyes to both parents and even My father and all other family members as well, and came back to Penang.

I have been to work and after 3 days off got a lot of OT (operation theatre) cases and my senior noticed wrong consent for surgery. Patient going for left leg operation and consent shows right leg. When I sent the patient to OT, I noted the Staff Nurse that this is wrong consent and requested the doctor to write up new consent since the doctor was in same OT place. My senior and I noted our sister about this matter and she asked "Why you all never call the doctor at ward itself? If like this the OT staff will flag Riskman (error alert) and we need to answer for it. Yesterday also this same issue happened and today also like this". She was shouting at my senior and I didn't know that wrong consent will mean that you will need to put up Riskman

but my senior knew and didnt even say a word. My Senior told to my sister, that we were sorry and made a mistake, the sister ordered both of us to sign counseling letter. I felt something off, I didn't know that yesterday got 1 incident happened like this, as I came from 3 days offs. My senior also didn't say a word, I myself confess to OT staff and noted to up new concern but still need to sign counseling letter for what? I cannot accept this situation and I really didn't know how to handle this....."

Session 5: Active Coping

"I've mentioned before that my boyfriend is entertaining everyone else except me, after speaking with Dr. S and the consultation, ***I'm currently adjusting my behaviour in a good way. I started to think maybe I can talk to them also instead of hiding from them and let my bf to socialize as he is living his life and I'm living mine for myself.*** It doesn't mean he needs to be there only for me, right? Well, he can be there and I think maybe his stress level will reduce by now after I started to understand him.

All seem to be fine. I didn't tortured my bf to VC (video call) me all the time and ***give him space, but I felt alone in my room. I started making myself occupied after finishing my work. I've been to grocery shopping and doing all this house chores and passed my day.***

Without VC with my bf feels odd but will get used to it for both of our good and realised our fights in the relationship less after I started to think everything positively. Thank you Dr. S".

Session 6

"I was canceled on my night shift at 6pm and I asked my bf "hey they cancelled me today, since your mother is also back can ***I come to your house today and he said it's fine, it's already late and you have to go back to work tomorrow, you will be tired and also wasting money just for quick hours,"… I understand that he is thinking about my goodness but felt like his efforts for me were less, I don't know how to say it, why I'm so eager to see him but he doesn't have the same feelings for me. But I've got myself calm and think back the whole thing, if he says no for one time, it doesn't mean he doesn't love me, I have understood the situation and yes I also will get tired as he said why not I can try to understand him this time instead of making this a issue.***

My night shift went well, and nothing big or major happened. No admissions, uneventful, and the same current stable patients***. I'm grateful for this peaceful night".***

Session 7: Social Support

"I went to work with my nice colleagues. We laughed, enjoyed work, and carried out some case studies. ***In the nicest ways about the exercise and diet, I guess I did make a difference instead of eating heavily at night, I ate some whole grain breads and milk, which is not full for me, but yeah, I did some change. HaHa!***

We went out with my bf and friends, and we took a suite to stay the night. It was a great experience and enjoyable nights. I was more friendly and used structural support to socialise more with them. I didn't isolate myself, didn't use phone while with them, and talked out loud about the diet. I was with friends and couldn't say no to their choices. I ate very unhealthy and very heavy foods for these two full days, even breakfast, lunch, dinner, and even 3 meals also took rice, tea time, and supper some more heavy foods...

Started working today and my friends who drop me at work, I ate morning breakfast Roti canai at the same Nasi Kandar shop, and started work. At work, I didn't eat anything and ate Nestum after finish work, as work also tiring. ***Then I'm unable to carry out exercises but I remember for every day I will walk to Hospital from my room to start work and also after finishing work, so if I calculate the minutes into steps (Google help!) maybe it will be 1800 to 2,200 steps.***

I've been working and eating café food at the hospital. I eat one pau for breakfast and rice for lunch. At night, I ate a bun, and that's it. I'm not able to carry out my exercise. I'm too tired and exhausted after work, bye!!!!".

Session 8

I went back to my bf's home and stayed for the holidays. When I noticed his behavioural change on cleanliness of the house, I got irritated. I started to open up the things and what I am actually irritated about, he was trying to prove his POV (point of view) as he was busy with work and parttime jobs as well and tired. His voice raised during the argument. I decided to pause for a second, think, and told him nicely that don't do like this next time.

On this day, after my work finished, ***we went for a gym exercise and after one hour went for swimming at his university. I felt productive a little bit on my own instead of just sitting at home relaxing.***

We went to many places with our friends, I mean me and my bf. ***We went for Nasi Kandar, as usual I didn't say no but I tried to use a portioning method for my plate, quite filling with just vegetables hehehe!***

Last-minute cancellation on night shift (as expected). Then we just relaxed at home. ***I think back and I realise I became more socialising with my friends. Also, I don't know how many hours I have relaxed without my phone. Quite surprising ah!!!***