

**'No Panic': How Helpful is Self-Help Recovery?**

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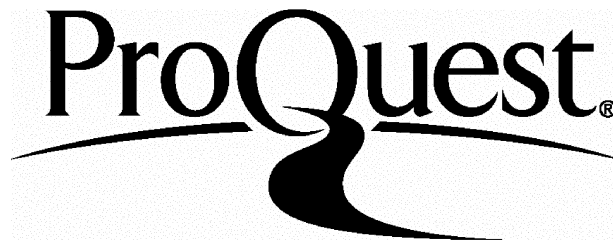
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### **Abstract**

Self-help approaches are playing an increasingly important role in the treatment of psychological and behavioural difficulties. Experimental research supports the efficacy of self-help media in the treatment of panic and agoraphobia; however, little is known about the effectiveness of treatments offered by self-help organisations. This study examined whether twenty-five participants of a self-help group telephone recovery programme, offered by a national self-help organisation ('No Panic'), reported significant and reliable reductions in symptoms of panic, agoraphobia and life disruption by the end of treatment. Fourteen of the participants also rated their symptoms at three-month follow-up. All participants were asked about their satisfaction with the group, and were interviewed about their treatment histories and expectations of the recovery programme.

Significant reductions were reported in number of panic attacks, the severity of fearful body sensation, catastrophic thoughts, anxiety and depression, agoraphobic avoidance when with a companion and symptom interference with daily life. The changes in fearful body sensations, catastrophic thoughts and anxiety and depression were maintained at follow-up. Nearly three-quarters of participants had achieved reliable change in three or more symptom measures. Only one-third were panic free at the end of the recovery group. Satisfaction at the end of the recovery programme was related to severity of fearful body sensations. At follow-up, satisfaction was related to severity of catastrophic thoughts. Qualitative data suggested that one of the satisfying aspects of the self-help recovery programme was the experience of being in a group with people who had similar difficulties. These findings, and their implications for clinical practice and future research, were discussed.

## Introduction

### **Overview**

Self-help groups form an increasingly large and important aspect of helping services. They are making a significant impact in health care services around the world, particularly in the United States (Jacobs and Goodman, 1989) and it is likely that they will play an increasingly important role in Britain's health care services.

Self-help groups provide an alternative to existing professional services. Barker et al (1990) report that "community surveys within psychiatric epidemiology (reviewed by Goldberg and Huxley, 1980) suggest that the one-year prevalence rate for psychiatric illness is around 25%" (p.281). They are clear that professionals alone can not meet this magnitude of need for mental health care. Further, they suggest that this prevalence figure may be an underestimate and that many people are using alternative forms of help, including self-help. The development of self-help organisations has been linked to disillusionment with professional services and supportive institutions (Hatch and Kickbusch, 1983). They can be defined as "member governed voluntary associations of persons who share a common problem or who rely on experiential knowledge at least partly to solve or cope with their common concerns; emotional help is one kind of help given" (Borkman, 1990a, p. 323). Self-help groups can be seen to involve themselves in all aspects of social and individual concerns, psychological and behavioural difficulties being one aspect of this.

'No Panic' is one such British self-help organisation. As their name suggests, they offer help to individuals who have difficulties related to anxiety, that is those people who have experienced panic, phobias and obsessions and compulsions. 'No Panic' became a registered charity in 1992 and has been offering its members

telephone recovery groups since 1994. It currently has a national and international membership of two-thousand. Approximately 300 members have taken part in the recovery programmes since their introduction.

This study is an investigation into the effectiveness of these self-help recovery programmes in reducing members' symptoms of panic and agoraphobia.

In introducing this study, some background information about self-help is provided, followed by a description of current models of panic and agoraphobia. Given that this is a study about outcome, some of the issues and difficulties relevant to this field of research are discussed. This is then followed by a review of the research to date on the effectiveness of therapies conducted by professionals, paraprofessionals and those utilising a self-help format.

### **Self-help: History and Background**

#### *Terminology*

The literature on self-help is fraught with difficulties in terminology and definitions. The American literature speaks of 'mutual aid groups' and research there seems to have advanced beyond testing the efficacy of self-help into exploring the ways in which mainstream healthcare services can develop positive relationships with these groups (Borkman, 1990a).

The terms 'mutual aid' and 'self-help' are often used interchangeably in the literature. Borkman (1990a) attempts to differentiate these terms. She suggests that mutual aid groups have a membership of people who have come together to share a common interest or problem, housing co-operatives being an example. Such groups have a history amongst the politically and economically disadvantaged and were concerned with resource exchange and political activism. In contrast, self-help groups have their roots in health and human services, they rely on the sharing of

experiential knowledge and emotional support. Members are responsible not only for obtaining from the group the support and help needed for their own welfare, but also for providing help to others. They are governed by their members rather than by professionals. Self-help is the term that will be used through this paper with the intention of conveying that each member both receives and provides aid.

### *Origins*

Self-help groups in the West roughly date from the 1930's, Alcoholics Anonymous, probably the most well known and now the largest self-help organisation, was initiated in 1935. Its introduction was followed by other groups such as for parents of sick children. This then led to groups for those who were stigmatised in society, those with life long medical conditions such as diabetes and those who had undergone medical procedures such as heart surgery. Self-help groups for those coping with life transitions such as bereavement and for those dealing with psychological difficulties began in the 1950's and continue to develop today.

### **Self-help Today**

#### *Use*

Despite its increasing importance, relatively little research regarding the self-help movement in Britain has been published. There is a lack of epidemiological data on 'who' and 'how many people' participate in self-help groups not only in Britain but also in other countries. Differing estimates have been made regarding the numbers of people utilising self-help organisations. Jacobs and Goodman (1989) estimated that 6.25 million people in the US use self-help groups each year, this figure is equivalent to the number of people receiving psychotherapy from professionals (Borkman, 1990a).

The National Institute of Mental Health (NIMH) has investigated the use of

self-help groups as part of its research into the mental health service system in the US. Lieberman and Snowden (1994) employed this research to calculate the prevalence of people using self-help organisations. The data illustrated that 2.8% of those with mental health needs had used self-help groups at some time in their lives. This compares with 15.7% who had sought professional mental health services. Of those individuals who had sought self-help, 71% had used both self-help groups and professional mental health services at some time in their lives. This data illustrates the important role that self-help plays as either the sole or an additional service for those with mental health needs.

### *British Self-help*

In Britain, the charting of the extent and use of self-help groups remains to be carried out. However, an informative study regarding the nature of self-help organisations in Britain was carried out some time ago at the Policy Studies Institute by Richardson and Goodman (1983). They outline the nature and functions of self-help groups and make some broad-brush observations which are still applicable today:

- Members of self-help groups vary in age, background and in the length of time they had experienced their difficulties. This leads to varied demands on the group.
- Such groups are essentially small organisations and, as organisations, they have chairs, committees, secretaries and so on.
- Most groups tend to have a few key members who carry out most of the work, not only in terms of practical running of the group but also in terms of providing most of the help members gain from it.
- Self-help groups provide direct help to members in order to help them cope with the problem in question; they also act as pressure groups to obtain

more resources and to educate the general public about their particular concern.

- They have one advantage not present in statutory services: the opportunity for members to gain from and provide help to other people with difficulties similar to their own.

### *'No Panic'*

The self-help organisation 'No Panic' involved in this study also have the features described above. 'No Panic' was formed in 1989. The founder, who has difficulties related to anxiety himself, was a volunteer with the self-help organisation, 'Phobic Action'. The organisation is based in Shropshire and receives some funds from Shropshire Mental Health Joint Collaborative Team and Shropshire Social Services Mental Health Division. 'No Panic' offer:

- A telephone help-line which provides counselling and information daily between 10 am and 10 pm.
- Twelve week telephone group recovery programmes for those with phobias and obsessions.
- Twelve week telephone individual recovery programmes.
- Local self-help group meetings for members.
- Information, support and advice to statutory and other voluntary services.

All of the these services are provided by trained volunteers who have at some time experienced or continue to experience anxiety problems themselves. All volunteers with 'No Panic' are trained in counselling skills and are supervised by other members. Training for the help-line was planned by a British Association of Counsellors (BAC) trained counsellor but is provided by members. Only those volunteers who have experience of work on the help-line are eligible for training as



facilitators for the telephone recovery work. This training has also been planned with the help of a trained counsellor. It draws from cognitive behavioural models of anxiety and employs a graded exposure structure. Prior to leading a recovery group, volunteers 'shadow' a more experienced member through the recovery programme. It may be argued that the help offered is informed by professionals and therefore is 'paraprofessional' help.

### **The Nature of Panic and Agoraphobia**

#### *Symptoms*

A panic attack is characterised by any or all of the following: fear, feeling dizzy or faint, choking, shortness of breath, fears of dying or thoughts of losing control. Agoraphobia is defined as anxiety about being in places or situations in which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack. Situations usually avoided include being outside the home alone, travelling alone, being in tunnels, bridges, and in open spaces. In patients who seek treatment, panic disorder typically occurs before agoraphobia (Garvey, Noyes and Cook, 1987; Franklin, 1987). Agoraphobia is characterised less by the fear of certain situations and more by a fear of having a panic in those situations. It seems that panics are experienced across anxiety disorders but they are seen as expected, cued and are given more meaning by those presenting with panic and agoraphobia (Barlow, 1988) than for those with other anxiety problems such as generalised anxiety disorder.

#### *Prevalence*

Data from the NIMH Epidemiological Catchment Area Survey give 6-month prevalence rates of .08% for panic and 3.8% for agoraphobia. Robins and Regier (1991) estimate the prevalence of the DSMIV diagnostic category of panic as 2%

lifetime frequency while agoraphobia is just under 6%. Panic disorder presents with an equal sex ratio (Myers et al., 1984) while around three-quarters of the sufferers of agoraphobia are female.

Those with panic disorder and agoraphobia tend to also suffer additional distress, particularly the occurrence of major depression and increased risk of suicide (Weissman et al., 1989). Furthermore, individuals with panic disorder are also more likely to be diagnosed with personality disorders when compared to the rest of the population (DSM IV's cluster C, comprising dependent, avoidant and obsessive compulsive disorder [Mauri et al., 1992]). Chambless et al. (1992) found personality disorder rates of rates of 91% in a clinical sample of agoraphobics – mostly of the avoidant or dependent type.

### *Etiology*

There have been many investigations of biological predisposition to panic attacks. Investigators have noted the possibility of biological predisposition through four main types of information: the specificity of responses to biological challenge tests, the differential response to particular pharmacological treatments, the spontaneity of panic attacks, and a familial tendency. Regarding the pharmacological responses, as early as the 1960s, Klein (1964) argued that tricyclic antidepressants reportedly blocked panic while benzodiazepines reduced anticipatory anxiety.

More recent studies do not support these findings, indicating that tricyclics and benzodiazepines appear effective for both panic and anticipatory anxiety (Kahn et al. 1986). Attempts to induce panic attacks through challenge tests, in which individuals are asked to hyperventilate, indicate that anxious volunteers reach higher levels of arousal in response to these challenges than others. This is probably because they have higher baseline levels of arousal to begin with (Holt and Andrews,

1989a; 1989b).

Individuals with panic tend to describe them as 'coming out of the blue', that they are spontaneous and this is certainly how they were initially understood by clinicians. Barlow (1988), and others since, prefer to think of panic attacks as cued or uncued rather than spontaneous. They suggest that, while individuals often experience the first panic as sudden and surprising, the majority describe further attacks as cued or expected. As regards the evidence for a genetic component to panic, studies indicate some support for a predisposition to anxiety proneness or neuroticism (Torgerson, 1983) rather than specifically to panic disorder or agoraphobia.

As well as the above, various other factors have been investigated as possible risks in the onset of panic and agoraphobia. A number of studies have found that the onset of the panic is often preceded by stressful life events. The evidence points to the idea that stressful life events combined with a tendency to see these events as having a very negative impact may be a risk combination (Franklin and Andrews, 1989). Additional risk factors which may explain why events are seen so negatively by these individuals include trait anxiety, lack of social support and poor physical health (Andrews, 1991).

#### *A Cognitive-Behavioural Model*

Panic disorder and agoraphobia share with other anxiety disorders a general tendency toward anxiety proneness. Barlow (1988) has suggested that the increased vulnerability to anxiety implies that the usual flight-fight response of anxiety is more easily triggered in those with panic and agoraphobic symptoms. For most people, this emergency response may be triggered under potentially dangerous circumstances. For those with panic, it may be triggered in the absence of potential

danger but in response to the negative perception of life stressors (i.e. it is a false alarm). The flight-fight response is therefore triggered inappropriately and consequently, the individual learns to expect that certain situations will trigger the 'alarm'. One of the strongest predictors of agoraphobic avoidance is the expectation that a panic attack will occur in a given situation (Telch et al., 1989). Since a biological substrate for panic attacks has yet to be identified, attention is being directed to searching for etiological factors that channel an individual with high trait anxiety to develop panic disorder and agoraphobia as opposed to another anxiety disorder.

In current understandings of panic, particular attention has been given to hyperventilation and cognitive processes. Hyperventilation can produce symptoms similar to those reported during a panic attack. A high proportion of panic patients appear to hyperventilate during a panic attack. Cognitive models of panic attempt to explain how hyperventilation relates to the experience of panic. It is acknowledged that somatic symptoms and sensations may be produced by a variety of causes but not all individuals worry about them to the same extent (Clarke and Hemsley, 1982). One of the main distinguishing feature of those with panic and those without is that the former have a higher expectation of danger and a fear of losing control (Sanderson, Rapee and Barlow, 1989).

A further difference is that those with agoraphobia and panic disorder have a cognitive bias in which attention is automatically oriented toward threat-related information. Further, recall for such information is also higher than that for other information. This cognitive bias extends to the interpretation of ambiguous stimuli, so that ambiguous internal and external stimuli will be more likely to be interpreted as threatening by these individuals. This interpretation of threat is the trigger to the

anxiety which produces the physical sensations of flight and fight. These sensations in turn are interpreted as threatening and future attacks are anxiously anticipated. Agoraphobic avoidance has been understood in terms of conditioning so that pairing of a situation with panic sensations leads the situation to acquire fear-provoking properties. The individual then avoids this situations in an effort to avoid the unpleasant sensations of panic (Clark, 1988).

### **Treatment of Panic Disorder and Agoraphobia**

#### *Cognitive Behaviour Therapy*

From the model described above, it can be seen that effective treatment of panic disorder and agoraphobia needs to involve the control of panic attacks, the cessation of avoidance behaviour and ideally, a reduction in the vulnerability to panic attacks. Exposure work, relaxation, cognitive restructuring and medication may all play a role in effective treatment.

*In-vivo* exposure involves the patient carrying out a graded programme of exposing themselves to situations usually avoided through fear of panic. It has been shown to be the most effective form of treatment for agoraphobia. Barlow (1988) states that with exposure alone around 75% of agoraphobics will experience some benefit. There are a number of ways in which exposure work can be conducted. It is possible for patients to begin with imaginal exposure of their least-feared to most-feared situations, followed by accompanied exposure and then exposure alone. In order to re-learn that feared situations are not in themselves fear evoking, patients remain in the situation until they no longer feel anxious. To assist patients in coping with the physical sensations of anxiety triggered by exposure work, they can be trained in the use of breathing retraining and relaxation.

However, the fear of panic attacks does not appear to be the only factor

responsible for avoidance behaviour. Clum and Knowles (1991) examined the literature and found eight explanations of the development of avoidant behaviours. They concluded that while the development of agoraphobic avoidance was almost always preceded by panic attacks, the avoidance itself was not a function of panic frequency, severity or age of onset. They suggest that avoidance is predicted by three patterns of cognitions: the expectation of negative or catastrophic outcomes (Telch et al., 1989); perception of panic triggers (Craske et al., 1988) and an inability to cope with the symptoms of a panic attack (Craske et al., 1988).

Clinically, the implications from these findings are that treatment needs to modify these beliefs as well as employing exposure to the situations avoided. Indeed, it can be said that if these beliefs are not modified, exposure work may be limited. Overvalued beliefs may be modified through informing patients about the causes of panic attacks and explaining that situations in themselves are not the cause of the sensations of panic. They can also be modified by taking each catastrophic thought the patient has and testing the reality of them through exposure work and diary keeping. Educating patients that panic symptoms are not in themselves catastrophic can help them feel more in control so that when the symptoms occur, they are not given too much significance. Additional education about anxiety management, including breathing and relaxation exercises, can improve feelings of confidence. Treatment packages employing *in-vivo* exposure and cognitive restructuring, result in 90% of panic patients showing considerable improvement (Beck et al., 1992).

### *Role of Medication*

In addition to cognitive-behavioural packages of treatment, there are also drug treatments which may be considered either as an adjunct or as an alternative form of treatment, because:

- They may be less financially costly.
- Some patients are not motivated to take part in or may not respond to psychological intervention.
- Some patients may themselves prefer it as a treatment of choice for a variety of other reasons.

There are four pharmacological treatments which are generally employed in the treatment of panic and agoraphobia: tricyclic antidepressants, the benzodiazepines, beta-blockers and monoamine oxidase inhibitors. In a review of medication effectiveness, Clum (1989) estimates that behaviour therapies in general are successful with 54% of patients, tricyclics with 19% and high potency benzodiazepines with 42%. A more recent study indicated that cognitive behavioural therapy (CBT) is successful in 74% of individuals, the tricyclics in 45% and the high potency benzodiazepines in 51% of patients with panic and agoraphobia (Michelson and Marchione, 1991). However, in terms of unwanted side effects, the tricyclics can be unpopular with patients because of the anti-cholinergic effects while the high potency benzodiazepines are often avoided by both patients and doctors because of the possibility of dependence.

Having described the nature of panic and agoraphobia and treatment options, there now follows a discussion of the issues related to researching treatment effectiveness and a review of some of the outcome studies conducted in the field of panic and agoraphobia.

### **Researching the Effectiveness of Treatments**

#### *Efficacy and Clinical Effectiveness*

Roth and Fonagy (1996) make a clear distinction between the efficacy of a therapy and its clinical effectiveness. The former is a statement about the results a therapy

achieves in a research trial while the latter is an indicator of the results of the therapy in routine clinical practice. These writers explore some of the difficulties encountered by those interested in carrying out research in the field of treatment outcomes. Design issues can confound the conclusions drawn from outcome research; Table 1 summarises these. The table was developed to outline the main points, made by Roth and Fonagy (1996), regarding the strengths and limitations of different study designs used in the evaluation of treatment effectiveness and efficacy.

In addition to study design, further considerations include the types and breadth of measures. Roth and Fonagy suggest that studies should aim to incorporate measures from differing perspectives e.g. patient and therapist, that they consider different symptom domains, affect, cognition and behaviour and differing domains of functioning such as work and social functioning. They also suggest that studies incorporate one or several follow-up periods in order to provide some indication of the possibly longer term effects of therapy and the maintenance of treatment gains.

#### *Outcome Research*

Gould et al. (1995) carried out a meta-analysis of treatment outcome studies for patients with panic disorder with or without agoraphobia for the years 1974 to March 1994. They excluded studies which failed to employ a control condition, those that did not randomly assign participants and those which included participants who did not have panic disorder. A total of forty-three studies were analysed. The bulk of studies looking at the effectiveness of medication compared exposure with imipramine and found no increased effect than with imipramine alone. One study by Marks et al. (1993) compared the effectiveness of benzodiazepine medication with exposure. Results showed a panic free rate of 62% and a drop out rate of 15%. Studies comparing cognitive behaviour therapy with medication treatments using



Table 1: Overview of study designs

Design	Strengths	Weaknesses
Single case	Useful in looking at treatment innovations.	Can provide rich data. Quick and convenient to carry out in clinical practice. Patients may not be representative as they are often highly selected. The lack of a control condition means interpretation of specific and non specific factors in treatment are hard to differentiate.
Randomised -Control Trials	Allows differentiation of the effects of treatments and controls for extraneous variables.	Time consuming and expensive. More difficult for longer term therapies to utilise. Generalising may be difficult as the rigor in patient selection and those providing the treatment is not a reflection of clinical practice.
Open Trials	Allows naturalistic protocols relevant to clinical practice.	Lack of control group makes it difficult to differentiate specific and non specific factors in treatment.

placebo control groups showed that cognitive behavioural interventions yield higher panic free rates than those for pharmacotherapy (70% as opposed to 57%). Mean drop out rates were higher in patients receiving medication treatment (20% as opposed to 6% in CBT intervention).

In summary, medication, CBT and combination interventions were shown to be more effective than control conditions. Antidepressants and benzodiazepines

appear equally effective but the latter showed lower drop-out rates indicating more tolerance. CBT interventions that included a combination of cognitive restructuring and exposure elements appeared to be the most effective.

Gould et al. (1995) draw attention to the use of control groups in comparing studies of treatment outcome. They report one study by Robinson et al. (1990) which found a largely diminished effect size for CBT for depression when studies that used wait-list controls were eliminated from the analysis. They found that in the case of panic, the exclusion of wait-list controls made no significant change to the effect size. This small change suggested to them that those on pill placebo or psychological placebo groups had little advantage over wait-list controls for those with panic than for those with depression. Comparisons are difficult as it may be argued that groups are not comparably severe; those who agree to take part in a randomised control trial are a rarefied sample. Pollack (unpublished data reported by Gould and Clum, 1995) reports that 80% of patients presenting for panic treatment at a hospital anxiety disorders clinic refuse randomisation.

To summarise, utilising the frequency of panic as well as overall measures of outcome, the results support the idea that cognitive behavioural therapy is at least as effective as medication treatments for panic disorder and agoraphobia. CBT appears to be associated with lower attrition rates and shows maintenance of treatment gains over a longer period than medication treatments. Gould et al. (1995) also examined the financial costs of both types of treatment, assuming CBT treatment comprised of 15 sessions followed by one session in the first year and four in the following. While more costly in an absolute sense, they argue that CBT treatment carries a relatively low cost when one considers the risks of side effects and discontinuation of treatment associated with medication.

*Professional and Paraprofessional Treatments*

Having established that professional treatment leads to better outcomes than no treatment at all, it is interesting to see if treatment offered by paraprofessionals achieves outcomes similar to those of professionals. In 1979, Durlak carried out a review of forty two studies which compared professional and paraprofessional therapists for cases involving specific target problems such as insomnia, obesity and enuresis.

Professionals comprised experienced psychologists, psychiatrists and social workers. Paraprofessionals constituted adults with professional backgrounds who had not completed a clinical training in mental health, e.g. medical students or community volunteers. Most of the studies reviewed found no difference between the two types of helpers in terms of effectiveness on measurable outcomes. Durlak concluded that “paraprofessionals achieve clinical outcomes equal to or significantly better than those obtained by professionals” (Durlak 1979, p.80). Two further reviews and meta-analyses have been conducted, both of which have shown that either there are no differences between professionals and paraprofessionals or that the results favour paraprofessionals as more effective helpers (Nietzel and Fisher, 1981; Hattie, Sharpley and Rogers, 1984). However, these outcomes were achieved by paraprofessionals who had either received close supervision from a professional or those who were treating less severe difficulties such as mild behaviour problems in college students.

Berman and Norton (1985) carried out a further review, which included the studies reviewed by Durlak. They note the difficulties encountered by previous researchers in ascribing ‘professional’ or ‘paraprofessional’ labels to helpers. In their review, they included as ‘professional’ only those who had completed their training

and excluded those paraprofessionals who had had either extensive preparation or prior experience with the therapy task and those who had received close supervision from a professional. They looked at interventions for phobias, psychosis, obesity and social adjustment, using five common forms of treatment: behavioural, cognitive-behavioural, humanistic, crisis intervention and counselling. Outcome was measured from four different sources: patient, therapist, independent observer and behavioural indicator.

Berman and Norton found that participants achieved comparable levels of improvement across five different outcome measures (symptom distress, global adjustment, social adjustment, work-school adjustment and personality traits), whether treated by professionals or paraprofessionals. They were also interested in which conditions indicated which type of help as the treatment of choice. They found that when treatment was brief, professionals achieved better outcomes while paraprofessionals appeared to be more effective with treatments of longer duration. They also found that professionals were more effective with patients who were older. One explanation given for this difference is the fact that the therapists were older than the paraprofessionals – therapists are more effective with patients closer to their own age.

Christensen and Jacobson (1994) point out some of the difficulties with studies comparing the effectiveness of professional and paraprofessional help. There is the issue of how one defines a professional and paraprofessional and what is assumed about their potential to help. There is a lack of clarity in the literature about the definition of 'paraprofessional' – this makes comparison between studies at best difficult and at worst invalid. It seems that paraprofessionals can be seen as individuals who offer professionally based help without the qualifications or training

of a professional. However, the skills overlap between paraprofessional and professional helpers may be higher than assumed in some studies. It is hard to identify what is being compared in such studies. Is it the skills of the helper, the benefits of the helpers training or the model of treatment being offered? Some of these difficulties are avoided in studies comparing professional help with self-help and this body of work will now be discussed.

### *Self-help Treatments*

Research into the processes and outcomes of self-help carries with it many contradictions. There is a view that the self-help organisation is significantly different from statutory health services and therefore needs to be studied through a different methodology (Powell, 1994). However, there is also pressure within self-help organisations and from the professional health care community for empirical evidence supporting their effectiveness. This has led to some fruitful alliances between self-help organisations and researchers in forming alliances which are mutually beneficial. When the outcome research shows self-help as successful, it can provide the self-help organisation with much needed resources.

Early work treated self-help as just an informal and less sophisticated form of traditional treatments offered by professional. More recently, the focus has shifted toward viewing self-help more as a social movement concerned with the broader links between individual, interpersonal and social change. Along with this shift, there has followed a change in the ways in which the self-help organisation is researched. There is a movement away from treatment-efficacy-type studies toward an ecological framework. That is, an increasing amount of literature now exists on how self-help groups shape the social networks of their members and there is a growing interest in how self-help groups exist in a complex system of community support

(Borkman, 1984).

Researchers are also becoming increasingly aware of the need to understand the experiences of self-help members as the principle means of understanding the self-help phenomenon. This has meant the use of a narrative (or story-telling) approach to the investigation of self-help process (Cain, 1991). However, as the focus for this study was the effectiveness of exposure based self-help treatment for the symptoms of panic and agoraphobia, the research reviewed will be limited to those studies with a similar focus.

Recent reviews of self-administered treatments such as self-help books and audio tapes with or without minimal therapist contact indicate outcomes comparable to those achieved with therapist help. Scogin et al.(1990) carried out a meta-analysis of studies which compared such self-administered treatments with a no-treatment control condition or therapist-administered treatment. The problems treated fell in to four broad categories of 'habit problems' such as smoking, 'emotional problems' such as depression and anxiety, phobias, 'skills' training such as difficulties with parenting and 'others' such as sleep problems. The researchers found that self-administered treatments were more effective than no treatment and equally as effective as therapist-administered treatments. However, they note that all of these difficulties are relatively circumscribed and that self-administered treatment may not be as effective with more global, less clearly identified difficulties.

In 1993, Gould and Clum published another meta-analysis of self-help treatment approaches, that of media based treatment approaches such as manuals, audio-tapes and videotapes which are used by individuals independently of a helping professional. Some of the studies did involve contact with a professional but only at assessment or for ongoing monitoring. Only those studies incorporating randomised

groups of self-help treatments with no-treatment, wait-list or placebo controls were included. A total of 40 studies were analysed.

They concluded that self-help treatments were more effective with skill deficits and diagnostic problems such as fears and depression than with habit problems such as smoking. They found that self-help showed a similar dropout rate to psychotherapy and control subjects. The results support the effectiveness of self-help approaches for the kinds of problems they target, i.e. those that used a behavioural approach. Furthermore, when the review analysed the effectiveness of self-help in comparison with therapist-assisted intervention, the results indicate similar effectiveness. They also found that these subjects generally also maintained their treatment gains at follow-up. However, since few of the studies independently confirmed the diagnosis of conditions, it is impossible to say if the participants were equivalent to clinical populations.

Tyrer et al. (1993) carried out a two-year study comparing the effectiveness of drug treatment, CBT and self-help with psychiatric outpatients suffering from anxiety disorders including panic. Patients were randomly assigned and given treatment for six weeks, contact was then reduced over another four-week period. There were no overall differences in compliance rate or efficacy between the three modes of treatment. The researchers were also interested in the effects of personality status on treatment, they found that those with personality disorders as assessed by the Personality Assessment Schedule (PAS; Tyrer and Alexander, 1979) fared less well with self-help and CBT therapies, particularly between weeks 32-52 of the study. They point out that there have been no studies comparing these treatment methods with panic disorder *per se*.

In 1995, Gould and Clum carried out a study examining the effectiveness of

self-help treatment based on the book 'Coping with Panic' (Clum, 1990) and also including an informational videotape on panic and a relaxation audio tape. They compared the progress of the treatment group to a wait-list control. Participants were randomly assigned to either the treatment or wait-list group and all met the criteria for panic disorder with or without agoraphobia. In order to be more stringent than previous studies about diagnosis prior to treatment, the diagnosis of panic was based on a standardised clinical interview for anxiety disorders (Anxiety Disorders Interview Scheduler Revised [ADIS-R; DiNardo et al., 1988]). Three graduate students in clinical psychology were recruited as observers in making diagnostic judgements and were trained in diagnosing panic disorder. All potential participants were given the ADIS-R by one of the observers and all interviews were videotaped. These were then rated independently by observers and yielded a reasonable inter-rater reliability of kappa .72. Participants completed pre-post questionnaires assessing their expectation of panic attacks, expectation of improvement, their thoughts during a panic attack and ways of coping with panic attacks. They were also asked to complete weekly measures which assessed their frequency and total severity of panic attacks, the severity of the physical symptoms of panic, the severity of cognitive panic symptoms and the severity of behavioural avoidance. In order to motivate participants in practising the coping strategies, they were asked to keep a weekly log of the amount of time they spent practising specific coping techniques including self-exposure. The training period lasted four weeks, with a follow-up eight weeks later. The results supported the hypothesis that self-help is an effective treatment for panic disorder and agoraphobia. All participants significantly improved on all measures from pre-treatment to follow-up. At follow-up, the self-help treatment group were significantly more improved than the wait-list control group on



measures of agoraphobic avoidance and coping with panic attacks. Furthermore, over two thirds of the treatment group met the criteria for clinical improvement, being panic free following treatment (Clum, 1989).

A previous similar study (Gould, Clum and Shapiro, 1993) employing the self-help book alone had not supported these results and therefore, the researchers attribute the success of the self-help package in this study to the inclusion of a videotape and audio-tape. The finding that participants continue to improve over the follow-up period may be attributed to the fact that they continue to use the self-help resources of the book, the videotape and the audio-tape. They also suggest that the effect of therapist contact, although minimal, cannot be ruled out as contributing to the positive gains.

#### *Group Self-help Treatments*

Self-help organisations usually offer help through a group format. There is minimal research looking at the effectiveness of this group exchange of help. It is easy to imagine that groups may be helpful in providing some reassurance to members that they are not alone in their experience of the distressing symptoms of agoraphobia. Also, the opportunity afforded within groups for members to learn from each other's attempts to cope with agoraphobia may add considerably to members' confidence.

Two studies looking at the effectiveness of therapist-assisted groups for those with agoraphobia found no difference in outcome between group and individual treatments (Hafner and Marks, 1976; Emmelkamp and Emmekamp-Benner, 1975). Sinnott et al. (1981) compared group treatment for agoraphobia for individuals who lived near each other with individuals living in different neighbourhoods. They found that the 'neighbourhood' group showed more improvement which was maintained at three-month follow-up. They suggest that the neighbourhood group

offered the potential for continuing co-operation beyond the life of the therapy, thus providing the potential for longer term maintenance of therapy gains.

More recently, Roth and Fonagy (1996) report a study by Robinson et al. (submitted). These researchers carried out a study examining the effectiveness of group-based cognitive therapy conducted in a panic disorder clinic. A total of forty-five patients were treated with group-based cognitive therapy while twenty patients acted as wait-list controls. A comparison of panic frequency at the end of therapy and at nine-month follow-up indicated that 73% of the treatment group were panic-free while 5% of the control group were panic-free at these points. However, they also found that when they compared the two groups on measures of agoraphobic avoidance, when accompanied and when alone, the treatment group had only achieved a significant change in avoidance behaviour when accompanied but not in avoidance behaviour when alone. Given these encouraging findings for therapist-delivered group treatment of agoraphobia, it is interesting to see if the results of self-help group treatment show similar findings.

#### *Self-Administered Treatment*

Ghosh and Marks (1987) carried out a study in which they assigned 46 agoraphobics to receive exposure instructions in one of the following ways: from a therapist, via computer instruction or through reference to a book describing anxiety management through self-exposure. All participants were initially screened and assessed for agoraphobia. Those in the therapist and computer-assisted treatment conditions were seen at weekly intervals during the treatment phase and three times during the six-month follow-up. Those in the book-instructed group were only seen three times during the treatment phase and three times during follow-up. The results illustrated treatment outcomes which were similar to those obtained by therapist-assisted

programmes. The degree of pre-treatment handicap in the agoraphobic participants was equivalent to other outcome studies and yet the amount of clinician time needed by these individuals was just 2.7 hours with those using the computer programme and 1.5 hours for those using the self-help book. Al-Kubaisy et al. (1992) looked at the efficacy of the combined treatment of therapist assisted exposure and self exposure, with self exposure alone and relaxation alone. The participants had mixed phobias, 30% were agoraphobic. The results indicated that both exposure conditions; self-exposure or therapist assisted, showed comparable gains and both showed significantly greater gains than relaxation alone.

Taylor (1984) reported a single case study using telephone instructed exposure treatment for agoraphobia. McNamee et al. (1989) extended this into a larger study of telephone guided self-treatment. They assessed thirty-seven agoraphobics over the telephone; of these, twenty-three agreed to participate. Their study compared telephone and manual guided exposure to telephone-guided relaxation without exposure. They found a significant difference between the two groups, the self-exposure group having improved significantly more than the relaxation group on measures of social adjustment and phobia severity. This improvement was slower than in trials where therapists are involved in the guided exposure. The researchers attribute this finding to a number of factors: the lack of any face-to-face contact with a clinician, the high severity of pre-treatment agoraphobic symptoms in comparison with other studies, and low levels of motivation indicated by the relatively low completion rate of only 46%.

## **The Present Study**

### *Rationale*

The evidence for the effectiveness of exposure-based programmes, both in individual

and group-based formats, in the treatment of panic and agoraphobia has been presented. This research illustrates comparable outcomes whether treatment is professionally assisted, paraprofessionally administered, self-instructed or telephone-instructed. As discussed, all outcome studies, including the one undertaken here, have to be carried out with some degree of compromise between internal and external validity. There is currently no research on the effectiveness of self-help telephone recovery programmes for people with panic and agoraphobia. There is also a lack of naturalistic studies into the effectiveness of exposure-based recovery programmes offered by a self-help organisations, as opposed to the effectiveness of an experimentally engineered, self-administered or paraprofessionally administered exposure programme.

### *Research Questions*

The main question addressed by this study was:

1. Do participants of the telephone recovery programmes report a significant decrease in the symptoms of panic and agoraphobia by the end of the programme and at three-month follow-up?

Additional questions were:

2. Are there any relationships between changes in participants' symptom severity, satisfaction with the recovery programme and demographic variables?
3. Are there differences in the treatment histories of individuals for whom the groups were helpful and those for whom they were not?

## **Method**

### **Overview**

Thirty-eight members of a national self-help organisation 'No Panic' agreed to participate in the study. All participants took part in one of 9 self-help telephone recovery programmes for those suffering from panic and agoraphobia. The groups were organised and run by volunteer members of the organisation. Self-report diagnostic measures of agoraphobic symptoms were administered before, midway, at the end of the recovery programmes and at three-month follow-up. Information regarding each participants' symptoms, current treatments and treatment history was obtained through a structured telephone interview conducted either before or near the beginning of the recovery programmes. Individual satisfaction questionnaires were administered at the end of the programme and at follow-up.

Details of the design, participants and procedure will be given followed by a description of the measures used.

### **Design**

The aim of the study was to compare the participants' symptom severity and levels of distress before, during, and at the end of the recovery groups, with another assessment at three-month follow-up. The study therefore employed a within-subjects design. The study was not designed to compare self-help treatment with other forms of treatment.

The aim was to assess whether those taking part in the recovery groups reported a decrease in symptoms and distress by the end of the programme. A further aim was to obtain some information about participants' feelings of satisfaction with the recovery programme, their previous treatment histories and perceptions of change.

## Participants

The participants were recruited through the national self help organisation 'No Panic'. All the individuals who decided to take part in the recovery groups offered by 'No Panic' (sixty people) over the course of nine months were sent the information regarding this study through 'No Panic's recovery group organiser. The only exclusion criterion was a score of less than 11 on the Agoraphobia sub-scale of the Fear Questionnaire. Those with high depression scores were included as this was common. Thirty-eight members (63%) of those sent the information consented to take part and, of these, two (3%) dropped out of the recovery programme in the first six weeks and therefore could not continue in the research. A further two participants did not return the questionnaires at mid-way or at the end of the recovery programme. At the time of writing, nine participants had not yet reached the end of their recovery programme and only fourteen had reached three-month follow-up. All participants had a history of panic and agoraphobia for at least a year. The mean duration of the symptoms was 12 years and four months.

The average age was 43 years; further demographic details are given in Table 2.

Table 2: Gender, education, marital status and medication of subjects

Gender	Medication (anti-depressant)	Education	Marital Status
24 Female	11 (44%) Yes	14 (56%) Secondary Education	17 (68%) Married
1 Male	14 (56%) No	4 (16%) Tertiary Education	5 (20%) Single
		7 (28%) Further Education	3 (12%) Divorced

**Ethical safeguards**

Ethical approval for the study was obtained from the Joint University College Hospital and University College London Ethics Committee (see Appendix 1). Potential participants were sent an information sheet giving details of the study (Appendix 2), a consent sheet making it clear they could withdraw from the study at any time (Appendix 3) and a set of questionnaires. These were all sent by the organiser of the recovery groups. The contact details of the researcher were provided on the information sheet so that individuals could ask any questions prior to agreeing to take part. Those who returned the consent forms were telephoned by the researcher and initially asked if they had any questions, if they understood what the research entailed and whether they still wanted to take part. They were also advised that they could contact the researcher at any time during the course of the study if they had questions or if they no longer wished to take part. Participants were informed that, at the end of the study, they would receive a summary of their own progress through the course and a summary of the research findings as a whole.

**Procedure**

The researcher initially made contact with the organisers of 'No Panic' who agreed to send out the information about the study and the first set of questionnaires to all prospective recovery group members. Those who telephoned or wrote asking for more information, or returned the consent form, were then directly contacted by the researcher.

*Stage one*

All those consenting were telephoned and interviewed about their symptoms and past and current treatments and their hopes for the recovery programme. As

participants often completed and returned the forms very near the beginning of the recovery group sessions, it was not always possible to interview each participant prior to the start of the group. However, this is not likely to have had an important impact on the information obtained. The semi-structured interview lasted 30-45 minutes (see Appendix 4). Participants then took part in a twelve-session group recovery programme conducted over the telephone. The sessions were one hour long and were held weekly. Each participant was asked to call into a Community Network service which enabled the group to communicate using a Teleconference facility. The general structure and content of the programme is described in Appendix 5.

*Stage two*

Participants were sent the same set of questionnaires as in Stage one and were asked to complete these between the sixth and seventh sessions; the mid-way point in the recovery programme (Appendix 6).

*Stage three*

At the end of the full twelve sessions, participants were asked to complete the symptom questionnaires again along with a Satisfaction Questionnaire about the group as a whole (Appendices 6 and 8).

*Stage four*

Participants were again contacted three-months after the end of the programme, they were asked to complete the symptom questionnaires and a Satisfaction Questionnaire (Appendices 6 and 8).

All questionnaires and interviews were scored and summarised by the researcher.



## Measures

A total of seven measures were administered, of these, Questionnaires 1 to 6 were administered at all four stages. The questionnaires were:

1) Body Sensations Questionnaire (Chambless et al., 1984): This is a 17 item self report scale concerning sensations associated with autonomic arousal. Each item is rated on a five point scale ranging from 'not frightened by this sensation' (1) to 'extremely frightened by this sensation' (5), which indicated how anxiety provoking the participant found each sensation. The total score was derived by averaging across the individual item ratings. The scale has a high reliability; alpha coefficient =.86 and a test-retest reliability coefficient of .67.

2) Agoraphobic Cognitions Questionnaire (Chambless et al., 1984): This is a 15 item self-report scale which assesses the intensity of thoughts about harmful consequences which may accompany the physiological aspects of panic. Each item is rated on a five-point scale ranging from 'thought never occurs' (1) to 'thought always occurs' (5), of the frequency with which this thought occurred when the participant was anxious. The total score is computed by averaging responses across individual items. The measure has a high reliability (alpha coefficient =.80) and a test-retest reliability coefficient of .86.

3) The Mobility Inventory for Agoraphobia (Chambless et al., 1985): This is 26 item self report scale designed to measure agoraphobic avoidance behaviour both alone (MIALO mobility alone sub-scale) and when accompanied (MIACC mobility accompanied sub-scale). Each item is rated on a five-point scale in which a rating of 1 indicates the situation is 'never avoided' and 5 indicates it is 'always avoided'. It also includes an item which asks participants to estimate how many panic attacks they have experienced in the last seven days (MIPAN frequency of panic item). The

MIALO sub-scale has a high reliability of alpha coefficient =.90 and a test-retest reliability coefficient of .76. The panic frequency item has a lower test-retest reliability of .60, this is attributed to the high amount of variability in the occurrence of panic (Marks, 1970).

4) Fear Questionnaire (Marks and Mathews, 1979): This is a 24 item self-report scale which provides phobia ratings and anxiety and depression ratings (FQANX anxiety and depression sub-scale). It incorporates an agoraphobia sub-scale (FQAG agoraphobia sub-scale), a social phobia sub-scale (FQS) and Blood Injury Phobia (FQBI). Participants are asked to rate how often they would avoid each of 15 situations because of fear or other unpleasant feelings. The scale ranges from 0-8 where 0 represents 'would not avoid it' and 8 represents 'always avoid it'. The agoraphobic sub-scale (FQAG) has a test-retest reliability coefficient of .89. The anxiety and depression sub-scale (FQANX) has a test-retest reliability coefficient of .82. The agoraphobia sub-scale is a useful index in that it provides a straightforward comparison with published studies. Mavissakalian (1986) suggests that a score above 30 is typical of severe agoraphobics and a post-treatment score below 10 is an excellent clinical response.

5) Effect on Life Scale (Marks, 1977): This is 7 item scale which provides a measure of the amount of impact a psychological problem has on the individuals daily life: work; home; social and private. Reliability remains to be tested on this measure.

6) Beck Depression Inventory (Beck, 1961): This is a 21 item self-report questionnaire assessing the severity of symptoms associated with depression. It has been shown to be reliable and valid for use with a number of patient populations (Beck et al., 1988). A total score over 30 is indicative of moderate to severe

depression.

7) Satisfaction Questionnaire (adapted from one being used by 'No Panic' [Appendix 7] and the Client Satisfaction Questionnaire [Larsen et al. 1979]), see Appendix 8: This comprised a 9 item self report scale assessing the helpfulness of aspects of the recovery programme. This is followed by two questions about helpful and unhelpful aspects and a final question about whether the participant would recommend the programme to a friend. There are two versions, one is administered at the end of the recovery programme and the other, at three-month follow-up. The questionnaire at follow-up additionally includes an item about whether participants had taken part in a befriending group since the end of the recovery programme. The final score is an average of the scores across all but one item (Question 9).

## **Results**

There were three main questions of interest in this study:

- Is there a reliable and significant change in the severity of the symptoms of panic and agoraphobia across the phases of recovery: pre, mid, post and follow-up?
- Is there a relationship between participants' reports of a reduction in symptoms and their feelings of satisfaction with the recovery programme?
- Are there any variables which predict or differentiate those participants who achieve a reliable change in symptom scores and those who do not?

The first section comprises the results of the analysis of the symptom measures. The next section is a summary description of the interview data along with an analysis of how these relate to outcome and Satisfaction scores. Since there are fewer participants for whom follow-up data is available compared to those at the end of recovery programme, there is a separate section on the analysis of changes in symptom scores and Satisfaction scores between the end of the recovery programme and at follow-up. The chapter ends with some comments made by participants about their contact with professionals in the past and their comments about the helpful and less helpful aspects of the recovery programme.

### **Changes in Symptom Severity**

A total of twenty-four participants had completed questionnaires for the pre, mid and post phases of recovery. One participant did not complete the questionnaires at midway but did complete them for the other two phases. A total of fourteen participants had reached the three-month follow-phase and they all completed the questionnaires (eleven participants had not reached follow-up). Twenty of the participants had missed one or none of the group sessions. One member had missed four of the sessions and three members had missed two.

Table 3: Table of mean scores for each recovery stage and results of Pre-Post repeated measures ANOVA with two tailed significance levels.

Questionnaire Measure	Score	PRE	MID	POST	FU n=14	Pre-Post F (1,23)	Effect Size
Body Sensations	Mean	3.18	2.48	2.15	2.29	24.84***	1.28
	SD	1.13	0.86	0.85	1.13		
Agoraphobic Cognitions	Mean	2.48	2.23	2.07	1.77	12.33***	0.51
	SD	0.80	0.83	0.75	0.86		
Fear (Agoraphobic)	Mean	5.47	4.39	3.82	3.71	12.26***	1.73
	SD	2.58	2.80	2.54	2.97		
Fear (Anxiety / Depression)	Mean	5.34	4.40	3.39	3.09	20.74***	1.06
	SD	1.84	2.25	2.13	2.65		
Panic Frequency	Mean	5.53	3.77	2.20	3.14	3.49*	0.36
	SD	9.33	5.79	3.16	7.99		
Mobility (Alone)	Mean	3.64	3.42	3.28	3.27	.59 <sup>T</sup>	0.29
	SD	1.21	1.14	1.16	1.37		
Mobility (Accompanied)	Mean	3.12	2.84	2.72	2.67	5.90**	0.32
	SD	1.25	1.23	1.19	1.29		
Effect on Life	Mean	4.01	3.07	2.38	2.70	15.46***	0.88
	SD	1.87	1.90	1.80	2.38		
Beck Depression	Mean	22.44	18.00	12.28	13.36	21.91***	0.85
	SD	11.12	12.78	8.52	13.68		

two-tailed significance : \*\*\*p<.001    \*\*p<.005    \*p<.05    <sup>T</sup> trend (p<.056)

Table 3 presents the mean scores for each of the symptom measures of interest at different stages in the recovery programme: before the first session (pre),

between session six and seven (mid), at the end of the last recovery session (post) and at three-month follow-up after the end (FU). The measures described are the Body Sensations Questionnaire (BSQ), the Agoraphobic Cognitions Questionnaire (ACQ), the Agoraphobic sub-scale of the Fear Questionnaire (FQAG), the Anxiety and Depression sub-scale of the Fear Questionnaire (FQANX), the frequency of panic score incorporated in the Mobility Inventory (MIPAN), the Alone sub-scale of the Mobility Inventory (MIALO), the Accompanied sub-scale of the Mobility Inventory (MIACC), the Effect on Life Scale (LIFE) and the Beck Depression Inventory (BDI).

Given that we do not have a diagnostic assessment of the participants symptoms, it is not possible to conclude that the participants symptoms meet the criteria for a diagnosis of panic disorder with or without agoraphobia. It is informative to compare the mean scores for the symptom questionnaires in this study with means from other studies where the population did meet the diagnostic criteria for panic disorder. The pre-treatment means for the clinical population employed in the development of the Body Sensations Questionnaire was 3.05 reported by Chambless et al. (1984), clearly the mean in this study of 3.18 is higher than this, suggesting a similar degree of severity in symptoms as a clinical population. The pre-treatment mean of 2.48 for the Agoraphobic Cognitions Questionnaire in this study also exceeds that of 2.32 reported in Chambless et al. (1984). This is also the case for the alone sub-scale of the Mobility Inventory for Agoraphobia mean of 3.64 in this study which exceeds 3.35 (Chambless et al., 1985).

In order to establish whether the mean scores for each questionnaire changed significantly over time and also to see at which stages change occurred, a repeated measures of analysis of variance (MANOVA) with contrasts was carried out. These

results are also summarised in Table 3.

If we look at the data comparing differences in scores between the beginning and the end of the programme we find that there is a significant overall difference between scores from pre, mid and the post phases of the recovery programme. This difference is found for the following measures: the Body Sensations Questionnaire, the Agoraphobic Cognitions Questionnaire the Agoraphobic and Anxiety sub-scales of the Fear Questionnaire, the frequency of panics in the Mobility Inventory, the Accompanied sub-scale of the Mobility Inventory, the Effect on Life Scale and the Beck Depression Inventory. Participants' scores on the alone sub-scale of the Mobility Inventory were not significantly different though there was a trend towards difference across the three stages of recovery. This is an interesting finding because this sub-scale is the only measure which asks in detail about participants' avoidance behaviour when they are alone; it enquires about how often they avoid situations such as travelling on trains when they are alone. This finding, when contrasted with the significant finding for the Accompanied sub-scale of the same measure, indicates that participants avoid fearful situations less as the recovery programme progresses but this only applies to situations in which they are accompanied. This result suggests that despite a reduction in the severity of catastrophic cognitions and somatic symptoms, and reduced avoidance when accompanied, participants report no significant change in their avoidance behaviour when alone.

The contrast analysis revealed that for each measure, except the Body Sensations Questionnaire (BSQ), this significant difference in means occurs at the first point of comparison, between the beginning and midway point of the recovery programme. This indicates that the most gains are made in the first six weeks of the twelve week programme. In the case of the BSQ, the contrasts analysis illustrated

that there was also a significant difference between scores from midway and the end of the recovery programme ( $F(1,24)=5.06, p<.05$ ). This measure illustrates continuing significant reductions in the reported severity of participants' fearful body sensations for last half of the recovery programme.

#### *Correlations with symptom change*

In order to see if symptom changes were related to each other and to Satisfaction ratings pre-post changes in symptom scores were calculated and Pearson product-moment correlations were carried out. Change scores were also correlated with participants' age, duration of illness and Satisfaction scores at the end of the recovery programme. Table 4 summarises the significant results at two-tailed significance.

The results indicate a highly significant, positive correlation between the pre-post changes in Agoraphobic Cognitions and Body Sensations scores and between the Alone sub-scale of the Mobility Inventory and the Agoraphobia sub-scale of the Fear Questionnaire. These indicate that reductions in ACQ scores are accompanied by reductions in BSQ scores; this is to be expected given that the two scales are highly correlated (Chambless et al., 1984). Similarly, the reduction in scores for the Alone sub-scale of the Mobility Inventory is accompanied by reductions in the Agoraphobia sub-scale of the Fear Questionnaire. This is also not surprising since they both enquire about how often situations are avoided. The two measures have also been shown to be highly correlated (Chambless et al. 1985). Further less significant correlations can be seen between reductions Body Sensations and the Anxiety sub-scale of the Fear Questionnaire scores, the Anxiety sub-scale and Agoraphobic Cognitions and finally, the Anxiety sub-scale and the Alone sub-scale of the Mobility Inventory. It seems that reductions in feelings of anxiety and



Table 4: Correlations between pre-post change in symptom measures and Satisfaction at the end of the recovery programme

	ACQ	BSQ	FQAG	FQANX	MIALO	MIACC	SATIS
Agoraphobic Cognitions (ACQ)							
Body Sensations (BSQ)	.65***						
Fear – Agoraphobia (FQAG)	.20	.33					
Fear – Anxiety / Depression (FQANX)	.53*	.55*	.34				
Mobility – Alone (MIALO)	.25	.34	.74***	.46*			
Mobility – Accompanied (MIACC)	.19	.24	.66***	.38	.59**		
Satisfaction	.48	.40	.11	.20	.51	.34	

two-tailed significance: \*\*\*p<.001 \*\*p<.005 \*p<.05

depression as measured by the Anxiety sub-scale of the Fear Questionnaire are related to a reduction in the severity of fearful body sensations; a reduction in severity of catastrophic cognitions and a reduction in the avoidance of phobic situations. The only measure which correlates with participant's Satisfaction scores at the end of the recovery programme is the Body Sensations Questionnaire; decreases in the severity of fearful body sensations of panic relates to increases in Satisfaction scores at the end of the recovery programme.

Further correlations between the pre-post change in scores for each measure and participants' age or duration of illness yielded non-significant results, Table 5 summarises these:

Table 5: Correlations between pre-post change in scores and participant's age and duration of symptoms

	Duration of Symptoms	Participants' Age
Agoraphobic Cognitions	-0.14	-0.02
Body Sensations	-0.21	-0.1
Fear (Agoraphobic)	0.14	-0.05
Fear (Anxiety / Depression)	0.34	-0.03
Mobility (Alone)	0.14	-0.05
Mobility (Accompanied)	0.32	0.05

This indicates that changes in symptom scores were not related to the age of the participants nor the length of time they had their illness. This is somewhat surprising since one may have expected to find a negative correlation between duration of illness and symptom improvement; the longer the duration, the less participants improve.

### **Reliable Change**

The results indicate that participants reports of improvement are statistically significant but it may be that these results are a spurious finding resulting from aggregating individual scores and averaging them across all participants. Jacobson, Follette & Revenstorf (1984) highlight some of the limitations of the 'significance test'. They point out that the averaging of improvement scores across participants precludes any way of determining the proportion of clients who benefited from the treatment and the proportion who did not. Further, they make the point that statistical significance is a way of demonstrating an 'effect', or a means for inferring a difference between groups, which has little to do with the practical importance of the effect. In response to such considerations, many researchers are now advocating and incorporating the use of clinical significance for evaluating psychotherapy outcomes. However, the difficulty with clinical significance is that there is little consensus about its definition. Jacobson et al. (1989) go on to list no less than six different definitions of clinical significance utilised by various researchers. They note for example, that agoraphobia treatment outcome literature has frequently included either reports of the proportion of people improved (Jansson & Ost, 1982) or further distinctions such as markedly vs. moderately improved (Hand et al., 1974). They note that these proportions are not reported clearly and the criteria for classifying participants as improved or not vary from study to study. Some define clinically significant improvement as a 50% reduction of anxiety/ avoidance (Jansson & Ost, 1982) and others use a change of two or more points on an eight point scale of anxiety/ avoidance (Emmelkamp & Kuipers, 1979). More recently, the criterion has been defined as participants being 'panic free' following treatment (Clum, 1989). In this study, only 32% of the participants reported having had no panic attacks during

the week preceding completing the questionnaires. However, the validity of these criteria are questionable, making their use of dubious value in the field of outcome research. Jacobson et al. (1984) go on to suggest that the researcher concern him/herself with statistically reliable improvement. That is, a measure of improvement which classifies the participant according to whether the amount of change is of significant magnitude as to exceed the margin of measurement error. Such a criterion enables the researcher to see how many people in the sample improved enough to rule out chance as a plausible alternative explanation to the treatment. They propose a Reliable Change Index in which the participant's pre-test score is subtracted from their post-test score and divided by the standard error of measurement.

To test whether participants show a reliable improvement on each of the symptom measures of interest in this study, a Reliable Change score was calculated for each of the participants who completed questionnaires before the start and at the end the recovery programme ( $n = 25$ ). The number of participants who showed reliable change and the number who showed non-reliable change for each measure is summarised in Table 6. Table 7 illustrates how many participants achieved reliable change in how many measures.

Table 6 illustrates that a large number of participants achieved a reliable change in pre-post scores for the ACQ and FQANX scales. As one would predict from the non-significant MANOVA finding, none of the participants achieved reliable change in the Alone sub-scale of the Mobility Inventory. The results show that a roughly similar number of participants achieved reliable change in BSQ and FQAG scales. Table 7 shows the number of participants who achieved reliable change on one or more measures. This frequency table illustrates that most of the

Table 6: Number of participants who showed a reliable improvement for each measure

Measure	Reliable Change	Non-Reliable Change
Body Sensations (BSQ)	10	15
Agoraphobic Cognitions (ACQ)	24	1
Mobility – Accompanied (MIACC)	6	19
Mobility – Alone (MIALO)	0	25
Fear – Agoraphobia (FQAG)	14	11
Fear - Anxiety /Depression (FQANX)	23	2

Table 7: The total number of measures on which participants achieved a Reliable Change

Number of measures	Number of participants who achieved Reliable Change
1	1
2	6
3	9
4	8
5	1
6	0

participants (16) achieve reliable change on three or more measures. One can see from this table that each participant achieved a reliable change in scores for at least one of the measures, mainly the ACQ.

Since the reliable change index can be considered a more robust and practically more meaningful method for describing outcome than statistical significance, further data analyses were carried out using Reliable Change as the grouping variable.

#### *Demographic data and reliable change*

How do the demographic variables and interview data relate to reliable change? For example, do those participants with positive past experiences of help and realistic expectations of the recovery group achieve more improvements than would be expected? Table 8 provides an indication of the number of participants who found their GPs or past professional contact helpful and the number of participants who expected the recovery group to either be of no help at all ('not help'), to help in coping with the symptoms of panic ('help cope') or to provide help in regaining a symptom free life ('help normal').

Table 8 illustrates that roughly half the total number of participants reported finding their past contact with professionals other than their GPs helpful. In contrast, two thirds reported that their GP had been or continued to be unhelpful in dealing with the symptoms of panic. With respect to the expectations of the recovery programme, half of the participants had the realistic hope that the group would not 'cure' their symptoms of panic and agoraphobia but may help them find ways of coping with the symptoms. The majority of the remaining participants reported a wish for the symptoms to be cured through taking part in the group. In order to see whether these variables were related to changes in pre- post symptom scores, a chi-square analysis

Table 8: Summary of responses to questions about the helpfulness of professionals and expectations of the recovery group

	Past professional helpfulness	GP helpfulness		Expectations of recovery group
	Freq. (%)	Freq. (%)		Freq. (%)
Helpful	13 (52)	9 (36)	Not help	2 (8)
Unhelpful	12 (48)	16 (64)	Help cope	13 (52)
			Help normal	10 (40)
Total	25 (100)	25 (100)	Total	25 (100)

was carried for these variables. A chi-square was also carried out to see if group facilitator or medication related to changes in scores. A logistic regression was carried out to see if reliable change was predicted by duration of illness, age of participants and Satisfaction scores.

As most participants showed a reliable change on the Agoraphobic Cognitions scale and the Anxiety sub-scale of the Fear Questionnaire, the analysis could not be carried out on these measures. Similarly, since no-one reliably changed on the Alone sub-scale of the Mobility Inventory, no further analysis was carried out with this measure.

The analysis of pre-post changes in scores indicated a significant correlation between reduction in the severity of fearful body sensations and increasing satisfaction. The results of this analysis employing reliable change as a grouping

variable, indicated that neither Satisfaction, age or duration predicts reliable change in the severity of body sensations (BSQ) or severity of agoraphobia as assessed by the agoraphobic sub-scale of the Fear Questionnaire (FQAG). To see if there were significant differences in observed and expected frequencies between those who reliably changed and those who did not on the variables of medication, past professional helpfulness, expectations of change and which 'No Panic' member facilitated the recovery group, a chi-square analysis was carried out. The results indicated no significant differences between observed and expected frequencies for any of these variables for those who changed reliably, and those who did not, on the BSQ and FQAG measures.

#### **Follow-Up Data**

A total of fourteen participants had completed follow-up questionnaires. All participants had taken part in a 'befriending group' at the end of the recovery programme, the duration and frequency of these was decided by each group, facilitators did not always take part.

#### *Symptom Change*

A repeated measures *t* test comparing the mean scores at the end of treatment and at follow-up was calculated for each of the variables, Table 9 summarises.

The results of a comparison of scores at the end of the recovery programme and at three-month follow-up (FU) are similar to those already discussed for the pre-post comparison. The table indicates that there is a significant improvement in scores for five of the 8 scales, the BSQ, ACQ, FQAG, FQANX and BDI all illustrate a statistically significant improvement. Participants report a decrease in the severity of catastrophic cognitions, fearful body sensations and anxiety and depression. However, the frequency of panics, the amount of avoidance of agoraphobic



Table 9: Repeated measures *t* test comparing post and follow-up scores for each measure

Measure	Score	POST	FU (n=14)	<i>t</i> (13)
Body Sensations (BSQ)	Mean	2.15	2.29	3.28*
	SD	0.85	1.13	
Agoraphobic Cognitions (ACQ)	Mean	2.07	1.77	4.08***
	SD	0.75	0.86	
Fear-Agoraphobic (FQAG)	Mean	3.82	3.71	2.17*
	SD	2.54	2.97	
Fear-Anxiety (FQANX)	Mean	3.39	3.09	3.47**
	SD	2.13	2.65	
Panic Frequency (MIPAN)	Mean	2.20	3.14	.12
	SD	3.16	7.99	
Mobility Alone (MIALO)	Mean	3.28	3.27	.11
	SD	1.16	1.37	
Mobility Accompanied (MIACC)	Mean	2.72	2.67	.02
	SD	1.19	1.29	
Effect on Life (LIFE)	Mean	2.38	2.70	1.65
	SD	1.80	2.38	
Beck Depression Inventory (BDI)	Mean	12.28	13.36	3.52**
	SD	8.52	13.68	

two-tailed significance : \*\*\* $p < .001$  \*\* $p < .005$  \* $p < .05$ .

situations and the degree of interference with daily life show no significant change from the end of the recovery programme to three-month follow-up. Participants neither improve nor deteriorate on these measures.

#### *Correlations at Follow-Up*

Pearson product-moment correlations between the difference in scores at the end of the recovery programme and at three-month follow-up were carried out. These illustrate a relationship between the change in Agoraphobic Cognitions scores and participants Satisfaction scores at follow-up ( $r = .60, p < .05$ ). This indicates that as the difference between the ACQ scores increases, so the follow-up Satisfaction scores increase; those reporting a decreased severity in Agoraphobic cognitions at follow-up, also reported being more satisfied with the recovery programme at follow-up. A further positive correlation was found between the change in scores for the Mobility Alone sub-scale of the Mobility Inventory and the duration of the illness ( $r = .55, p < .05$ ), an increase in duration correlated with a decrease in scores for MIALO between the end of the recovery programme and at three-month follow-up. This is a counter-intuitive finding since it illustrates that as the duration of the illness increases, so the amount of reported improvement on the alone sub-scale of the the Mobility Inventory increases in the time period between the end of the recovery programme and follow-up.

#### **Interview data**

In addition to the symptom measures, it is informative to have an overview of the sorts of comments made by participants about their experiences of help before contacting 'No Panic' and after the end of the recovery programme. Table 10 summarises the information obtained through the semi-structured interview conducted with each participant at the beginning of the recovery programme.

Table 10: Professionals seen in the past and their helpfulness

Past help	Total	Least helpful	Most helpful
Counsellor	6	1	3
CPN	13	6	2
Day Hospital	3	0	1
Clinical Psychologist	12	6	3
GP	25	14	0
Medication	23	3	2
Psychiatrist	13	5	2
Voluntary agency	2	0	0
Alternative medicine	12	2	1

#### *Previous help received*

All of those who took part had initially gone to their general practitioner (GP) for help. They all reported being extremely frightened by their first panic attack and being convinced they were physically ill. In the cases of four of the participants, their GP was unable to make a diagnosis and they were referred to heart specialists or neurologists. One participant stated that she 'begged for help' from her GP but was only offered the input of a community psychiatric nurse when she threatened to commit suicide and was admitted to hospital.

All participants were asked about the sort of help they had received in the past and which they had found most and least helpful. Table 10 illustrates the total number of participants who received help from different professionals and the number who found them least or most helpful.

Eleven (44%) of the participants reported being unsure if any of the help they had received in the past had made any difference at all; that it had been neither helpful nor unhelpful.

Table 10 illustrates that all of the participants had seen their GPs about their symptoms of panic, of these, fourteen (56%) stated that they had found their GP to be the least helpful person they had seen. Many felt that “he didn’t know anything about psychiatric problems, “he didn’t know what was wrong, I felt a nuisance”. Similarly, 50% of those who received help from a Clinical Psychologist considered them to be least helpful, some of the comments made include “he was cold and didn’t understand”, “he blamed my past”, “ he saw me four times and said there was nothing more he could do for me...I had it too long”. It appeared from the participants’ descriptions of the type of help offered that five of the Clinical Psychologists worked within a CBT framework, while six were using a more analytic approach and one was working in a family therapy framework. The three Clinical Psychologists considered most useful also appeared to have worked within a CBT framework of graded exposure and homework setting, they “gave practical advice” and “knew about agoraphobia”.

### *Future Help*

Participants were asked at follow-up, if they planned to seek further help. One said she was going to become a ‘helpliner’ for ‘No Panic’ with a view to facilitating recovery groups herself. Three stated they would be asking to take part in ‘No

Panic's' one to one counselling. Four said they were awaiting an appointment to see a Clinical Psychologist. Two were waiting to see a Behaviour Therapist. Of the remaining, one person was considering hypnotherapy, one an anxiety management group, one was waiting to see a 'case manager' and one did not intend to seek further help.

In relation to the 'No Panic' recovery programme, twenty two people (88%) when asked at the end, stated they would definitely recommend it to other people with similar problems. When asked at follow-up, thirteen people (92%) said they would definitely recommend the recovery groups.

#### *Attributions of Change*

Although this study was limited to finding out if the self help groups offered by 'No Panic' led to reductions in symptoms of panic and agoraphobia, it is interesting to note some of the comments often made by the participants about why they felt they had they improved.

In the Satisfaction Questionnaire, participants were asked "How improved are your difficulties and what are the reasons for this?" Participants numbered 30, 23, 21, and 6 improved on the majority of symptom measures. Participants numbered 2, 4, 12 and 27 showed less improvement. Some of their comments at the end of the recovery programme and at follow-up are listed below:

Question: "How improved are your difficulties and what are the reasons for this?"

No. 30

"Being given the encouragement and confidence by others who suffer with the same sort of problem. Realising I'm not the only one and I'm not mad or stupid or weak. Proving to myself (through exposure therapy) that my

phobias are what I've made and that they can be overcome".

No. 23

"I don't fear the "symptoms" anymore and understand why I have them. I know I have to 'face' rather than avoid. I know it is anxiety that causes the symptoms ...the group helped me realise all this and taught me how to manage the panic rather than to avoid it...Being part of the group was a very rewarding experience...I have found 'No Panic' very organised and efficient and it's comforting to know they are always on the end of the phone should I need them...I still have the thoughts but I don't believe them now".

No.21

"Being told how to handle your panic attacks and feelings of stress has been the main advice for me, also listening to relaxation tapes and putting them into practice has helped me when I feel stressed out".

No.6

"Greater understanding of the symptoms of anxiety i.e. can't come to any serious physical or mental harm. Realising that I'm not the only one who suffers from it. Importance of doing relaxation exercises . Exposure therapy. Great support from the other members in the group and the group leader".

(Comment at three-month follow-up).

"Difficulties seemed to have increased over the last month. I am better than when the course began, but believe that more support is required following on from the course and that the telephone support group on a monthly basis is insufficient".

No.2

"I like to attempt the small tasks set and discuss the following week how I

coped. Wishing to support other members of the group. I have gained in confidence to share my problems with others who have become friends.”

(Comment at three-month follow-up)

“I find it a relief in talking to others who understand what I am going through and I have made new friends”.

No.12

“because other people have the same symptoms...without the help of ‘No Panic’ I wouldn’t have understood my problems, my doctors are rubbish, no panic has been really helpful and made me understand panic, and anxiety and phobias”.

No.27

“I’ve learnt how to change negative, illogical thoughts into positive, logical ones...just talking over my problems and sharing experiences and advice was a great help”.

Question: “How improved do your difficulties still need to be and what might help you do this?”

No.4

“Talking and being more honest about my feelings and difficulties and more self exposure work. Also, our group are continuing to talk once a week by ourselves, so I feel this contact will be helpful”.

No.6

“Continuation of relaxation exercises. Continuous exposure therapy”.

No.2

“To carry on with the phone sessions, and would maybe like to attend a

support group in Haringey”.

No.27

“I think I would benefit from one to one counselling”.

Question: “Please describe things which were less helpful or difficult”.

No. 31

“Self exposure to one’s greatest fears is one of the hardest and most tiring thing to undertake. The lack of understanding by people in general can make recovery very lonely and sometimes disheartening if you have a setback or failure”.

No 27

“I wish I had more time to discuss in depth my problem. I felt as if the group leader was showing more interest in the others...I’d previously been on a stress and anxiety relief course and knew a lot of what we were told already so towards the end I felt as though it was a waste of time. Not dwelling on my problems is one thing I know that helps”.



## Discussion

This study was concerned with self-help treatment for those with panic and agoraphobia. It set out to examine any changes in the reported severity of symptoms for people taking part in a telephone self-help recovery programme offered by the national organisation 'No Panic'. Additionally, it set out to investigate whether any changes in symptoms were related to participants' pre-treatment histories, expectations of treatment or facilitator effects. Twenty-five members of the self-help organisation completed the study.

Each participant was asked to complete questionnaires regarding the severity of panic over the last seven days; the symptoms included:

- The severity of the physiological sensations of panic.
- The severity of the catastrophic thoughts accompanying panic.
- The frequency of panic attacks.
- How often situations such as travelling on trains were avoided when alone and when accompanied.
- The severity of feelings of anxiety and depression.
- The degree to which the symptoms interfere with daily life.

These symptoms of panic were assessed at three points: before the recovery began (pre), halfway through the programme (mid) and at the end (post). A further fourteen participants were assessed at three-month follow-up. In addition to symptom questionnaires, participants were asked to complete Satisfaction questionnaires, at the end of treatment and at three-month follow-up. Participants were also interviewed regarding their treatment histories and their expectations of the recovery programme.

The analysis of results comparing symptom severity at the beginning of the

recovery programme and severity at the end indicated a significant change in all of the symptoms measured except for avoidance behaviour when alone. There was a significant reduction in the number of panic attacks, the severity of fearful body sensations, catastrophic thoughts, anxiety and depression, avoidance behaviour when accompanied and symptom interference with daily life. In terms of reliable change, nearly three-quarters of participants had improved on three or more symptom measures. All except one person had shown a reliable reduction in the severity of the catastrophic cognitions associated with panic. However, only one third of the participants were 'panic free' at the end of the recovery programme. Satisfaction at the end of the recovery programme was correlated with the severity of fearful body sensations. Participants who reported a reduction in the severity of fearful body sensations also reported being more satisfied with the recovery programme. There were no significant relationships between symptom reduction and duration of illness, age of participant, group facilitator, helpfulness of their GP, and whether participants were taking medication.

A comparison of symptom severity at the end of recovery and at three-month follow-up revealed a significant reduction in severity of fearful body sensations, catastrophic cognitions, anxiety and depression. However, the finding at the end of treatment of a significant reduction in the degree to which the symptoms interfered with daily life was not found at follow-up. There was no difference from the end of treatment to follow-up on how participants daily lives were affected by the symptoms of panic. Further, the earlier pre-post finding of a significant reduction in avoidance behaviour when accompanied and a reduction in the frequency of panic, was not found when comparing severity of symptoms between the end of the recovery programme and follow-up. This indicates that at follow-up, participants

report a reduction in the somatic and cognitive aspects of panic and agoraphobia, but they do not report a significant change in their agoraphobic avoidance behaviour.

Satisfaction at follow-up was related to reductions in the severity of catastrophic cognitions, those reporting a decrease in severity of catastrophic thinking also reported being more satisfied with the recovery programme at follow-up. One curious finding was the significant correlation between duration of illness and the severity of avoidance behaviour when alone. The longer the duration of panic and agoraphobia, the greater the reduction in the severity of their avoidance behaviour when alone.

This chapter begins with a discussion of research findings with reference to outcome studies utilising professionally-assisted cognitive behaviour therapy. The strengths and weaknesses of this study will be discussed, followed by a discussion of future research possibilities. The chapter ends with an overview of the clinical implications of this research.

### **Symptom Change**

It can be seen that by the end of the recovery programme, participants had made a significant improvement across all measures. It is interesting to note that virtually all participants reported having a reliable change in catastrophic thoughts during a panic attack. Judging by participants' comments, this seemed attributable at least partly to increased knowledge about the symptoms of panic. As Clark (1986) and others note, people who experience panic attacks have a tendency to misinterpret the sensations of panic as indicative of an immediately impending physical or mental disaster. One of the aspects of the recovery programme is that it provides an opportunity for all group members, including the facilitator, to talk about their experience of the physiological sensations of panic and the fearful thoughts that accompany them. The

group then examines the reality of these catastrophic thoughts to see if they are a 'false alarm' rather than based on real threat. It may be that this aspect of the programme made a contributed to this change in cognitions at the end of treatment and at follow-up.

In comparing the results of this study with those of therapist-assisted treatment studies, it is interesting to note that the overall effect size in this study is higher than that reported in a meta-analysis of therapist-assisted treatment (Gould et al., 1995). More detailed comparison indicates that the effect sizes seen for the agoraphobic and Anxiety sub-scales of the Fear Questionnaire are similar to that found for therapist-assisted treatments (Marks and Mathews, 1979). The effect size for the Mobility Inventory - alone and accompanied sub-scales - was lower than for the comparable study of therapist-assisted group treatment conducted by Robinson et al. (submitted). This illustrates comparable reductions in the symptoms of panic for the recovery programme and therapist-assisted treatments. Avoidance behaviours, however, show less improvement than would be expected in therapist-assisted treatment.

What was least improved was the degree to which participants reported being able to go out alone, interestingly, this was also found by Robinson et al.(submitted) in their study of professionally-assisted group treatment. By the end of the recovery programme, none of the participants showed a reliable increase in their ability to go out unaccompanied. Professional opinion would say this is a disappointing outcome since this is the core difficulty for those with agoraphobia. However, this measure did not correlate with participants' Satisfaction score. One explanation for this finding is that during the recovery programme, participants are encouraged to set their own exposure goals. Group facilitators and group members encourage each

other but each person is asked to take responsibility in setting goals and is left to decide if they want to share this with the group. Given this, it is not surprising that individuals show least change on what, for many, is the most difficult aspect of the recovery programme. It is also understandable that they do not see this lack of change as being a reflection on the usefulness of the recovery programme. It is likely that participants experienced difficulties in carrying out exposure work for reasons not related to the content of the recovery programme but more to the lack of individual contact with the facilitator. In the study by Hand et al. (1974) which involved group exposure for agoraphobics, the participants commented that 'I didn't want to let the others down' or 'I didn't want to let the doctor down'. This study found that many of the participants would not engage in exposure tasks unless taught and accompanied by the therapist; they wanted the therapist to be with them during early exposure sessions. Hand et al. explain their results in terms of low self-esteem in participants. The more recent study of housebound agoraphobics by McNamee et al. (1989) suggested that while therapists do not need to accompany patients, therapist contact might be an important aspect of treatment effectiveness. It may be that this aspect of recovery is the most difficult to carry out through the minimal support of a telephone self-help group.

At follow-up it was found that increasing duration of illness related to increases in participants' reporting of being able to go out alone. It may be that this result indicates the importance of duration of illness on prognosis. It may be that the longer an individual has avoided situations, the more motivated he or she is or the more likely any small change in behaviour will be noticed and therefore reflected in the severity scores.

### **Feelings of Satisfaction**

A large majority of participants said that they would recommend the 'No Panic' recovery programme to others with panic and agoraphobia. Participants' reports of satisfaction at the end of the recovery programme were not related to any variable apart from the severity of fearful body sensations. Those who were less frightened of the fearful body sensations accompanying panic also reported being more satisfied with the recovery programme. The finding at follow-up was different; at this point in recovery, those that reported a reduction in catastrophic thoughts during a panic attack also reported being more satisfied with the recovery programme. It may be that, in the earlier stages of recovery, participants value the changes in the severity of fearful body sensations. At follow-up, however, participants are perhaps more concerned with the thoughts accompanying panic and value a reduction in the severity of these. It may be that the important factor in participant's perception of maintenance of gains is the severity of their catastrophic thoughts. This explanation is supported by the findings of Clark et al. (1994) in which a comparison of applied relaxation, imipramine and cognitive therapy suggested that cognitive therapy was the most effective at one year follow-up.

It is somewhat surprising that Satisfaction scores were related only to the two symptom measures mentioned and also, that they were not related to any other factors such as group facilitator or expectations about the recovery programme. It appears, from the comments made by some of the participants, that one of the most satisfying aspects of the recovery programme was the experience of being in a group with people who had similar difficulties. Participants stated that they were surprised how similar their experiences of panic were. They found it helpful that the group facilitator spoke about recovery from his/her own experiential as well as theoretical

knowledge, something which professional helpers had been unable to provide. Participants also said they felt less embarrassed in talking about their catastrophic thoughts in the group because they felt they would not be judged and that someone else in the group would also have experienced that thought. Part of the success of 'No Panic' for these individuals was the fact that they did not feel the co-members or facilitators were distant. This was despite the fact that they did not meet any of the other group members face-to-face. Some participants formed friendships with each other and kept in touch in between weekly sessions and during the three-month follow-up period. Some also spoke to the group facilitator between sessions or telephoned the 'No Panic' help-line when embarking on an exposure task or when they experienced a panic attack.

A few participants noted difficulties with the recovery programme. Not everyone found the group format helpful, they felt there was not enough time to discuss their individual difficulties in depth and that the facilitator was not always assertive enough with those members taking up a lot of the session time. Interestingly, none of the participants complained about the lack of face-to-face contact; they were pleased to be able to take part in a recovery programme which did not involve having to leave home as this had been a source of frustration in services offered by professionals, particularly psychiatrists and clinical psychologists. One clear recommendation made by participants at follow-up was that they felt they would have benefited from a phasing-out of sessions rather than an end at week twelve. All participants took part in the befriending groups, which could be organised to run as often as they wanted. However, some felt that it would have been useful to have more of a formal arrangement to meet on the telephone every fortnight for a few months as part of the recovery programme and to then meet as a

befriending group after the main recovery programme was over. Indeed, one of the notable issues in the treatment of agoraphobia is the need for long term follow-up and support (Brown and Barlow, 1995), something which participants said they had not received from statutory services and something they had hoped to receive from 'No Panic'. A few participants said they would become volunteers with 'No Panic' as a way of continuing their own improvement and in order to 'give back' some of the help they had received.

### **Strengths and Weaknesses of the Current Study**

There is already much support for the efficacy of self-help for those with agoraphobia in experimental studies. There is also some support for the effectiveness of group CBT for agoraphobia in a dedicated clinical setting. However, there is currently no information regarding the usefulness of a telephone self-help programme, such as that being offered by 'No Panic'. This research aimed to be a naturalistic study of a self-help recovery programme currently being offered in this country. It did not aim to compare the effectiveness of self-help with other forms of help, nor was it aimed at determining why self-help is effective. The study employed a single-group, within-subjects repeated measures design. The main question being asked by this research was 'do people who are agoraphobic report a reduction in the symptoms of agoraphobia when they take part in a self-help telephone recovery group?'

There are some strengths in the design of this study. It enabled each participant to act as his/her own 'control' so that changes in symptom scores were charted over time for each individual. The use of measures assessing different aspects of panic and agoraphobic symptoms afforded the opportunity to differentiate those symptoms for which participants' showed the most gains from those which



showed the least. Enquiring about how severely symptoms interfered with participants' lives and their feelings of satisfaction enabled an examination of how symptom change related to changes in daily life and perceived usefulness of the recovery programme.

The interview data provided information about the kinds of help participants had received before contacting the self-help organisation and how useful they had found this help.

However, as was discussed in the introductory chapter, there are aspects mentioned by Roth and Fonagy (1996) in relation to outcome research that need to be considered here.

### *Measures*

There are difficulties with employing self-report inventories as the sole measure of symptom severity. The majority of agoraphobia treatment research relies on self-rating fear inventories as dependent measures of therapeutic change. Kinney and Williams (1988) note the difficulties inherent in the use of self-report scales in agoraphobia research without the use of validation through objective behavioural criteria. They suggest that self-efficacy scales may be used as an alternative to fear and mobility inventories. They explain that self-efficacy scales have an advantage over inventories because they are designed to measure specific thinking patterns – self-perceptions of coping capabilities. In contrast, inventory measures request a single fear or avoidance rating of globally defined situations (e.g. 'high places'). While self-efficacy scales were not intended to replace measures of behaviour, they are useful because they ask people about their self-perceived ability to perform a range of specifically defined tasks within a given kind of activity. For example, a self-efficacy scale would ask people to judge their functional capability of perform

various height related tasks, such as standing at the top of ten steps and looking down for fifteen seconds or standing at the top of twenty steps and looking down for thirty seconds. Kinney and Williams (1989) carried out a study comparing how well self-efficacy scales and fear inventories correlate with behaviour tests. Thirty-seven agoraphobics were asked to complete self-efficacy scales along with the Fear Questionnaire (Marks and Mathews, 1979) and The Mobility Inventory for Agoraphobia (Chambless et al, 1985). Participants were then asked to carry out behavioural tests of their feared situations and were asked to give an anxiety rating for each task. Kinney and Williams (1989) predicted that the self-efficacy scales would correlate more highly with participants' actual behaviour than the fear or mobility inventories. Either direct observation or indirect indices of behaviour were used to verify participants' performance on the behavioural tests. The results indicated that the inventories weakly correlated with behaviour and anxiety ratings while self-efficacy scales correlated highly. The researchers suggest that self-efficacy scales should be used in preference to inventories but neither are a substitute for objective behavioural measurement of therapeutic changes in agoraphobia.

Perhaps a compromise in the present study would have been the use of behaviour diaries (Mathews, Gelder and Johnston, 1981) along with the use of self-efficacy scales. It may be that diary keeping would have had the added effect of motivating participants to carry out exposure tasks (Gould and Clum, 1995) as well as providing more valid information about changes in avoidance behaviour. Indeed, given the low correlation demonstrated by Kinney and Williams (1988) between the Mobility Inventory and participants' behaviour, the finding of no significant behaviour change in this study should not necessarily lead to the conclusion that participants' behaviour actually did not change.

One of the considerations in designing this research was the ease with which participants could understand and complete the questionnaires sent to them. Since the participants lived in different parts of the country and obviously found it difficult to go out, the researcher did not meet any of them face-to-face. The only personal contact occurred at the beginning of the project during the telephone interview. Although participants had the opportunity to contact the researcher at any time during the research, only two actually did so. Both participants telephoned with specific questions regarding how to complete some questionnaire items. Given the complexity of self-efficacy scales and the time required by participants to complete daily behaviour diaries, it is possible that, had these measures been incorporated, fewer members of the recovery programme would have taken part in the research or that there would have been more risk of misunderstanding the questionnaires. It is possible that a future study could incorporate single case studies in conjunction with the quantitative data collected here.

This study relied only on participants' subjective assessments of the severity of the symptoms of panic and agoraphobia. Additional assessments from group leaders, other group members or spouses could have been incorporated. This would have provided additional reliability data to either support or not support the changes reported by participants themselves.

#### *Other variables not studied*

It is not possible to make conclusions about the reasons for the improvements observed in this study. The efficacy of pharmacotherapy treatment in combination with CBT has been demonstrated and medication may have been a factor. Medication was not monitored throughout the study. The results indicated no differences in outcome between those who reported taking medication at the start of

the recovery programme and those who did not. This seems to provide support for the notion that medication was not a factor in improvement. However, it may be that participants were reluctant to say that they were taking medication. It is somewhat surprising that those who reported taking medication were taking anti-depressants rather than benzodiazepines. Given the stigma associated with taking benzodiazepine medication, it is possible that fewer participants reported usage than was the case. It is also possible that people who seek self-help may also be the people who are less likely to accept medication with the side effect of dependence. Another possibility is that those with severe symptoms and severe depression related to panic symptoms are also more likely to seek out self-help as a 'last resort', when they have had little success from other services. Certainly, judging by some of the comments, some of the participants felt that statutory services had failed them because their symptoms had been too long-term.

Although no facilitator effects were found, perhaps one of the factors that could have been an important ingredient in symptom reduction is group membership. Group cohesion has been shown to be important in the success of group therapy (Hand et al., 1974). It may be that this was an important aspect of participants' recovery. Comments made by most individuals suggest that the group cohesion was an important element in their feelings of satisfaction with the recovery programme.

#### *Follow-up period*

Another difficulty with this study was the relatively short follow-up period of three-months. A recent study by Brown and Barlow (1995) examined the importance of follow-up studies for panic patients. They found that patients with more severe pre-treatment symptomatology showed evidence of treatment gains at three-months but were more likely at two-year follow-up to have poorer outcomes. This indicates that

panic disorder tends to be a chronic difficulty; the maintenance of therapy gains need to be assessed over longer follow-up period than three months. This is not to say that following people up for longer does not carry its own problems – it becomes harder to ascribe maintenance of gains solely to the treatment. Additionally, it has been noted that symptom change may occur at various stages in the follow-up period. Participants may not show stability in treatment gains so the finding of no further improvement at three-months in this study is not necessarily an indication that participants will not show further gains or deterioration at six-month or one-year follow-up. A future study would need to include longer follow-up periods.

### *Participants*

The fact that the study did not incorporate a formal screening assessment for a diagnosis of panic disorder with or without agoraphobia makes it difficult to generalise from this sample across the clinical population. The similarity between the participants' and clinical populations' mean scores on the symptom measures and the fact that all participants had a history of symptoms for over a year indicates that they are probably not too dissimilar. Further, all of the participants stated at interview that their GP or a psychiatrist had told them that they had panic disorder.

It can be argued that the population involved in this study was a rarefied sample. The group members who chose to take part in the research were those more motivated to do well and so were more likely to make most use of the recovery programme and more likely to report a reduction in symptom severity. Random allocation and the use of comparison treatment group would have been a useful way of controlling for the problem of uncontrolled selection. This may not, however, provide a practical solution, as participants who did not want self-help may be likely to drop out of treatment.

One encouraging aspect of the research was the relatively low attrition rate; most people who initially decided to take part in the research completed the recovery programme and completed the research. All participants who had reached the three-month follow-up period completed the questionnaires. However, the total number of participants who completed the measures at all three stages of recovery is relatively low, a larger sample would have provided a more reliable basis for the effectiveness of the recovery programme.

Another difficulty in generalising from this study is the possibility that there are significant differences between those with agoraphobia who seek self-help and those who do not. There is currently a paucity of research addressing the membership characteristics of self-help groups. Powell (1994) and others have presented data suggesting that self-help group members in the United States are more likely to be Caucasian, male, with a mean education level of twelve years (Lieberman and Snowden, 1994). The research presented here did not aim to provide an in-depth description of the characteristics of those who took part in the recovery groups. Given this, it is not possible to say a great deal about whether the population studied was similar to that found in clinical settings. The study of group CBT in a clinical setting by Robinson et al. (submitted), described their group population as 60% female, 67% married, with a mean age of 39 years and a mean duration of symptoms of 5 years. In comparison, this study included more females; the participants were older and had a longer duration of panic and agoraphobic symptoms. It is also unclear if the participants in this study are a fair representation of the membership of 'No Panic'.

### **Implications for Future Research**

This initial study of the effectiveness of telephone self-help provides promising

results. There are various ways in which this research can be taken forward. One direction would be to focus on the self-help process and the possible reasons why participants in the recovery groups improve. This could involve telephone observation of the group sessions and an analysis of sessions using grounded theory as an approach. Alternatively, or in addition, research could focus on detailed case studies of individuals. This could include a description of the participant's life history, symptom history and help sought. Both methods would provide rich data, the first on the group process and the latter on how particular individuals with panic disorder experience different forms of help.

The results found in this study that participants report a reduction in symptoms can be explained in a number of ways. The literature on specific and non-specific factors in therapy illustrates the need for outcome research to incorporate a randomised, controlled designs. Without this there is a greater risk that any number of factors could explain the results. A randomised-controlled trial comparing a self-help group, such as that offered by 'No Panic', with a professionally assisted treatment group and a wait-list control group would provide valuable data. In this case, a detailed analysis of the therapy offered in each condition coupled with monitoring of symptom severity would give an indication of how self-help compares with professional help. This experimental approach carries with it the risk of changing the nature of self-help. Assigning individuals randomly to either the self-help or professional groups may confound an important ingredient of what makes self-help successful, that individuals choose it as a form of help.

Borkman (1990b) used the term 'experiential knowledge' to refer to the knowledge people acquire when they live through and resolve a problem. It has been assumed that experiential knowledge is the essential ingredient that distinguishes

self-help from other types of help and it is highly valued by members of self-help groups (Hasenfield & Gidron, 1993). However, it is a challenge to researchers to operationalise the concept of experiential knowledge in investigating the nature of self-help. Powell and Cameron (1991) highlight a number of issues relevant to how researchers can take a role in self-help initiatives. They note that policy makers and researchers often prefer quantitative research methods and findings as they lend themselves to policy initiatives based on sound reliable and valid data, which can be generalised across populations. Powell and Cameron suggest that research using a qualitative approach be sponsored by research organisations since this is not only more likely to be acceptable to self-help leaders but also because they are more suited to the complexity of the self-help process. They also suggest that research moves on from studies of effectiveness to studies about participation in self-help. Further thoughts were related to the issue of researchers being involved in observing self-help groups and the probable disruptive effect this can have on the group process. However, they recommend collaborative working between professionals and self-help groups, as this can be useful to the self-help organisation in clarifying priorities and reflecting on current practice.

'No Panic' have been collecting satisfaction data since the recovery groups began and have been revising the groups in response to the comments made by participants. They hope to use this research in a similar way, to inform their current practice. It is envisaged that this project forms the basis for further collaborative work investigating the other forms of help offered by 'No Panic', such as help offered to those with obsessions and compulsions and help provided for carers of people with anxiety disorders. 'No Panic' are considering routinely incorporating the measures used in this study as part of the information sent to members at the



beginning and end of the recovery programmes.

Further research is needed in the utility of self-help telephone recovery for people with panic and agoraphobia. This approach is particularly important for those who are housebound and it may also be an effective way of providing longer-term support after professional therapy.

### **Clinical Implications**

This study indicates that those who take part in the self-help recovery programme offered by 'No Panic' report a reduction in their symptoms of panic and agoraphobia. Some of these changes are maintained through to follow-up. This finding provides tentative support to the growing body of literature suggesting that cognitive behavioural interventions are successful in different modes of delivery – therapist, group, paraprofessional, self-administered and self-help. In this case, the CBT model was employed by the facilitators of the recovery groups to structure a twelve-week recovery programme conducted over the telephone. The evidence for the effectiveness of CBT has been discussed in the introductory chapter but there are other clinical implications to the findings of this study, which will now be discussed.

#### *What seems to be helpful in self-help?*

Reissman (1990) suggests a number of benefits to being both a help receiver and a help provider:

- Being a helper leads to positive feelings about having something to give.
- It is an active role rather than a passive role as may occur when receiving help alone.
- Helping is socially useful and may lead to feelings of increased status
- It encourages the helper to be open to learning, so that they can both help effectively and learn how to help themselves.

It may be that being in the helper role assists people in making the most of their experience when they are in the role of helpee. This has important implications for professionally-assisted therapies; an active involvement of the client is likely to be more successful in creating change.

*Collaboration between professionals and self-help*

Reissman (1990) describes that one of the differences between self-help organisations and professional help is the fact the former comprises members, people who are both receiving and providing help to others. Professional help involves individuals who are either in the role of helper or helpee. The self-help approach enables many more people to offer help so that there is an expansion of resources. This expansion provides an opportunity for professional resources to be used more efficiently. Professionals can change their focus of work to educating lay members of the public in the skills and knowledge they have acquired. They can also concentrate their energies into providing help for those people who would benefit most from it or who actively choose that form of help.

At first glance this new paradigm makes sense in a society in which professionals find themselves under ever increasing pressure with limited resources. However, Reissman (1990) points out some of the resistance that can be seen from professionals about this change of paradigm. He states how, in Western society, there is a view that help is a commodity that is bought, sold, promoted and marketed. This context is often not talked about explicitly but it often inevitably affects the ways in which professionals are trained and the attitudes that are fostered. It can set up an asymmetrical relationship in which professionals have a vested interest in not sharing their knowledge or their help-giving role. The process of years of training and specialising in a field of help-giving reflects the view that people can benefit

only from receiving help from those trained to provide it. The types of interaction that can be engendered by the view that professionals have a privileged access to skills and knowledge, is that they can be seen by help-seekers as uninvolved. Judging by some of the comments made by the members of 'No Panic', some professionals were seen in this way - psychiatrists, clinical psychologists and GP's especially.

This study lends support to the potential usefulness of self-help in the reduction of the symptoms of panic and agoraphobia. Although this study was limited in that inferences regarding the causes of change cannot be made with confidence, when seen in the context of other self-help research, which reports positive findings, it is clear that clinical psychologists need to become more educated about and more involved in self-help initiatives. This involvement is important for a number of reasons:

- Some clients may find self-help more beneficial than professional help; clinicians need to bear this in mind when suggesting treatment options.
- Some clients may benefit from a combined treatment package of self-help and professional help, perhaps at different stages in recovery or provided in parallel.
- Self-help organisations may value and benefit from collaboration with professionals. Collaborative work is possible at all levels, including clinical, research and training/supervision projects.
- Professionals can benefit from the experiential knowledge of self-help members. The accessibility of professional help and the ways in which treatment packages are implemented are of particular concern to people who are housebound through agoraphobia.

- Professionals may benefit from collaborative work, as this may be a better use of their skills. It may enable them to spend more time working with individuals who require their specific skills and training.

Given the fact that resources are limited and that the demand for psychological services are increasing, it is likely that clinical psychologists will need to become more involved with self-help organisations. Future collaborative work has the potential to produce some creative and valuable treatment innovations for a range of psychological difficulties, including panic and agoraphobia.

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**Appendix 1: Ethical Approval**

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DT/cw

19 August, 1996



PLEASE ADDRESS ALL INTERNAL CORRESPONDENCE TO:  
Mrs Iwona Nowicka  
UCLH Research and Development Directorate  
9th Floor, St Martin's House  
140 Tottenham Court Road

Ms B Tanna  
Sub-Department of Clinical Health Psychology  
UCL

Dear Ms Tanna

The Joint UCL/UCLH Committees on the Ethics of Human Research

COMMITTEE A

Number: 96/93 (PLEASE QUOTE IN ALL FUTURE CORRESPONDENCE)

Title: 'No Panic' - How helpful is self-help recovery?

Thank you for your letter of 26 July 1996 outlining what we agreed in our previous meeting. I am happy that you are taking all precaution necessary to ensure the participants safety. You may now go ahead with this study.

Yours sincerely

Dr F D Thompson  
Chairman

NB. The Secretary of Committee A is now Mrs Iwona Nowicka who can be contacted on 0171 380 9579.

**Appendix 2: Participant Information Sheet**



## 'No Panic'- how helpful is self-help recovery?

Dr. Nancy Pistrang, Senior Lecturer and Ms. Bhavna Tanna, Trainee Clinical Psychologist.

Sub-Department of Clinical Psychology (Philips House),  
University College London,  
Gower Street,  
London WC1E 6BT  
Phone: 0171-380 7895/7896

### **INFORMATION :**

We together with 'No Panic' are inviting you to take part in a new study looking at the effectiveness of their telephone recovery groups. The NHS is sometimes unable to provide accessible and appropriate help for people who may have fears about going out or for people who carry out rituals. The recovery programme offered by 'No Panic' merits a study of how people feel before they start the programme and how they feel afterwards. The information that we hope to collect should be useful in developing ideas about possible treatment alternatives for other people who also have these problems.

### **What's involved if you take part?**

**Step 1:** Before you start the 12 week programme, you would need to fill in and return the enclosed consent form and questionnaires which together take about 30 minutes. We will then contact you to take part in a telephone interview about your current difficulties - this will take about 45 minutes.

**Step 2:** After 6 and 12 sessions, you will be asked to fill in the questionnaires again - taking 20-30 minutes.

**Step 3:** Three months after the end of the programme, you will be asked to complete the questionnaires a final time - taking 20-30 minutes.

**Optional step 4:** If you decide to take part, we are happy to discuss with you the results of your questionnaires and the overall findings.

### **Confidentiality:**

All written and interview information will be held in confidence. No individual's identity will be revealed in any formal or informal presentations of the study.

### **Decision to take part:**

You do not have to take part in this study if you do not want to. If you do decide to take part, you may withdraw at any time without having to give a reason. Your decision to take part or not will not affect your participation in the 'No Panic' recovery programme in any way.

**Further Information:** Please do not hesitate to contact us if you at any time have questions about any aspect of this study.

All proposals for research using human subjects are reviewed by an Ethics Committee before they can proceed. This proposal was reviewed by the University College London Ethics Committee.

We are obliged by the Ethics Committee to have details of your doctor's name and telephone number. This information will be used *only* in an emergency and you will be informed if we need to make contact with them.

**Appendix 3: Consent Form**

**CONSENT FORM**

**'No Panic' - how helpful is self-help recovery?**

Dr. Nancy Pistrang and Ms. Bhavna Tanna

Delete as necessary

- |                                                                                                                              |        |
|------------------------------------------------------------------------------------------------------------------------------|--------|
| 1. Have you read the information sheet about this study?                                                                     | Yes/No |
| 2. Have you had an opportunity to ask questions and discuss this study?                                                      | Yes/No |
| 3. Have you received satisfactory answers to all your questions?                                                             | Yes/No |
| 4. Have you received enough information about this study?                                                                    | Yes/No |
| 5. Which researcher have you spoken to about this study?                                                                     | .....  |
| 6. Do you understand you are free to withdraw from this study<br>- at any time<br>- without giving a reason for withdrawing? | Yes/No |
| 7. Do you agree to take part in this study?                                                                                  | Yes/No |

Signed ..... Date .....

Name in Block Letters .....

**Appendix 4: Telephone Interview**

## **Semi-structured Telephone Interview**

- 1) How would you describe your problem?
- 2) Could you describe any help or treatment you are currently receiving?
- 3) How did you hear about 'No Panic'?
- 4) What kinds of help have you sought to date?
- 5) Which aspects of the help were useful?
- 6) Which aspects were less useful?
- 7) Have you received any help from 'No Panic' before this group recovery programme?
- 8) If so, which aspects of this help were useful?
- 9) Which aspects were less useful?
- 10) Did you have any concerns about joining the recovery programme?
- 11) What do you hope to gain from the programme?

**Appendix 5: Recovery Programme**

## **Outline of Recovery Programme**

The recovery plan is programmed over 12 weeks, one session per week. Each member is sent an outline of the structure of each session before the group begins, they are expected to have read this and to carry out the homework task set in each session outline. The sessions can be summarised as follows:

### Session 1:

Members are asked to introduce themselves and say something about their difficulties. Issue of confidentiality, the unfamiliarity of teleconferencing and the format of the sessions are discussed. This may be followed by questions from the members and general getting to know each other.

### Session 2:

Members discuss the nature of anxiety: it's helpful and less helpful aspects. The role of biological and psychological aspects is introduced.

### Session 3:

Members are asked to discuss how their difficulties stem from an inappropriate anxiety response. They are asked to think about aspects of their lives that is affected by anxiety.

### Session 4:

At this point, members are given information about the role of avoidance and the need for exposure in order to overcome their phobia. They are encouraged to imagine an initial exposure task.

### Session 5:

This session is focussed on the difficulties members have had in the exposure task. This session may open up discussion about shared catastrophic thoughts.

### Session 6:

Members are encouraged in setting further exposure goals and it's suggested that they keep a diary of successes. The importance of relaxation training is discussed.

#### Session 7

Members are asked to plan and carry out an initial exposure task. Potential difficulties are discussed.

#### Session 8

This session is focussed on discussing the reality of fears accompanying exposure.

#### Session 9

Members are asked to think about continuing the exposure tasks and discuss how success with this will lead to changes in their daily lives.

#### Session 10

Members are asked to continue building on their successful exposure, the group are encouraged to exchange experiences and goals.

#### Session 11

The focus is on the ending of the group and reflecting on progress. Changes in catastrophic thoughts and behaviour are highlighted.

#### Session 12

Members are asked to discuss future goals and the future of the group – they have the option to continue meeting informally.



# NO PANIC

## PATRONS

ILLIS DENNIS, IMOGEN STUBBS, PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.

## PLANNED RECOVERY PROGRAMME USING TELECONFERENCES

### INTRODUCTION

WHO? THE COURSE IS TO HELP PHOBIA AND O.C.D. SUFFERERS OVERCOME THEIR FEAR.

WHAT? IT IS A BASIC 12 WEEK, ONE HOUR PER WEEK, TELEPHONE COURSE.

WHEN? AT CHEAP RATE TELEPHONE TIMES, USUALLY IN THE EVENING.

WHY? BECAUSE YOU WANT TO GET BETTER.

COST? NOTHING EXCEPT FOR THE COST OF A ONE HOUR TELEPHONE CALL FROM YOUR HOME TO A 'COMMUNITY NETWORK' TELECONFERENCE FACILITY IN EITHER BIRMINGHAM, LONDON, NORTHERN IRELAND OR SCOTLAND.

EACH COURSE WILL RUN FOR A 12 WEEK PERIOD, HOWEVER IT CAN BE EXTENDED TO MEET THE NEEDS OF THE COURSE MEMBERS.

THE COURSE IS DESIGNED TO HELP PEOPLE WHO SUFFER WITH PHOBIAS AND O.C.D. TO START AND MAKE STEPS ALONG THE ROAD TO RECOVERY. PEOPLE WHO CARE FOR SUFFERERS MAY ALSO LIKE TO PARTICIPATE IN THE COURSE TO HELP THEIR 'SUFFERER' GET BETTER. THE COURSE USES SELF-EXPOSURE BEHAVIOUR THERAPY AS THE BASIS FOR RECOVERY. WHILE NO THERAPY GUARANTEES SUCCESS, AT THIS PRESENT TIME, THIS METHOD HAS THE HIGHEST SUCCESS RATE. YOU WILL BE EXPECTED TO FACE UP TO YOUR FEAR ON A STEP BY STEP BASIS. WE DO NOT PLAN TO THROW YOU INTO YOUR WORST SCENARIO AND LET YOU SINK OR SWIM. THE PROGRESS YOU MAKE WILL DEPEND ON THE AMOUNT OF EFFORT YOU ARE PREPARED TO PUT IN. **NO PAIN - NO GAIN !!** YOU WILL ALSO BE EXPECTED TO READ ONE SECTION OF THIS MANUAL EACH WEEK PRIOR TO EACH WEEKLY TELECONFERENCE. DON'T LEAVE IT UNTIL THE LAST MINUTE PRIOR TO EACH SESSION, YOU WILL NOT BENEFIT AS MUCH IF YOU DO.

IF YOU ARE NOT PREPARED TO CARRY OUT ALL OF THE ABOVE, DON'T WASTE YOUR TIME AND OURS BY TAKING THE COURSE. THERE ARE OTHERS WAITING WHO ARE PREPARED.

THE COURSE TAKES PLACE ON THE TELEPHONE USING THE 'COMMUNITY NETWORK' TELECONFERENCE FACILITY. THIS SYSTEM ENABLES A GROUP OF PEOPLE TO TALK TO EACH OTHER AS THOUGH SITTING AROUND A TABLE. EACH GROUP HAS A TRAINED GROUP LEADER WHO WILL GUIDE THE GROUP THROUGH THE COURSE.

THE FIRST WEEK WILL BE AN 'INTRODUCTORY' SESSION. THIS WILL ENABLE PEOPLE TO GET USED TO THE 'TELECONFERENCE' IDEA, TO GET TO KNOW THE OTHER MEMBERS OF THE GROUP, TO ASK ANY RELEVANT QUESTIONS AND TO FULLY UNDERSTAND WHAT IS EXPECTED OF THEM.

ANYONE ABOUT TO UNDERTAKE EXPOSURE THERAPY WHO MAY HAVE OTHER HEALTH PROBLEMS IS ADVISED TO CHECK THINGS OUT WITH THEIR G.P. IN ORDER TO ENSURE THAT THE ANXIETY EXPERIENCED DURING EXPOSURE THERAPY IS NOT DETRIMENTAL TO THEIR HEALTH

IF YOU WOULD LIKE MORE INFORMATION ABOUT THESE COURSES, PLEASE RING MARY, OUR CONFERENCE SECRETARY, ON 01686 623315.

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE"**

REGISTERED OFFICE: 93, BRANDES FARM WAY, RANDLAY, Telford, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE: 01952-590005, HELPLINE: 01952-590545, FAX: 01952-270962

REGISTERED CHARITY NUMBER 1018184.

# *NO PANIC*

*PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.*

## TELECONFERENCE WEEK ONE

QUESTIONS I WANT TO ASK. (WRITE HERE ANY QUESTIONS YOU WANT ANSWERED).

NAMES OF OTHER GROUP MEMBER. (WRITE IN THE NAMES OF YOUR OTHER GROUP MEMBERS)

PAGE (2)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, Telford, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.

# NO PANIC

*PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.*

## TELECONFERENCE WEEK TWO

### UNDERSTANDING THE FEAR FACTOR

PHOBIAS CENTRE AROUND OUR NATURAL REACTION TO 'FEAR'. FEAR IS REALLY ONLY ANOTHER WORD FOR ANXIETY, AND ALL OF US, PHOBIC OR NOT, EXPERIENCE ANXIETY MOST DAYS OF OUR LIVES. WILL THE CAR START? WILL THE KIDS BE O.K.? WHEN ANXIETY REACHES THE STAGE WHERE 'THE FEAR BECOMES ILLLOGICAL AND UNREASONABLE', THEN IT IS CALLED A PHOBIA

FEAR IS A NATURAL RESPONSE IN ALL OF US. IT KEEPS US SAFE BY MAKING SURE THAT MOST OF THE TIME WE ARE NOT IN DANGEROUS SITUATIONS. HOWEVER, SOMETIMES WHEN WE ARE NOT THINKING ABOUT WHAT WE ARE DOING, WE DO THINGS WHICH ARE DANGEROUS, E.G. STEPPING OFF THE PAVEMENT WITHOUT LOOKING, AND NEARLY GETTING RUN OVER. THE SHOCK TO OUR SYSTEM, WHEN SOMETHING LIKE THIS HAPPENS, IS NOT VERY PLEASANT. WE SWEAT, SHAKE, TREMBLE, PROBABLY FEEL SICK AND OUR HEART POUNDS. THE VEHICLE WILL PROBABLY SOUND A HORN, AS IT GETS CLOSE, AND OUR 'FEAR' RESPONSE MAKES US JUMP BACK ON THE PAVEMENT AS QUICKLY AS WE CAN. THUS OUR 'FEAR' RESPONSE HAS GOT US OUT OF DANGER. WITHOUT THE 'FEAR' RESPONSE WE WOULD HAVE JUST STOOD IN THE ROAD, WITH OBVIOUS CONSEQUENCES.

FEAR IS A SKILL WHICH WE HAVE LEARNED AS WE GREW UP. HOW MANY TIMES DO WE SEE CHILDREN RUN ONTO A BUSY ROAD? THEY HAVE NOT YET FULLY LEARNED THE 'FEAR' RESPONSE.

THUS HAVING ESTABLISHED THAT WE NEED FEAR TO SURVIVE, WHAT HAS THIS GOT TO DO WITH A PHOBIA? THE ANSWER IS THAT OVER A PERIOD OF TIME, SUFFERERS HAVE LEARNED TOO MUCH FEAR, AND SO GET IT WHEN THERE IS NOTHING TO BE FRIGHTENED OF. THEREFORE THE DISTRESSING FEELINGS, THAT A 'NORMAL' PERSON GETS EVERY NOW AND AGAIN, ARE A CONTINUAL PART OF A PHOBIA SUFFERERS LIFE.

WRITE DOWN HERE SOME EXAMPLES OF 'NORMAL' FEAR AND HOW IT KEEPS US SAFE.

PAGE (3)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, TELLFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.

# NO PANIC

*PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.*

## TELECONFERENCE WEEK 3

### UNDERSTANDING ANXIETY

WHAT HAS ANXIETY TO DO WITH PHOBIAS AND O.C.D.?

IT IS THE BASIS ON WHICH PHOBIAS AND O.C.D. OPERATE. ANXIETY IS A NORMAL PART OF OUR LIVES. IT OPERATES VIA THE NERVOUS SYSTEM AND IS PART OF THE MESSAGE SYSTEM OF THE HUMAN BODY. IT IS PART OF OUR MAKE-UP AND IS ESSENTIAL TO OUR WELL BEING. WITHOUT IT WE WOULD NOT FUNCTION PROPERLY. HOW DOES ANXIETY WORK? IT WOULD REQUIRE A MEDICALLY QUALIFIED PERSON TO EXPLAIN THE FULL CHEMISTRY OF ANXIETY, BUT WE ONLY NEED TO UNDERSTAND WHAT IT DOES TO US.

THIS WEEK WE WILL TALK ABOUT ANXIETY AND THE ROLE IT PLAYS ON PHOBIAS AND OBSESSIVE DISORDERS.

WRITE DOWN HERE HOW YOU THINK ANXIETY AFFECTS US.

PAGE (4)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE!"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDIAY, TILFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.

# NO PANIC

*PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.*

## TELECONFERENCE WEEK 4

LEARNING ABOUT THE BASICS OF SELF-EXPOSURE BEHAVIOUR THERAPY.

'NO PANIC' IS BASICALLY A SELF-EXPOSURE SOCIETY, AND SCIENTIFIC SURVEYS SHOW THAT THIS IS THE MOST EFFECTIVE METHOD OF OVERCOMING PHOBIAS AND OBSESSIONS. SELF-EXPOSURE IS A METHOD WHICH INVOLVES, IN THE CASE OF PHOBIAS GRADUATED STEP BY STEP EXPOSURE TO THE FEARED OBJECT OR SITUATION, OR IN THE CASE OF OBSESSIONS THE GRADUAL STEP BY STEP REDUCTION OF THE RITUALS. IF NECESSARY IN THIS TELECONFERENCE WE SHALL ALSO LEARN ABOUT 'COGNITIVE' THERAPY WHICH CAN BE USED TO HELP PEOPLE WHO HAVE OBSESSIVE THOUGHT PROBLEMS WITHOUT RITUALS.

WRITE DOWN HERE YOUR THOUGHTS ON THE FIRST STEPS YOU MIGHT LIKE TO CONSIDER IN YOUR PERSONAL RECOVERY PROGRAMME.

PAGE (5)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, TILFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018181.

# NO PANIC

PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.

## TELECONFERENCE WEEK 5

WHAT HAPPENS TO US AS WE START OUR SELF-EXPOSURE?

THIS WEEK WE ARE GOING TO LOOK AT THE FEELINGS WE SHALL EXPERIENCE WHEN WE ARE CARRYING OUT OUR EXPOSURE WORK & HOW WE CAN DEAL WITH IT.

WRITE DOWN HERE ANY EXPERIENCES THAT YOU MAY HAVE HAD WHILST TACKLING YOUR PROBLEM.

PAGE (6)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE!"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, HILFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.



# NO PANIC

*PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.*

## TELECONFERENCE WEEK 6

PLANNING YOUR FIRST STEPS AND KEEPING A DIARY.

THE MOST IMPORTANT PART OF PLANNED SELF-EXPOSURE IS REPETITION AND KEEPING RECORDS OF YOUR PROGRESS.

THIS WEEK WE SHALL DISCUSS HOW TO START WORKING OUT YOUR PROGRAMME, AND THE ROLE A DIARY PLAYS.

WRITE DOWN HERE THE FIRST EXPOSURE THAT YOU FEEL YOU CAN TACKLE, HOW IT RELATES TO WHAT YOU ARE CAPABLE OF DOING NOW. ALSO WRITE DOWN WHY YOU FEEL A DIARY MIGHT HELP.

PAGE (7)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE!"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, UFFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.

# NO PANIC

PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.

## TELECONFERENCE WEEK 7

FIRST SELF-EXPOSURE WEEK.

THIS WEEK WE SHALL BE STARTING ON THE PHYSICAL SIDE OF THE RECOVERY PROGRAMME. FOR ALL ANXIETY DISORDER SUFFERERS THIS WILL MEAN TAKING THE FIRST STEPS TO FACING UP TO OUR ANXIETY, AND PROVING IT CAN'T ACTUALLY HARM US.

THOUGHT FOR THE WEEK: PROPER RELAXATION WILL HELP, IF YOU'RE NOT DOING RELAXATION, IT IS TIME YOU DID!!

WRITE DOWN HERE HOW YOUR FIRST EXPOSURE SESSIONS WENT, HOW MUCH OF YOUR TARGET YOU ACHIEVED AND ANY QUESTIONS THE SESSIONS BROUGHT UP.

(8)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, TELFORD, SHROPSHIRE, TF3 2JQ.  
TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.  
REGISTERED CHARITY NUMBER 1018184.



# NO PANIC

PATRONS: I.E.S DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.

## TELECONFERENCE WEEK 8

THIS WEEK WE SHALL LOOK MORE CLOSELY ABOUT WHAT ACTUALLY HAPPENED WHEN YOU CARRIED OUT YOUR SELF-EXPOSURE, IN TERMS OF THE FEELINGS YOU EXPERIENCED, AND THUS WE WILL UNDERSTAND WHY THOSE FEELINGS CANNOT ACTUALLY HARM US OR ANYONE ELSE.

THOUGHT FOR THE WEEK: TO TRY IS TO SUCCEED, ONLY NOT TRYING IS FAILURE. NO-ONE ACHIEVES COMPLETE SUCCESS ALL THE TIME!!

WRITE DOWN HERE THE FEELINGS YOU EXPERIENCED WHILST DOING YOUR SELF EXPOSURE, AND ANYTHING AWFUL THAT HAS HAPPENED TO YOU BECAUSE OF YOUR EXPOSURE WORK.

(9)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE!"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, HILFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.

# *NO PANIC*

PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.

## TELECONFERENCE WEEK 9

THIS WEEK WE SHALL LOOK MORE CLOSELY AT HOW SUCCESS BREEDS SUCCESS AND HOW OUR PERSONALITIES CHANGE AS WE GET BETTER.

THOUGHT FOR THE WEEK: DON'T JUDGE YOUR PROGRESS AGAINST OTHER PEOPLES WE ARE ALL INDIVIDUALS AND WE ARE AT DIFFERENT STAGES!!

WRITE DOWN HERE HOW YOU THINK YOU MIGHT CHANGE AND THE EFFECTS THIS WILL HAVE ON YOU AND OTHERS.

(10)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE!"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDIAY, TELFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.

# NO PANIC

PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.

## TELECONFERENCE WEEK 10

THIS WEEK WE SHALL LOOK MORE CLOSELY AT HOW OUR STYLE OF LIVING WILL CHANGE, HOW WE SHALL BENEFIT FROM OUR EXPERIENCES AND WHAT THE FUTURE WILL HOLD.

THOUGHT FOR THE WEEK: EATING REGULARLY HELPS TO PREVENT BLOOD SUGAR LEVELS FLUCTUATING AND THIS IN TURN HELPS TO STOP US BEING ANXIOUS!!

WRITE DOWN HERE HOW YOU THINK YOUR LIFESTYLE MIGHT CHANGE AND WHAT THE FUTURE MIGHT HOLD.

(11)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE!"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, LEFORD, SHROPSHIRE, TF3 2JQ.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018181.

# NO PANIC

PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAV, M.Phil, PhD C.Psychol, A.F.B.P.

## TELECONFERENCE WEEK 11

THIS WEEK WE SHALL LOOK AT THE PROGRESS WE HAVE MADE SINCE WE STARTED OUR SELF EXPOSURE, AND SEE HOW FAR WE HAVE COME.

THOUGHT FOR THE WEEK: DON'T KID YOURSELF ABOUT WHERE YOU ARE AT. IT DOESN'T MATTER TO OTHERS AND THE ONLY ONE TO SUFFER WILL BE YOU!!

WRITE DOWN HERE THE THINGS YOU CAN NOW DO WHICH YOU COULDN'T DO AT THE BEGINNING OR THE THINGS WHICH ARE EASIER TO DO THAN THEY WERE.

(12)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE!"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDIAY, TETFORD, SHROPSHIRE, LE3 2IC.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545,

REGISTERED CHARITY NUMBER 1018184.

# NO PANIC

*PATRONS: LES DENNIS & PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.*

## TELECONFERENCE WEEK 12

THIS WEEK WE SHALL LOOK AT WHERE WE GO FROM HERE. DOES THE GROUP CONTINUE, AND WHAT STEPS COME NEXT.

THOUGHT FOR THE WEEK: THINK POSITIVE!!

WRITE DOWN HERE THE THINGS WHICH YOU WANT TO DO IN THE NEAR FUTURE AND HOW YOU PLAN TO ACHIEVE YOUR GOALS. ALSO WRITE DOWN WHAT YOU FELT ABOUT THE COURSE AND WHETHER OR NOT IT HAS HELPED YOU. DO YOU WISH THE COURSE TO CONTINUE.

(13)

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDIAY, HILFORD, SHROPSHIRE, TF3 2TG.

TELEPHONE: OFFICE, 0952-590005, HELPLINE, 0952-590545.

REGISTERED CHARITY NUMBER 1018184.

**Appendix 6: Correspondence**

Sub-Department of Clinical Psychology (Philips House)

University College London

Gower Street

London WC1E 6BT

Phone: 0171-380 7895/7896

Dear 'No-Panic' member,

Researchers at University College London, together with the agreement and assistance of the 'No-Panic' organisers, are carrying out a study of the 'No-Panic' self-help recovery programme. Very little research has been carried out in this area and we think that it is important to develop further our understanding of self-help recovery.

We would like you to take part in this study and an Information Sheet giving you more details is enclosed. If you decide to take part you should do the following:

Contact us if you have any questions.

Complete the enclosed Consent Form which shows that you agree to take part.

Complete the enclosed set of questionnaires and return them in the envelope provided. There are several short questionnaires which have been stapled together.

Please try and fill out all the questionnaires on the same day and return them still stapled together. You need only enter your name, the name of your GP, your telephone number and the date on the front page.

We hope that you decide to take part in this study.

Yours sincerely,

Ms. Bhavna Tanna

**Sub-Department of Clinical Psychology (Philips House)**

**University College London**

**Gower Street**

**London WC1E 6BT**

**Phone: 0171-380 7896/7897**

**Dear**

**It is now three months since you completed the 'No Panic' Recovery Programme. I would be grateful if you could complete and return the enclosed questionnaires for the last time.**

**Thank you for having taken part in this project.**

**I will send you a summary of the results of this research in June/July 1997 but please do not hesitate to contact me if you have any queries in the meantime.**

**Yours sincerely,**

**Ms. Bhavna Tanna.**



**Sub-Department of Clinical Psychology (Philips House)**

**University College London**

**Gower Street**

**London WC1E 6BT**

**Phone: 0171-380 7896/7897**

Dear

Enclosed are the questionnaires you kindly completed before the start of the 'No Panic' Recovery Programme. I would be grateful if you could complete and return these again sometime in the week after your last session.

Thank you.

I will write to you again three months from now but please do not hesitate to contact me if you have any queries.

Yours sincerely,

Ms. Bhavna Tanna.

**Sub-Department of Clinical Psychology (Philips House)**

**University College London**

**Gower Street**

**London WC1E 6BT**

**Phone: 0171-380 7896/7897**

Dear

Enclosed are the questionnaires you kindly completed before the start of the 'No Panic' Recovery Programme. I would be grateful if you could complete these again sometime in the week after your sixth session on.....

Thank you.

I will write to you again after your last session but please do not hesitate to contact me if you have any queries.

Yours sincerely,

Ms. Bhavna Tanna.

**Appendix 7: 'No Panic' Satisfaction Questionnaire**

# NO PANIC

## PATRONS

LES DENNIS, IMOGEN STUBBS, PROFESSOR KEVIN GOURNAY, M.Phil, PhD C.Psychol, A.F.B.P.

9TH JUNE 1995

OUR REF: CHSC616

MONTH 1 2 3 (PLEASE CIRCLE AS APPROPRIATE)

### TELEPHONE RECOVERY GROUPS

QUESTIONS 1 TO 7 ARE A LIST OF THINGS THAT YOU MAY, OR MAY NOT, HAVE FOUND HELPFUL ABOUT USING OUR TELEPHONE RECOVERY GROUP SERVICE OVER THE PAST MONTH. PLEASE READ THROUGH ALL THE LIST, THEN ANSWER EACH QUESTION BY PUTTING A TICK IN THE BOX THAT BEST APPLIES TO YOU.

	NOT AT ALL HELPFUL	SLIGHTLY HELPFUL	QUITE HELPFUL	EXTREMELY HELPFUL
1. HOW HELPFUL HAVE YOU FOUND IT TO BE ABLE TO TALK TO OTHERS ABOUT YOUR DIFFICULTIES ?				
2. HOW HELPFUL HAVE YOU FOUND THE SUPPORT AND COMMENTS OF THE OTHER GROUP MEMBERS?				
3. HOW HELPFUL HAVE YOU FOUND DOING EXPOSURE THERAPY?				
4. HOW HELPFUL HAVE YOU FOUND THAT YOU ARE NOT THE ONLY ONE WITH YOUR DIFFICULTIES?				
5. HOW HELPFUL HAVE YOU FOUND IT TO GAIN A BETTER UNDERSTANDING OF YOUR DIFFICULTIES ?				
6. HOW HELPFUL HAVE YOU FOUND THE SUGGESTIONS OF THE GROUP LEADER?				
7. HOW HELPFUL HAVE YOU FOUND IT TO BE ABLE TO OFFER SUPPORT AND HELP TO OTHERS?				

8. WHAT ELSE HAVE YOU FOUND HELPFUL?

9. WHAT HAVE YOU FOUND UNHELPFUL ?

10. HOW MANY SESSIONS HAVE YOU MISSED IN THE PAST MONTH ?

11. HOW MUCH IMPROVEMENT DO YOU FEEL YOU HAVE MADE ? (PLEASE CIRCLE)

NONE / A LITTLE / QUITE A BIT / A LOT / I HAVE GOT WORSE

12. HOW MUCH IMPROVEMENT DO YOU FEEL YOU STILL HAVE TO MAKE ? (PLEASE CIRCLE)

NONE / A LITTLE / QUITE A BIT / A LOT

13. WOULD YOU RECOMMEND THIS SERVICE TO ANOTHER PERSON ? (PLEASE CIRCLE)

YES, DEFINITELY, / PERHAPS / PROBABLY NOT / DEFINITELY NOT

DATE: \_\_\_\_\_

I WOULD LIKE TO THANK YOU IN ADVANCE FOR TAKING THE TROUBLE TO COMPLETE THIS QUESTIONNAIRE. THE INFORMATION YOU PROVIDE WILL BE OF GREAT VALUE.

COLIN M. HAMMOND,  
CHIEF EXECUTIVE.

QUESTIONNAIRE DEvised BY THE SHROPSHIRE PSYCHOLOGY CONSULTANCY SERVICE.

2

**"DON'T SUFFER ALONE - JUST PICK UP THE PHONE"**

REGISTERED OFFICE: 93, BRANDS FARM WAY, RANDLAY, TELFORD, SHROPSHIRE, TF3 2JQ,  
TELEPHONE: OFFICE: 01952-590005, HELPLINE: 01952-590545, FAX: 01952-270962  
REGISTERED CHARITY NUMBER 1018184.

**Appendix 8: Satisfaction Questionnaires**

# QUESTIONS ABOUT THE USEFULNESS OF THE RECOVERY GROUP

Name .....

Date .....

The questions below are about things you may or may not have found helpful about the 12 session Recovery Group. Your answers will not be shown to 'No Panic'. Please circle the number which best describes how helpful you have found certain aspects of the programme.

1	2	3	4	5
not at all	somewhat	moderately	very	extremely

Please rate ALL items.

1. How helpful have you found it to be able to talk to others about your difficulties?

1      2      3      4      5

2. How helpful have you found being in a group with others who have similar difficulties?

1      2      3      4      5

3. How helpful have you found the suggestions of the group leaders?

1      2      3      4      5

4. How helpful have you found the comments of other group members?

1      2      3      4      5

5. How helpful have you found being able to offer support to others?

1      2      3      4      5

6. How helpful have you found doing the exposure therapy?

1      2      3      4      5

7. How much has the group helped you understand how to overcome your difficulties?

1      2      3      4      5

8. How improved are your difficulties?

1      2      3      4      5

What are the reasons for this?

9. How much improved do your difficulties still need to be?

1      2      3      4      5

What might help you do this?

Please describe anything else you have found helpful:



**Please describe things which were less helpful or difficult:**

**How many sessions have you missed out of the total 12? .....**

**If a friend were in need of similar help, would you recommend the Recovery Programme to them?  
(please circle)**

**NO / PROBABLY NOT / PERHAPS / YES**

**ANY OTHER COMMENTS:**

**Thank you for completing these questions.**

# THREE MONTH REVIEW OF THE USEFULNESS OF THE RECOVERY GROUP

Name .....

Date .....

The questions below are about things you may or may not have find helpful about the 12 session Recovery Group which ended three months ago. Your answers will not be shown to 'No Panic'. Please circle the number which best describes how helpful you have find certain aspects of the programme.

1                      2                      3                      4                      5  
not at all          somewhat          moderately          very                  extremely

Please rate ALL items.

1. How helpful did you find it to be able to talk

to others about your difficulties?

1      2      3      4      5

2. How helpful did you find being in a group with

others who have similar difficulties?

1      2      3      4      5

3. How helpful did you find the suggestions of

the group leaders?

1      2      3      4      5

4. How helpful did you find the comments of

other group members?

1      2      3      4      5

5. How helpful did you find being able to offer

support to others?

1      2      3      4      5

6. How helpful did you find doing the exposure therapy?

1      2      3      4      5

7. How much did the group help you understand how to overcome your difficulties? 1 2 3 4 5

8. How improved are your difficulties since the group ended? 1 2 3 4 5  
What are the reasons for this?

9. How much improved do your difficulties still need to be? 1 2 3 4 5  
What might help you do this?

10. Have you taken part in a telephone support group with the other members of the Recovery group?

YES/NO

If 'yes', how helpful have you found this? 1 2 3 4 5

What are the reasons for this?

Please describe any help you have sought or are receiving since the group ended (e.g. medication/professional treatment or further help from 'No Panic'):

If a friend were in need of similar help, would you recommend the Recovery Programme to them?  
(please circle)

NO / PROBABLY NOT / PERHAPS / YES

ANY OTHER COMMENTS:

Thank you for taking part in this project by completing all the questionnaires I have been sending you. As I mentioned when we spoke on the telephone, you will receive a summary of the results of this research in June/July 1997 but please contact me in the meantime if you have any queries. Thank you again.