

**Are gains made in IAPT psychoeducational groups
maintained over time? A qualitative study**

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Charles Wykes

Date: 15-09-2013

To Mandy

My light in the darkness

Overview

Volume 1 of this thesis evaluates the effectiveness of brief Psychoeducative Group Cognitive Behavioural Therapy (PGCBT) groups for depression and anxiety disorders. Volume 1 is presented in three parts.

Part 1 is a systematic literature review of outcome studies on PGCBT for depression and common anxiety disorders, delivered in group format over eight or fewer sessions. Study quality was evaluated using the Downs and Black (1998) critical appraisal tool. Results indicated that the interventions were effective, more so for anxiety disorders than depression. Studies' qualities and methodologies were variable, making a meta-analysis impossible and weakening the findings. The quality of the current evidence base and methodological issues are discussed and avenues for further research suggested.

Part 2 is a qualitative study into what patients who completed a five session psychoeducative group delivered by an IAPT service found beneficial and how they incorporated benefits into their lives. Fifteen participants who showed reliable clinical benefit on a measure of anxiety or depression during intervention were interviewed approximately six months post-group and their responses evaluated using thematic analysis. Results showed that most people incorporated some CBT skills into daily life, either through deliberate use or less formal awareness of new ways to approach problems. However participants found the normative, cohesive and cathartic elements of the group more important in effecting change. Results were used to make recommendations to services in designing interventions and to highlight research opportunities.

Part 3 is a critical appraisal of the qualitative study focused on the background to choice of research topic and methodology, followed by consideration of conceptual issues, and practical and methodological limitations to the research. It concludes with a consideration of the research process on participants and the researcher.

Table of contents

Overview	4
Table of contents	5
Tables and figures	6
Acknowledgments	7
Part 1: Literature review	8
<i>Effectiveness of brief psychoeducational cognitive behavioural therapy groups for depression and anxiety</i>	
Abstract	9
Introduction	10
Method	15
Results	19
Discussion	40
Conclusions	46
References	48
Part 2: Empirical paper	56
<i>Are gains made in IAPT psychoeducational groups maintained over time? A qualitative study</i>	
Abstract	57
Introduction	58
Method	63
Results	73
Discussion	93
Conclusion	104
References	105
Part 3: Critical Appraisal	111
Critical appraisal	112
References	124

Tables and figures

Part 1

Table 1: Characteristics of previous reviews	14
Table 2: Database search terms	17
Figure 1: Flowchart of study selection	18
Table 3: Summary of studies' demographic features	20
Table 4: Frequency of measures used	22
Table 5: Summary of studies' design features	24
Table 6: Summary of studies' outcomes and quality rating	26

Part 2

Figure 1: Participants' journey though the recruitment process	66
Table 1: Participant demographics	67
Table 2: Actual and potential participants' PHQ-9 and GAD-7 scores compared	68
Table 3: Clinically reliable benefit for each participant	75
Figure 2: PHQ-9 and GAD-7 scores for participants at T1, T2 and T3	76
Table 4: Domains, themes and subthemes	79

Appendices

Appendix 1: Downs and Black quality appraisal questions	127
Appendix 2: Recruitment protocol for PWPs	130
Appendix 3: Participant information sheet	137
Appendix 4: Participant consent form	142
Appendix 5: NHS REC committee approval	144
Appendix 6: NHS Foundation Trust R and D department approval	148
Appendix 7: Sponsorship letter from University College London	150
Appendix 8: Certificate of insurance from University College London	153
Appendix 9: Quantitative measures and demographic capture form	155
Appendix 10: Interview schedule	158
Appendix 11: Raw codes exemplar	162
Appendix 12: Subthemes exemplar	164
Appendix 13: Theme feedback and comment form sent to participants	166

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Part 1: Literature review

**Effectiveness of brief psychoeducational cognitive behavioural therapy
groups for depression and anxiety**

Abstract

Aims: This review evaluates the effectiveness of brief Psychoeducative Group Cognitive Behavioural Therapy (PGCBT) for depression and common anxiety disorders when delivered over the number of sessions (5-8) routinely offered by IAPT and other stepped care services.

Method: Studies had to satisfy inclusion criteria relating to: i) intervention, ii) target problems, iii) outcome measures and iv) research design. Fifteen studies were identified from four electronic databases (MEDLINE, PsycINFO, EMBASE and CINHAL) and references of previous reviews.

Results: The evidence points towards brief PGCBT, offered in eight or fewer sessions, being of some effectiveness in reducing symptomatology; more so for anxiety disorders than depression. There is also evidence that brief PGCBT can help prevent relapse over time. Study quality was variable as assessed by the Downs and Black critical appraisal tool, with methodological issues and reporting deficiencies weakening the conclusions drawn.

Conclusions: Further high quality research is needed, replicating clinical practice, to determine what patients retain and benefit from in brief PGCBT and who will benefit most from such interventions.

Introduction

The prevalence of depression and anxiety disorders is moderately high, with approximately one in six adults having a mental health problem at any one time (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009), most commonly depression or an anxiety disorder (Layard et al., 2006). Costs, both personal and societal, are serious, with large impacts on health and economic wellbeing (HM Government, 2011) yet it has been known for many years that effective therapies exist to treat depression and anxiety disorders (Roth & Fonagy, 2005). Unfortunately availability has often been limited. McManus et al. (2009) reported that in 2007 in the UK that only 10% of people with depressive or anxious symptomatology were receiving psychological treatment. The Improving Access to Psychological Therapies program (IAPT) was created to bridge this gap, establishing a stepped care model of interventions based upon Cognitive Behavioural Therapy (CBT).

The effectiveness of CBT for treating depression and anxiety has been extensively researched. Butler, Chapman, Forman and Beck (2006) reviewed 16 meta-analyses, finding that for unipolar depression, generalised anxiety disorder (GAD), social phobia and panic disorder, CBT was effective with large effect sizes. Importantly these effects appeared to be maintained for one or more years post intervention. It was this large evidence base and the strongly positive findings that led IAPT to adopt CBT as the treatment modality of choice (Layard et al., 2006).

A further rationale for utilising CBT is that elements of the treatment are explicitly psychoeducational in nature. Psychoeducation is the delivery of knowledge to patients in areas that map onto treatment goals, usually depressive or anxious symptom reduction. The knowledge imparted should help the patient to engage in beneficial cognitive or behavioural change, such as techniques to notice links between reduced activity and low mood, or avoidance and consequent failure to overcome anxiety. The emphasis on teaching techniques as a core component of

CBT means it can be delivered in formats other than individual therapy, including groups, guided self-help, bibliotherapy or CBT accessed via a software package.

This review focusses on brief Psychoeducative Group CBT (PGCBT) treatments as part of the wider context of group CBT (GCBT). Within GCBT there is a high degree of variability in intervention delivery. Morrison (2001), in reviewing whether GCBT was as effective as individual therapy for depression and anxiety disorders, noted that most studies had evaluated groups of 10 or more sessions with small numbers of participants. Treatments delivered in this way appeared as effective as individual CBT and more cost effective. Brown et al. (2011) quantified this for a 10-12 session groups delivered to 8-12 participants by therapists working in an NHS setting, finding that GCBT was as effective as individual treatment for two thirds of the cost per patient. However there are findings that run counter to this. Cuijpers, van Straten and Warmerdam (2008), in a meta-analysis of studies comparing GCBT with individual CBT for depression, concluded it had a higher drop-out rate and was less effective at intervention end, albeit with a small effect size. They concluded this may not be clinically relevant as sample sizes were small and significance was lost at follow-up. Huntley, Araya and Salisbury (2012) performed a similar analysis and returned the same conclusions for GCBT versus individual CBT. They further noted that the evidence base on which to conduct meta-analyses was poor and there was very little data that could be used to support claims of GCBT cost-effectiveness in high income countries. That said, the studies reviewed were delivered over eight or more sessions and therapists were likely to be relatively high cost professionals.

In recent years there has been a drive to increase the potential cost savings from GCBT, through both decreasing treatment length and increasing participant numbers per group. White, Keenan and Brooks' (1992) Stress Control Workshop is an early example of a trial that compared CBT with purely cognitive and purely behavioural therapy delivered to groups of up to 24 people with GAD across six

sessions . Results were impressive and a modified approach to include depressive symptomatology continues to be used for classes of up to 160 people (Kellet, Clarke, & Matthews, 2007; White, 2010), offering a trans-diagnostic intervention, typically delivered by Graduate Mental Health Workers, at a relatively low cost per patient compared to lengthier GCBT with lower participant numbers.

This form of treatment is often used as part of a stepped-care model of service delivery, where people with a mental health disorder are either firstly given a psychoeducative intervention such as bibliotherapy or brief PGCBT and offered individual therapy if symptoms do not remit. Alternatively they may be screened for severity at assessment and assigned to an intervention considered appropriate. In the case of IAPT services, the guidelines for implementation (Department of Health, 2008) suggested the latter model, with patients with mild to moderate depression or anxiety disorders being offered low intensity treatment with a Psychological Wellbeing Practitioner (PWP). PWPs, an evolution of the Graduate Mental Health Worker role, are trained at postgraduate level in CBT based interventions based on NICE guidelines for depression (National Institute for Health and Care Excellence, 2009) and anxiety disorders (National Institute for Health and Care Excellence, 2011).

It is notable that the NICE guidelines recommend GCBT of 10-12 sessions, which as discussed above may not be much more cost effective than individual CBT based psychoeducation once higher drop-out rates and other factors are considered (Huntley, Araya, & Salisbury, 2012). Consequently many IAPT services deliver brief PGCBT over fewer sessions, with a recommendation for six (IAPT, 2010). As with White's (2010) Stress Control workshop, the emphasis is on education rather than therapy but content is derived from GCBT. Therefore it is important to evaluate the effectiveness of brief PGCBT for depression and anxiety disorders delivered over a limited number of sessions as it is likely that this format will become increasingly

commonplace as a frontline intervention in the UK, through the further roll-out of IAPT services (IAPT, 2011).

Previous reviews

There have been a number of recent reviews of therapy for mental health disorders that sought to evaluate effectiveness (Table 1). Whilst all included some analysis of GCBT interventions, most reviews have included therapies beyond individual CBT and GCBT (Cuijpers, van Straten, & Warmerdam, 2008; Hunot, Churchill, Teixeira, & Silva de Lima, 2007; Huntley et al., 2012; Krishna et al., 2011; Wilson, Mottram, & Vassilas, 2008). Previous reviews have also been focussed on specific problems, with Cuijpers et al. (2008), Wilson et al. (2008), Hollon & Ponniah (2010), Krishna et al. (2011), Feng et al. (2012) and Huntley et al. (2012) considering therapy for depression and Hunot et al. (2007) and Jónsson and Hougaard (2009) considering therapy for GAD and OCD respectively.

Reviews by Jónsson and Hougaard (2009) and Feng (2012) focussed exclusively on GCBT but the former only considered the effectiveness for OCD and the latter focussed on depression. Both reviews also included groups of over eight sessions.

Aims of the current review

As brief PGCBT becomes more widely used in the UK, this review seeks to evaluate the effectiveness of this treatment when delivered over the number of sessions typically offered by IAPT. Whilst previous reviews have evaluated GCBT over longer numbers of sessions, the focus of this review will be on interventions offered in up to eight sessions. Interventions for both depression and common anxiety disorders will be considered, something not typically seen in previous reviews but necessary as IAPT services typically offer brief PGCBT across the range of common mental health disorders. The results are intended to offer guidance to IAPT as to how such interventions can be improved.

Table 1: *Characteristics of previous reviews*

Review	Focus	Method	Main findings	Differences to current review
Hunot, V et al, 2007	Psychological therapies for GAD	Systematic review	Therapies using a CBT approach are more effective than TAU/WL in achieving clinical response at post-treatment; recovery rate 0.64. There were anxiety, worry and depression symptom reductions. Drop-out rates are higher in GCBT	Included individual therapy as well as groups. Focus was a particular anxiety disorder
Cuijpers et al, 2008	Individual vs. group psychotherapy for depression	Meta-analysis	Individual therapy is more effective (small effect size) post-intervention. This effect is lost at follow-up. Dropout rates are lower in individual therapy	Included therapies other than CBT and studies used groups of over 8 sessions. Focus was depression
Wilson et al, 2008	Psychotherapy for depressed older adults	Meta-analysis	Findings do not provide strong support for psychotherapeutic treatments for depressed older adults but suggest CBT may be of benefit	Included individual therapy as well as groups and focus was depressed older adults
Jónsson et al, 2009	GCBT for OCD	Systematic review and meta-analysis	Large effect sizes for some studies showing GCBT to be effective compared to wait-list controls and medication only controls	Focus on a particular anxiety disorder and some studies used groups of over 8 sessions
Hollon et al, 2010	Psychological therapies for mood disorders	Systematic review	CBT is effective in decreasing symptomatology and preventing relapse/recurrence. Other therapies (IPT, MBCT, BDT) are also effective	Included individual therapy as well as groups. Focus was mood disorders
Krishna et al, 2011	Group psychotherapy for depressed older adults	Systematic review	GCBT is effective for depressed older adults compared to WL but effect size is small. Other group therapies do not differ in effectiveness from CBT. Gains remain at follow-up	Included therapies other than CBT and studies used groups of over 8 sessions. Focus was depressed older adults
Feng et al, 2012	GCBT for depression	Meta-analysis	GCBT is effective for depression at intervention end with a moderate effect size. GCBT is effective for relapse prevention but effect size is small	Some studies longer than 8 sessions and focus was depression
Huntley et al, 2012	Group psychotherapy for depression in community settings	Systematic review and meta-analysis	GCBT vs. usual care alone showed a benefit post-treatment with gains remaining at follow-up. Individual CBT is more effective than GCBT post-treatment	Included therapies other than CBT and studies used groups of over 8 sessions. Focus was depression

Method

Inclusion and exclusion criteria

Studies chosen for review were selected on the basis of intervention characteristics, problem, population, outcome measures and research design.

Intervention characteristics

Studies were included if at least one of the evaluated groups was of eight or fewer sessions and the therapeutic modality was described as CBT. Studies were included if these groups were facilitated by one or more clinicians trained in CBT, the group met face-to-face and the participants received some psychoeducative content based on CBT principles.

Problems and populations

Studies were included if they treated adult patients with depression and/or an anxiety disorder as a current or recent primary diagnosis. Studies were excluded if patients had a co-morbid diagnosis of psychosis, bipolar-affective disorder, post-traumatic stress disorder, eating disorder, attention deficit hyperactivity disorder, chronic fatigue, substance misuse or serious alcohol misuse.

Patients under eighteen were excluded as were patients with a global learning disability, autism or Asperger's, traumatic brain injury, cognitive impairment or dementia. Studies that recruited participants from the general public or patients in primary or secondary care out-patient settings were included. Highly specific populations such as prisoners or war veterans were excluded as were studies where the population had a specific physical health condition such as cancer or chronic obstructive pulmonary disease that was seen as the causal factor of their mental health difficulty.

Outcome measures

Studies were included if they used one or more validated measures of psychological functioning or symptomatology.

Research design

Studies were included that used a comparison or control group or a prospective longitudinal design that compared two or more time points.

Publication details

Studies were included if published in English in a peer reviewed journal between 2000 and 2012.

Search strategy

Two strategies were used to identify studies. Firstly four major databases were searched: MEDLINE, which covers life sciences and biomedicine, PsycINFO, which covers psychological research, EMBASE, which covers life sciences and biomedicine and CINAHL, which covers biomedical research from a nursing perspective. Search terms were placed into three categories: type of group, therapeutic modality and disorder (Table 2). Searches were run on each database using the OR operator for each term within a category limited to peer-reviewed English language studies of adult humans. This generated more than 10,000 results per category. The three categories and the subject heading 'Treatment Outcome' were then combined with the AND operator. This resulted in 624 studies, a sufficiently small number to be manually inspected.

Secondly references from previous meta-analyses of GCBT were examined for relevant studies as were references from included studies. This found a further two studies.

Table 2: Database search terms

Type of group	Therapeutic modality	Disorder
“psychoeducat*” (keyword) “therapy group” (keyword) “group therapy” (keyword) “skills group” (keyword) “group treatment” (keyword) “treatment group” (keyword) Psychotherapy Group (MeSH)	“cognitive behavio* therapy” (keyword) “cognitive therapy” (keyword) “CBT” (keyword) Cognitive Therapy (MeSH)	“anx*” (keyword) “phobi*” (keyword) “OCD” (keyword) “obsessi*” (keyword) “compulsi*” (keyword) “mood” (keyword) “depressi*” (keyword) “dysthymi*” (keyword) Mood Disorders (MeSH) Depression (MeSH) Anxiety (MeSH) Anxiety Disorders (MeSH) Dysthymic Disorder (MeSH)

Note: keyword terms were created by the author, MeSH terms are standardised medical subject headings applied to sources indexed within each database

Studies not meeting all the criteria were excluded through consideration of the title, abstract or full paper. Of the excluded studies, approximately half were excluded for the population having a physical illness, a severe and enduring mental health difficulty or other co-morbid condition as described above. Of the remainder, most were excluded as the intervention was not GCBT and/or longer than eight weeks. Approximately 10% were excluded as the study did not meet the criteria for research design and a small number were excluded for not being in English or including participants below 18. Figure 1 outlines the exclusion process by numbers included and excluded at each point.

Analysis

As the studies evaluated differed in research design, sample size, outcome measures used and disorder treated, a systematic meta-analysis of intervention effectiveness was not possible. However the widely used Downs and Black (1998) critical appraisal tool offers a means to assess studies for methodological quality for randomised and non-randomised health care interventions. It was highly rated by Deeks et al. (2003) in a comprehensive review of tools for assessing non-randomised studies and was used here to systematically assess the quality of the

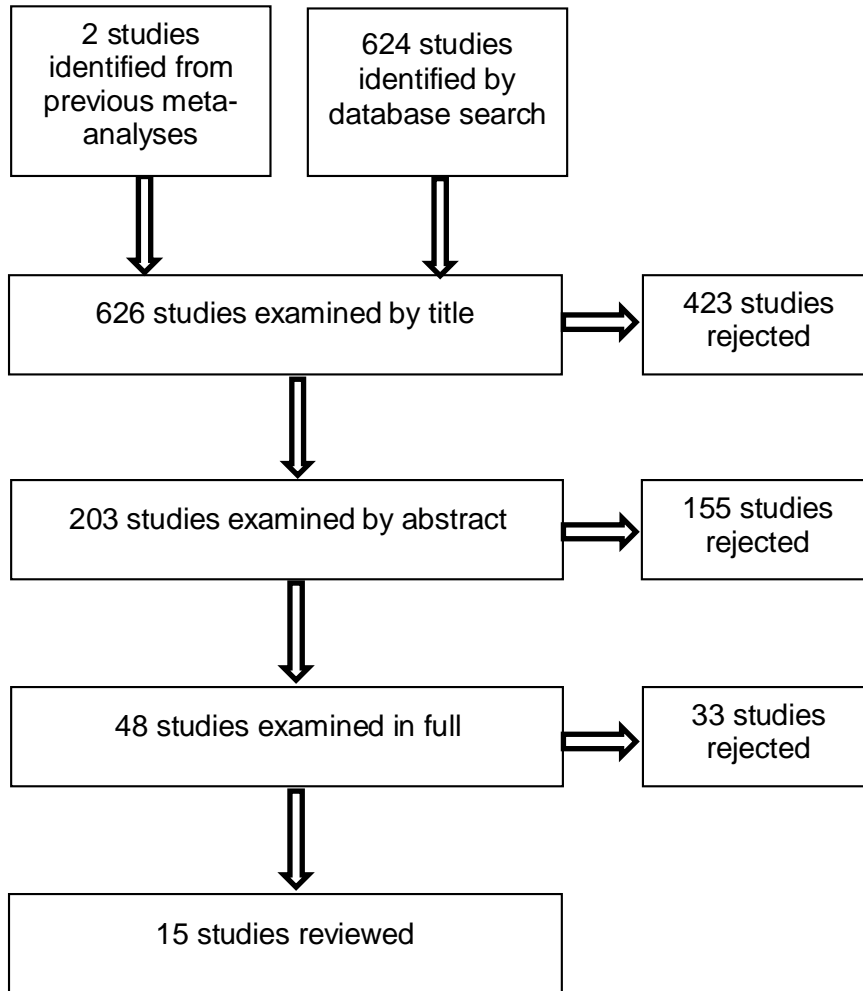


Figure 1: *Flowchart of study selection*

identified studies and so determine whether further research in the area is needed.

The tool comprises 27 questions in subsections as follows: reporting, external validity, bias, confounding and power (Appendix 1). Questions are scored as either 0 or 1 except question 5 which is scored as 0-2. In line with other health-care reviews that have used the Downs and Black Tool (Chudyk, Jutai, Petrella, & Speechley, 2009; Hooper, Jutai, Strong, & Russell-Minda, 2008), question 27 was scored as 1 (yes) or 0 (no) if the study had sufficient power to detect a clinically important effect. Total scores range from 0 to 28. Following the reviews cited above, score ranges were grouped into the following 4 quality levels: excellent (26 to 28), good (20 to 25), fair (15 to 19), and poor (less than 14).

Results

Fifteen studies met the inclusion criteria. Participants were drawn from populations within Australia (5), the UK (3), the US (3), Holland (2), Switzerland (1) and Germany (1). Ethnicities within samples were usually not specified in great detail. Gender distribution between studies was variable, ranging from 100% women to 39% women, although women comprised greater than 50% of participants in 13 studies. The mean age of participants also varied across studies, from 19.8 to 81.3. Treating clinicians included Psychiatrists, Clinical Psychologists, qualified and in-training CBT Therapists, Mental Health Nurses and Graduate Mental Health Workers. Disorders included depression and/or social phobia, hypochondriasis, obsessive-compulsive disorder (OCD) and generalised anxiety disorder (GAD). Table 3 outlines the demographic and clinical features of each study.

All studies included a psychoeducative CBT group of eight or fewer sessions but studies varied in comparison intervention, ranging from none to treatment as usual (TAU), other group psychotherapy, individual therapy and medication. Most studies included measurement points at intervention beginning and end and 12 also measured outcome at later follow-up. All studies used at least one validated self-report outcome measure but there was little consistency between studies in which were chosen. Table 4 details the frequency of measures used and Table 5 summarises the design features of each study.

The standard of reporting of study design and internal and external validity was mixed. To quantify this, each study was scored using the Downs and Black (1998) tool as described above.

A brief summary of the main findings and limitations of each study according to design and then disorder now follows and outcomes and overall quality scores are given in Table 6.

Table 3: Summary of studies' demographic features

Study	Population	Mean age at recruitment	Size and gender ratio at start of trial	Treating clinicians	Disorder
Bockting et al, 2005	Dutch adults	44.7	172, 73.3% women	Psychologists with 5 years+ experience	Recurrent depression currently in remission
Coon et al, 2003	US older women (50+)	63.7	169, 100% women	Clinical psychologists, Clinical Interns, Advanced Level Graduate Students, Master's Level Clinicians	Female caregivers (not necessarily suffering from a current affective disorder)
Seligman et al, 2007	US college students	Unknown	240, 65.0% women	Experienced CBT therapists	Mild/moderate depression
Wilkinson et al, 2009	UK older adults (60+)	73.9	43, 60.5% women	Clinical Psychologist with postgraduate CBT diploma	1+ episode of major depression in past year currently in remission and taking medication
Manicavasgar et al, 2011	Australian adults	45 (mean age of completers)	61, ratio unknown at start 45, 64.4% women at completion	Clinical psychologists assisted by medical or psychology students	Major depressive disorder
Richardson et al, 2006	Australian older adults (65+)	81.3 (mean age of completers)	7, ratio unknown	Not described in article, but facilitated by lead author, a Professor of Clinical Psychology	Depression
Buwalda et al, 2007	Dutch adults	41.0 (mean age of completers)	48, ratio unknown at start 44, 75.0% women at completion	Associate Professor of Clinical Psychology assisted by graduate students in Clinical Psychology	Hypochondriasis
Borgeat et al, 2009	Swiss adults	39	30, 53.3% women	Psychiatrist with 20 years' experience in CBT assisted by psychiatric clinicians with some CBT experience	Social anxiety
Bjornsson et al, 2011	US college students	19.8	45, 46.6% women	Advanced Clinical Psychology graduate student with 1+ year of supervised facilitation	Social anxiety
Houghton et al, 2007	UK adults	Unknown	191, 56.5% women	Mental Health nurses with CBT training	Any anxiety disorder
McEvoy, 2007	Australian adults	32.5	153, 39.2% women	Masters or Doctorate level Clinical Psychologists	Social anxiety
Kirsten et al, 2008	Australian adults	39.2 (mean age of completers)	200, ratio unknown at start 154, 72.1% women at completion	Masters or Doctorate level Clinical Psychologists	Any anxiety disorder

Study	Population	Mean age at recruitment	Size and gender ratio at start of trial	Treating clinicians	Disorder
Lamplugh et al, 2008	Australian adults	35.6	18, 83.3% women	Masters or Doctorate level Clinical Psychologists	Panic
Rufer et al, 2010	German adults	40	55, 61.8% women	Trained CBT therapists or trainees close to completion	Panic
Brown et al, 2004	UK adults	Unknown	134, 82.8% women	Clinical Psychologists supported by assistant Psychologists	Depression and/or anxiety disorders

Table 4: *Frequency of measures used*

Measure	Number of studies using
Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)	7
Beck Depression Inventory-II (BDI-II: Beck, Brown, & Steer, 1996)	3
Beck Anxiety Inventory (BAI: Beck, Epstein, Brown, & Steer, 1988)	3
General Health Questionnaire (GHQ-12: Goldberg & Williams, 1988)	2
State-Trait Anxiety Inventory (STAI: Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983)	2
Liebowitz Social Anxiety Scale (LSAS: Liebowitz, 1987)	2
Clinical Global Impression Scale (CGI: Zaider, Heimberg, Fresco, Schneier, & Liebowitz, 2003)	2
Social Phobia Scale (SPS: Mattick & Clarke, 1998)	2
Social Interaction Anxiety Scale (SIAS: Mattick & Clarke, 1998)	2
Clinical Outcomes in Routine Evaluation (CORE-OM: Evans et al., 2002)	1
Fear questionnaire (Marks & Matthews, 1979)	1
Customer Satisfaction Questionnaire (CSQ-8: Larsen, Attkisson, Hargreaves, & Nguyen, 1979)	1
Hamilton Rating Scale for Depression (HRSD: Hamilton, 1960)	1
Dysfunctional Attitude Scale (DAS-A: Douma, 1991)	1
Attributional Style Questionnaire (ASQ: Seligman, Abramson, Semmel, & von Baeyer, 1979)	1
Everyday Problem Checklist (EPCL: Vingerhoets & van Tilberg, 1994)	1
Negative Life Events Questionnaire (Kraaij & de Wilde, 2001)	1
Satisfaction with Life Scale (SLC: Diener, Emmons, Larsen, & Griffin, 1985)	1
Fordyce Emotions Questionnaire (Fordyce, 1988)	1
Self-Report Questionnaire for Costs Associated With Psychiatric Illness (TIC-P: Hakkaart-van Roijen, van Straten, Donker, & Tiemens, 2002)	1
State-Trait Anger Expression Inventory (STAXI: Spielberger, 1988)	1

Measure	Number of studies using
State-Trait Anxiety Inventory (Dutch version) (STAI-Dutch: van der Ploeg, Defares, & Spielberger, 1980)	1
Ways of Coping Checklist—Revised (WCCL-R: Vitaliano, Russo, Carr, Maiuro, & Becker, 1985)	1
Montgomery-Asberg Depression Rating Scale (MADRS: Montgomery & Asberg, 1979)	1
Social and Occupational Functioning Scale (SOFAS: Goldman, Skodol, & Lave, 1992)	1
Geriatric Depression Scale (GDS: Yesavage et al., 1983)	1
Groningen Illness Attitude Scale (GIAS: Bouman, 2002)	1
Social Avoidance and Distress Scale (SADS: Watson & Friend, 1969)	1
Social Interaction Self Statement Test (SISST: Glass, Merluzzi, Biever, & Larsen, 1982)	1
Sheehan Disability Scale (SDS: Sheehan, 1983)	1
Brief Fear of Negative Evaluation Scale (BFNE: Leary, 1983)	1
Separation Anxiety Symptom Inventory (SASI: Silove et al., 1993)	1
Adult Separation Anxiety Self-Report Checklist (ASA-CL: Manicavasagar, Silove, Curtis, & Wagner, 2000)	1
Anxiety Sensitivity Index (ASI: Reiss, Peterson, Gursky, & McNally, 1986)	1
Body Sensations Questionnaire (BSQ: Chambless, Caputo, Bright, & Gallagher, 1984)	1
Mobility Inventory for Agoraphobia (MIA: Chambless, Caputo, Jasin, Gracely, & Williams, 1985)	1
SF-36 (German version) (Ware & Sherbourne, 1992)	1
Panic and Anxiety Scale - Clinician rated version (PAS: Bandelow, 1995)	1
Rosenberg Self-Esteem Scale (RSES: Rosenberg, 1965)	1
Multiple Affect Adjective Checklist (MAACL: Zuckerman & Lubin, 1965)	1

Table 5: Summary of studies' design features

Study	Design	Comparison group	Intervention	Duration	Fidelity checks	Assessment points	Outcome measures
Bockting et al, 2005	RCT	TAU	PGCBT focussed on identifying and changing dysfunctional attitudes and homework on new attitudes	8x120 minute class of up to 8 participants	16hr pre-course training, sessions recorded and checked for adherence to protocol	Baseline, 12 week, 52 week, 104 week	HRSD, DAS-A, EPCL, Negative Life Events Questionnaire, TIC-P
Coon et al, 2003	RCT	TAU (wait list) or Anger management	PGCBT focused on the relationship between mood and pleasant events, problem-solving, developing self-monitoring techniques to assess both factors, behavioural activation, homework tasks	8x120 minute class of up to 10 participants and 2 booster sessions 4 and 8 weeks later	Pre-course training on intervention manual and supervision given during treatment	At assessment and 18 weeks	STAXI, BDI, WCCL-R, MAACL
Seligman et al, 2007	RCT	Assessment only	PGCBT focussed on the relationship between thoughts, feelings and behaviours, identifying and restructuring automatic negative thoughts and underlying beliefs, behavioural activation, interpersonal skills, stress management, homework tasks	8x120 minute class of up to 10 participants	25hr pre-course training and supervision from course developer	Pre- and post-group and at 26 week follow-up	BDI, BAI, SLC, Fordyce Emotions Questionnaire, ASQ
Wilkinson et al, 2009	RCT	TAU (Medication only)	PGCBT focussed on goal setting, behavioural activation, identifying and restructuring automatic negative thoughts, preventing relapse	8x90 minute class of up to 6 participants	Pre-course training on intervention manual. Sessions videoed and 25% scored for fidelity	Baseline, 26 weeks, 52 weeks	BDI, MADRS
Manicavasgar et al, 2011	Randomised to treatment arm	Mindfulness group	PGCBT focussed on links between thoughts, feelings and behaviours, identifying cognitive distortions, challenging negative thoughts, strategies to minimise worry and avoidance, homework tasks	8 classes (length not declared) of up to 10 participants	Sessions recorded and checked for fidelity to CBT using validated instruments	Pre and post-group, 26 weeks, 52 weeks	BDI-II, BAI, SOFAS
Richardson et al, 2006	Single group	None	PGCBT focussed on thinking errors, self-talk, behavioural activation and self-monitoring, homework tasks	8x120 minute class with up to 7 participants	Each session evaluated by patients and clinicians and improvements included in next session	Pre- and post-group and 12 week follow-up	GHQ-12, GDQ, BDI
Buwalda et al, 2007	Randomised to treatment arm	Problem-solving group	PGCBT focussed on misinterpretations that maintain vicious cycles, safety behaviours, avoidance and role of stress in maintaining hypochondriasis	6x120 minute class with 22 participants	Each session supervised to check adherence to manual	Pre- and post-group, 4 weeks post group, 26 weeks post-group	GIAS, STAI-Dutch, BDI

Study	Design	Comparison group	Intervention	Duration	Fidelity checks	Assessment points	Outcome measures
Borgeat et al, 2009	Randomised to treatment arm	Self-focussed exposure therapy group	PGCBT focussed on social anxiety, hierarchy of feared situations, exposure within the group, discussion of cognitive distortions in social anxiety and cognitive restructuring, homework	8x150 minute class with 15 participants	Unknown	Pre-, midpoint, post-group, 4 week, 12 week, 26 week and 52 week follow-up	LSAS, CGI, SADS, SISST, STAI, BDI-II, SDS
Bjornsson et al, 2011	Randomised to treatment arm	Group psychotherapy focussed on group dynamics	PGCBT focussed on in-session exposures to feared social situations, cognitive restructuring, homework	8x120 minute class of up to 7 participants	Supervision provided to facilitators, random sessions rated for adherence to model	Pre- and post-group	CGI, LSAS, SPS, SIAS, BFNE
Houghton et al, 2007	Single group	None	PGCBT model of anxiety, coping strategies, homework tasks	4x90 minute class of up to 25 participants	Unknown	Pre-course screening and 12 week follow-up	CORE-OM Fear CSQ-8 (follow-up only)
McEvoy, 2007	Single group	None	PGCBT focussed on social anxiety, hierarchy of feared situations, exposure within the group, cognitive restructuring, homework	7x240 minute class of up to 9 participants	Unknown	Pre- and post-group	SPS, SIAS, BDI-II
Kirsten et al, 2008	Single group	None	PGCBT focussed on anxiety, relaxation training, identifying and restructuring cognitive distortions, exposure therapy to fears, relapse prevention	8x90 minute classes of up to 8 participants	Weekly supervision provided	Pre- and post-group	BDI BAI, SASI, ASA-CL
Lamplugh et al, 2008	Single group	None	PGCBT focussed on cognitive restructuring, exposure within the group, strategies to 'surf' anxiety, homework	5x240 minute classes (over 1 week) of up to 5 participants	Daily supervision and therapist group discussion	Pre- and post-group and 4 week review	ASI, BSQ, MI, BAI, BDI-II
Rufer et al, 2010	Single group	None	PGCBT focussed on cognitive restructuring, exposure exercises, relaxation techniques, homework	5x150 minute classes of up to 7 participants	Weekly supervision provided	Pre- and post-treatment and 26 week follow-up	SF-36, PAS
Brown et al, 2004	RCT	Wait list	PGCBT focussed on identifying/challenging negative thoughts, assertiveness, problem solving, homework	1x420 minute class of up to 25 participants	Unknown	Pre-group, 12 week follow-up	BDI, GHQ-12, STAI, RSES

Table 6: Summary of studies' outcomes and quality rating

Study	Outcome at intervention end	Outcome at follow-up	Attrition rate during study	Downs and Black rating
Randomised studies evaluating PGCBT for depression				
Bockting et al, 2005	Not measured as study measuring relapse	PGCBT reduced relapse rate for patients with five or more previous depressive episodes (41% of sample) over the preceding 2 years (46% PGCBT group, 72% TAU group). PGCBT had no protective effect for those patients with two previous episodes over the preceding 2 years	165 (95.9%) patients remained in contact at follow-up	Good (23)
Coon et al, 2003	Outcomes measured at follow-up	Both PGCBT for depression and anger reduced levels of depression and anger or hostility. Positive cognitive coping strategy use increased in the anger management group. Self-efficacy increased in both groups. Effect sizes for the interventions' impact on outcome variables ranged from 5% to 10% of the variance	39 (23%) left the study before treatment began. No data given on attrition during treatment	Fair (18)
Seligman et al, 2007	Less symptoms of depression (moderate effect size) and anxiety (small effect size). Measures of life satisfaction and happiness higher. Optimistic explanatory style higher (moderate effect size)	Less symptoms of depression and anxiety maintained at follow-up but all effect sizes now small. Measure of life satisfaction higher, measure of happiness not significantly different. Optimistic explanatory style higher (moderate effect size)	227 (94.6%) completed the study	Fair (19)
Wilkinson et al, 2009	Not measured as study measuring relapse	Less relapse measured with MADRS but not significantly different to control group. No reduction in caseness as measured by BDI	36 (80%) patients remained in contact at follow-up	Fair (18)
Manicavasgar et al, 2011	Mean BDI and BAI scores decreased. No difference in SOFAS score	No change in scores at 26 or 52 week follow-up	45 (73.8%) patients remained at follow-up	
Non-randomised studies evaluating PGCBT for depression				
Richardson et al, 2006	Reduction in mean BDI, GDS, GHQ-12 scores	Symptomatology returned to pre- group levels on GDS. Partial return of symptomatology on GHQ-12 and BDI, unclear if gains still remained	5 (71.4%) patients remained at follow-up	Poor (7)
Randomised studies evaluating PGCBT for anxiety disorders				
Buwalda et al, 2007	Reduction in mean BDI, GIAS and STAI-Dutch scores with medium to large effect sizes	All gains continued to improve although not significantly	33 (75%) patients remained at follow-up	Good (20)

Study	Outcome at intervention end	Outcome at follow-up	Attrition rate during study	Downs and Black rating
Borgeat et al, 2009	Reduction in mean LSAS, SISST, STAI, SDS, BDI-II and SADS scores by treatment end	All gains remained at follow-up measurement points	26 (86.7%) patients remained at follow-up	Fair (17)
Bjornsson et al, 2011	8 (47.1%) showed clinically significant improvement on CGI, Mean LSAS, SPS, SIAS, BNFE scores showed reductions with medium effect sizes	N/A	39 (88.6%) patients completed the study	Good (24)
<i>Non-randomised studies evaluating PGCBT for anxiety disorders</i>				
Houghton et al, 2007	Outcomes measured at follow-up	Clinically significant and statistically reliable change found for 11/44 patients with CORE-OM, 6/55 patients for Fear	120 (41.2%) patients remained in contact at follow-up	Poor (11)
McEvoy, 2007	Mean SPS, SIAS and BDI-II scores improved with medium effect sizes. Over 50% of participants achieved reliable improvement on one or more outcome measures	N/A	125 (81.7%) patients completed the study	Fair (17)
Kirsten et al, 2008	Mean BDI and BAI scores improved with medium effect sizes. Higher adult separation anxiety was associated with increased likelihood of anxiety and comorbid depression remaining unremitted. Higher juvenile separation anxiety was associated with a greater likelihood of still being co-morbidly depressed	N/A	154 (77.0%) patients completed the study	Fair (16)
Lamplugh et al, 2008	BDI-II, BAI, BSQ and ASI scores improved	No further change in BDI-II, BAI, BSQ and ASI scores. MI-alone sub-scale score now improved	All patients remained at follow-up	Poor (10)
Rufer et al, 2010	All but two out of eight SF-36 subscales and all five subscales of the PAS improved with large effect sizes	Gains maintained at follow-up	43 (78.2%) patients remained at follow-up	Fair (15)
<i>Randomised studies evaluating PGCBT for depression and anxiety</i>				
Brown et al, 2004	Outcomes measured at follow-up	BDI, GHQ-12 and RSES scores improved, with a small effect size determined for the change in BDI. 45% of participants showed clinically significant improvement on BDI	79 (58.9%) patients remained at follow-up	Poor (14)

Studies targeting depression are presented first, followed by those targeting anxiety and mixed anxiety/depression. Within each disorder category, randomised designs are considered before non-randomised designs.

Randomised studies targeting depression

Five randomised design studies were reviewed. Four used a control group where either no treatment was offered or treatment as usual continued and one used a similar length intervention in the other treatment arm. Two studies investigated relapse rates, the other three investigated symptom reduction. Three studies sampled specific populations (two older adults, one college students), the other two sampled adults in general.

Bockting et al. (2005) described a longitudinal RCT that sought to determine if CBT could prevent relapse following depression. Following randomisation, 172 patients in remission from depression received TAU or eight week PGCBT in groups of up to eight patients. There were no differences between patients in either treatment arm, including use of medication. Relapse was assessed over two years using a clinical interview and the HRSD, and for patients with five or more previous episodes (41% of the sample), PGCBT was more protective than TAU (46% vs. 72% relapse).

This was a well-designed study, scoring as good (23) on the Downs and Black tool. External validity was high, patients being representative of those attending mental health services and the study parameters allowed patients with a wide variety of past treatments to take part, appropriate statistical measures being used to account for this in analysis. Randomisation protocols were robust and researchers at follow-up were blinded to participants' treatment. Treatment fidelity was well controlled with pre-group training and close supervision of experienced facilitators. The long follow-up length for the study added to the robustness of the

conclusion that brief PGCBT can lower depression recurrence in older adults with previous five or more previous episodes, although participant numbers were small.

Coon, Thompson, Steffen, Sorocco and Gallagher-Thompson (2003) presented a longitudinal RCT that sought to determine both the effectiveness of two different psychoeducative groups, depression management and anger management, for distressed caregivers and moderating and mediating variables on outcome. One hundred and sixty nine female caregivers aged 50 or over were randomised to TAU (wait list) or eight week classes for anger or depression management. Patients in both classes showed reductions in anger, hostility and levels of depression compared to the TAU group, measured by the STAXI, BDI, WCCL-R and the MAACL. Self-efficacy increased for patients in both classes and mediated the intervention effects. The pre-treatment level of depressive symptomatology and anger expression style served as moderators for the effects of both groups on coping and mood. Interestingly only the anger management class increased patients' positive coping strategies, possibly due to the anger management class teaching more cognitive strategies than the behavioural focussed depression management class. Effect sizes were small, possibly due to floor or ceiling effects as participants were included who did not meet caseness for depression or exhibit significant anger management problems.

The study scored as fair (18) on the Downs and Black tool. However there was no accounting for drop-out during the treatment phase of the study and although well-randomised, it was not possible to determine if participants were representative of the population from which they were drawn or whether the treatment facilities and treating clinicians were representative of the area. This served to lower external validity.

Seligman, Schulman and Tryon (2007) conducted a large RCT with US college students to evaluate the impact of an eight session PGCBT group for patients meeting criteria for mild/moderate depression on the BDI. Patients were

randomised to treatment or assessment only and followed up at treatment end and again at 26 weeks. Unusually for studies of this kind they also offered support post-group in the form of skills reminder emails and an optional online CBT skills course. However take up on the latter was minimal. The PGCBT group had fewer depressive and anxiety symptoms, as measured by the BDI and BAI, than the controls at both group end and six month follow-up but by six months effect sizes were small. The PGCBT group exhibited better wellbeing and greater improvement in optimistic explanatory style, with moderate effect sizes. Improved explanatory style was a mediator of the prevention effects from pre- to post-group for depressive and anxiety symptoms, as well as for improved wellbeing.

The Downs and Black score for the study was fair (19). This could have been improved with more information on participant demographics but external validity was problematic as the sample was drawn exclusively from college students. Internal validity was also lowered by no apparent accounting in analysis for the incomplete data at follow-up referred to in the study.

Wilkinson et al. (2009) reported on a small (n=45) RCT that evaluated relapse in a group of older adults (60+) taking medication for a past episode of depression. Depression severity was measured at baseline and 26 and 52 weeks after group start using the MADRS and BDI. Five of 18 participants who received eight sessions of PGCBT relapsed compared to eight of 18 TAU participants, although this did not achieve statistical significance. However scores on the BDI had increased for the PGCBT participants compared to the TAU participants. This may have been due to limitations in the BDI as a tool to accurately measure depression in older adults who are likely to experience physical ill-health.

The study had some notable strengths in that the small size allowed for a careful assessment of treatment fidelity as treatment was delivered by the same therapist throughout, although this meant generalisability was limited. The Downs and Black score for the study was fair (19), reflecting a high standard of reporting

and efforts to control bias. However external validity and confounding bias were not so well accounted for. In addition the study lacked power.

Manicavasgar, Parker and Perich (2011) presented a randomised study that compared PGCBT with group mindfulness for reducing depressive symptomatology. Forty-five participants completed eight sessions of either group treatment and were followed up at 26 and 52 weeks. There were improvement in both treatment arms, as measured by the BDI-II, the BAI and the SOFAS which was maintained throughout follow-up. There was no difference between treatment arms apart from a finding that within the PGCBT condition, participants with four or more previous episodes of depression demonstrated a greater reduction in depressive symptomatology than those with fewer than four episodes.

The study scored as fair (15) on the Downs and Black Tool, with some weaknesses in reporting, including no information on session length and less than comprehensive recruitment details. The latter impacted on both external and internal validity (bias). Sample size was small and as both treatment arms received an intervention it is uncertain how much the specific content of the intervention, beyond processes common to all group treatments, mediated gains.

Summarising the randomised studies targeting depression, brief PGCBT was shown to be of limited effectiveness in preventing relapse, with one study having reported a positive result for patients with five or more previous episodes and the other study having shown inconclusive results. The three studies that assessed symptom reduction all reported reductions which were maintained at follow-up but effect sizes where reported were small. There was a wide variety of outcome measures used and methods of reporting results, making a more systematic analysis of intervention effectiveness difficult.

Non-randomised studies targeting depression

Only one study met inclusion criteria for this review, a small (n=7) trial of an eight session PGCBT intervention for older adults, carried out by Richardson and Reid (2006). Five participants remained at 12 week follow-up but gains in symptom reduction measured using the BDI and GHQ-12 were partially lost by this point, and gains on the GDQ were completely lost. The authors attributed this disappointing outcome to physical health difficulties in an extremely elderly sample (mean age 81.3) which they suggest may have been managed with therapeutic top-up sessions; something participants expressed a wish for at follow-up.

The study scored as poor (7) on the Downs and Black tool. Reporting of recruitment, participant demographics and potential confounds or bias was weak or absent and there was no presentation of statistical analysis, meaning external and internal validity were very poor. Whilst the study was written up as action research it would not have been unreasonable for this information to have been included, alongside what was a comprehensive and interesting account of developing and modifying an intervention as it was delivered.

Randomised studies targeting anxiety disorders

Three studies that used a randomised design with participants with anxiety disorders were reviewed. All used a similar length intervention in the other treatment arm. All studies investigated symptom reduction. One study sampled a specific population, college students, the other two sampled adults in general.

Buwalda, Bouman and van Duijn (2007) conducted a randomised study comparing PGCBT against group problem-solving for hypochondriasis. Outcomes for the two treatment arms were measured at group end, four weeks and 26 weeks post-group. Both groups ran for six weeks with 22 participants in each group. Beneficial effects of both courses on the GIAS, BDI and the STAI were shown post-group and continued at both follow-up assessments with moderate or large effect

sizes. Analysis of reliable clinical benefit showed 16/22 (73%) participants in the PGCBT group to have achieved this at group end. At 52 week follow-up 8/14 (57%) remaining participants showed reliable benefit. Overall the PGCBT group was effective in reducing and maintaining reduction in hypochondriasis symptoms.

The Downs and Black score for this study was good (20). Drop-out and missing data was accounted for in analysis, along with inclusion of detailed information on confounding variables such as differences in drop-out rates between groups. Some confounds were controlled for; for example asking participants taking medication to remain on the same dosage during the study. Randomisation was a weakness as it appeared that the facilitators were directly involved in the procedure so introducing bias. It also appeared that facilitators collected outcome data at follow-up and so were not blinded to the intervention received.

Borgeat et al. (2009) presented a study that randomly allocated participants to either eight sessions of PGCBT or eight sessions of self-focussed exposure therapy, an approach that has little cognitive content and considerable in-group exposure work. Both interventions were equally effective with reductions in symptomatology at group end assessed with the LSAS, CGI, SADS, SISST, STAI, BDI-II and the SDS. The study followed up participants for a year post-group, finding that gains post-group were maintained. Interestingly the authors noted that the exposure therapy group showed less negative cognitions at group end despite little explicit efforts to address these during sessions. They suggested that for social anxiety it may be helpful to begin group work with exposure and bring more 'traditional' cognitive elements of PGCBT into treatment to provide tools to reinforce gains made. A strength of the study was that measures included clinician report measures (LSAS) as well as self-report measures.

The study scored as fair (17) on the Downs and Black tool. It was well reported and the considerable data collected was comprehensively analysed, although effect sizes and actual p values were not reported. However external

validity is questionable as the recruitment used a self-referral method meaning it was uncertain whether participants were representative of the population of social anxiety sufferers. Randomisation was also questionable as it was not made clear whether treating clinicians were involved in the process. Similarly it was uncertain whether any attempt to blind data collectors to treatment arm was made. Consequently internal validity was reduced with regard to bias. Confounding events and variables were also not reported, also weakening internal validity. The follow-up data collection included both a clinician delivered structured interview and a qualitative interview that may have served as a therapeutic intervention and so improved outcomes.

Bjornsson et al (2011) undertook a randomised study comparing eight sessions of PGCBT with group psychotherapy of the same duration for social phobia. Although the study found reductions in symptomatology in the PGCBT group on both self-report (CGI, SPS, SIAS, BFNE) and a clinician report measure (LSAS), once baseline and confounding variables had been controlled for, PGCBT performed no better than group psychotherapy and the latter treatment arm had less attrition and a higher rate of clinically significant improvement. Effect sizes were reported as medium.

The study scored as good (24) on the Downs and Black tool. There was careful accounting for confounding variables and rigorous blinding of post-group assessors to treatment arm, increasing internal validity. Reporting was of a high standard with recruitment, intervention, participant demographics and analysis impressively detailed. However external validity was weakened by the recruitment method which invited self-referral to the group; something that may exclude many social anxiety sufferers. Interestingly facilitators in the study all facilitated both treatment arms. Whilst fidelity to each model was rated by other experienced clinicians it may have been a source of bias, particularly as the authors explicitly

stated they hoped PGCBT would prove to be more effective, although this did not turn out to be the case.

Summarising the randomised studies targeting anxiety disorders, brief PGCBT was shown to be effective in reducing symptomatology but did not appear more effective than other group treatments, with one study suggesting it performed worse than psychotherapy of equal duration. Effect sizes where reported were medium or better. As with the randomised studies targeting depression, there was a wide variety of outcome measures used and methods of reporting results, making a more systematic analysis of intervention effectiveness difficult.

Non-randomised studies targeting anxiety disorders

Five non-random studies targeted a range of anxiety disorders. All looked at symptom reduction, with two also evaluating other factors associated with change.

Houghton and Saxon (2007) reported on a four session psychoeducative course delivered in a UK psychotherapy service. All patients with an anxiety disorder who the service found suitable were offered a place on the course which covered a CBT model of anxiety, detailed coping strategies and helpful behaviours and included homework tasks. Group sizes were larger than is usually seen, with up to 25 patients per group. The CORE-OM and Fear questionnaire were given at pre-course screening and at 12 week follow-up and the CSQ-8 post-course. Of 191 patients referred, 120 remained at follow-up. Clinically significant and statistically reliable change was found for 11/44 patients using the CORE-OM and for 6/55 patients using the Fear questionnaire and 102 patients completed the CSQ-8, reporting high levels of satisfaction with the course.

The study scored as poor (11) on the Downs and Black tool as no attempt was made to improve internal validity, participants being anyone who wished to take the course as opposed to matching attendee characteristics to those who opted for other therapy. Similarly no attempt was made to control for diagnosis or to include or

exclude participants who did not meet diagnostic criteria for a disorder. Internal validity was also reduced due to the lack of control group and no attempt being made to manage confounding variables or account for drop-out in the analysis. Finally reporting was poor, with actual p values not stated and minimal description of participant demographics, confounders and adverse events. However the study was presented in a short communication as opposed to a full article.

McEvoy (2007) carried out a study to benchmark the effectiveness of PGCBT for social phobia in a community mental health centre against previous studies. The study therefore collected data on 153 patients referred consecutively for treatment who were then placed into the PGCBT group. Although some exclusion criteria were in place (concurrent schizophrenia, schizoaffective disorder, organic brain dysfunction, or a level of substance use judged by the assessing clinician as likely to interfere with engagement in treatment), factors that might have resulted in exclusion from a randomised trial such as severity or co-morbidity with other disorders were not grounds for exclusion. The study thus reflected clinical practice. Participants received seven 240 minute sessions of PGCBT, which resulted in reductions in symptomatology. Medium effect sizes compared favourably to previous efficacy and effectiveness studies of both group and individual treatment with more than half of the treatment completers achieving reliable change and a third achieving clinically significant change on the SPS and the BDI.

The Downs and Black score for the study was fair (17) reflecting the lack of randomisation and some gaps in reporting, including loss to follow-up and confounding variables. Internal validity was therefore reduced. However external validity was high, reflecting the 'real world' sample. Confounding variables of co-morbid depression, age, medication and alcohol use noted within the highly inclusive sample were controlled for in the analysis of effect sizes. However other concurrent treatment or staff contact was not. It was notable that treatment fidelity

was not discussed in the study; again this perhaps reflects that in practice it may not be possible to provide in-depth supervision or assessment of sessions.

Kirsten, Grenyer, Wagner and Manicavasagar (2008) conducted a study into separation anxiety as an impacting factor on PGCBT effectiveness for anxiety disorders. Two hundred consecutive participants were recruited for an eight session PGCBT course administered as part of routine practice. One hundred and fifty four participants completed treatment. Similar to the McEvoy (2007) study described above, few exclusion criteria were in place, reflecting clinical practice. Participants received eight 90 minute PGCBT sessions in small groups of up to eight. Of primary interest to this review, both depression and anxiety symptomatology was reduced, as measured with the BDI and the BAI, with medium effect sizes. Higher adult separation anxiety was associated with increased likelihood of anxiety and comorbid depression remaining unremitted. Higher juvenile separation anxiety was associated with a greater likelihood of still being co-morbidly depressed.

The study scored as fair (16) on the Downs and Black tool, with some gaps in reporting confounding variables and details of completers versus non-completers. These omissions affected the internal validity of the study with regard to confounds and bias. The lack of a control group also served to weaken the study although the 'real world' recruitment and treatment protocol gave it high external validity. The cross-sectional nature of the study made causal conclusions about separation anxiety influencing symptomatology impossible and the lack of follow-up weakened conclusions about the effectiveness of the PGCBT intervention. As with other naturalistic studies, lack of control for factors that may also have influenced outcome such as other concurrent treatment or staff contact also limits the conclusions that can be drawn.

Lamplugh, Berle, Milicevic and Starcevic (2008) carried out a small study (n=18) into a PGCBT based intervention for panic. Interestingly they included both established psychoeducative content and an approach, 'panic surfing' that taught

participants to manage physiological panic symptoms through acceptance and recall of educative content as opposed to using strategies to control physiological responses such as breathing or relaxation. In another departure from standard practice, the five sessions ran on consecutive days. Symptomatology across four of the five measures used (ASI, BSQ, BAI, BDI-II) reduced by intervention end but effect sizes were not stated. At four week follow-up the MI-alone score had also reduced.

The Downs and Black score for the study was poor (10). It was let down by limited reporting and insufficient power. It had no information or accounting for confounding variables or bias so weakening internal validity. External validity was also reduced as it was not possible to determine if participants were representative of the population from which they were drawn.

Rufer et al. (2010) conducted a study to investigate changes in participant quality of life (QoL) following PGCBT for panic. Fifty-five consecutive participants were treated over five sessions in groups of up to seven. The clinician rated version of the PAS was used to assess symptomatology at group end and 26 week follow up and QoL was measured with the SF-36. Improvements in symptomatology were found post-group and maintained at 26 week follow-up. Effect sizes were large. Agoraphobia, disability, and worries about health were associated with decreased QoL, whereas frequency, severity and duration of panic attacks were not. Treatment responders showed better QoL than non-responders.

The study had a Downs and Black tool score of fair (15). Confounding variables and actual p values were not reported. External validity was high, participants appearing to represent the wider population but internal validity with regard to confounding variables was weak, some participants went on to individual therapy during follow-up and changes to medication took place during treatment or follow-up. That said, the use of a clinician rated outcome measure perhaps added weight to the claims of effectiveness and choosing to measure QoL as well as

symptom reduction strengthened claims that the treatment was of tangible benefit to participants.

Summarising the non-randomised studies targeting anxiety disorders, brief PGCBT was shown to be effective in reducing symptomatology. Effect sizes were reported where medium or better. As with the randomised studies targeting anxiety, there was a wide variety of outcome measures used and methods of reporting results, making a more systematic analysis of intervention effectiveness impossible.

Non-randomised studies targeting depression and anxiety disorders

One study was included in this category, conducted by Brown, Elliott, Boardman, Ferns and Morrison (2004). They reported on the three month follow-up to an RCT comparing a one day PGCBT workshop to a wait-list control. Of interest was both the short duration of the intervention being a one day course and the recruitment pathway which was explicitly self-referral. The group was named as a self-confidence workshop in order to appeal to participants who may have seen something targeting mental health difficulty as stigmatising. Participants were not screened for mental health disorder and the intervention operated as an introduction to a CBT based approach to manage negative thoughts, increase assertiveness and raise self-esteem. Results at follow-up were encouraging, with a decrease in depressive symptomatology as scored by the BDI and the GHQ-12. Self-esteem was increased as measured by the RSES. The effect size for change in BDI score was small but removing participants who did not meet caseness for depression on the BDI raised the effect size to medium. Reliable clinical improvement measured with the BDI was demonstrated, with 45% of the experimental group improving compared with 8% of the control group.

The Downs and Black tool score the study was poor (14). This reflected some gaps in reporting such as age of participants but the greatest weakness was in internal validity where the study was let down by lack of accounting for

confounding variables and no apparent attempt to blind assessors at follow-up. The study was also underpowered with a high attrition rate. However the implication that brief PGCBT can be delivered to people who might not otherwise engage was a positive finding and participants were followed up again after two years. The results were published in a separate paper (Brown et al., 2008) and included follow-up data on the wait-list control participants who had been offered the intervention at the end of the study. Despite a continuing high attrition rate, reductions in depressive symptomatology remained but only for participants who had met caseness for depression when they were first assessed.

Discussion

This review examined the effectiveness of brief PGCBT for depression and common anxiety disorders. Brief PGCBT reduced symptomatology for depression at intervention end with small effect sizes. Outcomes at follow-up were not well maintained, brief PGCBT showing limited effectiveness as a relapse prevention tool.

The quality assessment for the randomised depression studies found considerable attention to detail in reporting, good external validity and reasonable efforts to raise internal validity through controlling for bias and confounding variables. This adds weight to the conclusion that brief PGCBT for depression delivered in psychoeducative short groups may be no more effective compared to other treatments and whilst gains are made post treatment they may not be well maintained. This outcome is less positive than found in the analyses by Cuijpers et al. (2008), Hollon and Ponniah (2010), Krishna et al. (2011), Feng et al. (2012) and Huntley et al. (2012), although all these reviews considered longer interventions. It does offer support to Wilson et al. (2008) who concluded CBT for older adults may only be of limited benefit.

Brief PGCBT showed more promise for treating anxiety disorders. Studies that reported on outcome post-group found reductions in symptomatology for social

anxiety, hypochondriasis, panic and mixed anxiety presentations. Effect sizes were medium or better. A number of these studies also reported at follow-up and showed benefits were maintained in the majority of studies.

For the randomised anxiety studies reporting was good and overall the studies had reasonable internal and external validity. The quality of the non-randomised anxiety studies was less impressive but their findings add support to the conclusion that brief PGCBT of this duration is effective for some specific anxiety disorders. However it cannot be concluded from this that a single brief PGCBT protocol of the length reviewed here can be generalised to treat populations presenting with a range of disorders. This is in line with the reviews by Jonsson, Hougaard and Bennedsen (2011) and Hunot et al. (2007) that reported specifically tailored GCBT as being effective for OCD and GAD.

Two studies investigated brief PGCBT delivered to participants with any anxiety disorder. The results were mixed, with medium effect sizes for symptom reduction but gains at follow-up were not well maintained. The quality of both these studies was less than the randomised studies so the conclusion that brief PGCBT has limited effectiveness for mixed anxiety presentations is tentative.

Only one study offered an intervention targeted towards both anxiety and depression. The results were promising, showing clinically significant improvement for 45% of participants but the quality of the study was poor meaning the conclusion that trans-diagnostic brief PGCBT is effective is again tentative.

The evidence points towards brief PGCBT, offered in eight or fewer sessions, being of some effectiveness in reducing symptomatology; more so for anxiety disorders than depression. There is also limited evidence that brief PGCBT can help prevent relapse over time but the limited number of studies reviewed and methodological limitations within both them and this review mean that the findings here must be considered indicative of effectiveness rather than definitive.

Some studies also drew conclusions regarding moderating and mediating factors to effectiveness. Drawing firm conclusions from the limited evidence reviewed here would be unreasonable but findings that brief PGCBT was more protective against relapse when people had experienced four or more episodes of depression and that higher adult separation anxiety was associated with an increased likelihood of anxiety and depression failing to remit after trans-diagnostic brief PGCBT for anxiety suggest opportunities to target interventions towards certain groups.

Similarly findings that self-efficacy mediated the impact of brief PGCBT for depression and that improved optimistic explanatory style mediated the improved wellbeing seen after GCBT also suggest ways to focus the content of brief PGCBT.

Methodological issues

Although brief PGCBT has been used for several decades only a few studies that met inclusion criteria for this review were found. This may be due to the search strategy employed that limited studies to participants aged over 18 as several studies were excluded that offered brief PGCBT interventions to adults but allowed attendance by people aged 15 or 16 upwards (Kellet et al., 2007; Kitchiner et al., 2009). Similarly the decision to exclude co-morbidity with a large number of other disorders also limited study numbers as, for example, there is considerable extant literature on psychoeducational groups for people with dual diagnosis or chronic health conditions. It is likely that some of these studies may have evaluated the impact of brief PGCBT on depressive or anxious symptomatology.

The decision not to limit the review to RCTs or other randomised designs, although not in line with some previous reviewers, for example Hunot et al. (2007) and Feng et al. (2012), did allow consideration of studies that reflected actual clinical practice as it is often difficult or prohibitively expensive to run randomised studies. Whilst such 'real world' studies may lack control or alternative treatment

comparisons, they can still offer interesting findings that open up further areas of research.

The above said, all the studies reviewed had methodological limitations. Using the Downs and Black (1998) critical appraisal tool allowed some quantification of these and it was notable that no studies achieved an 'excellent' score and only three achieved a 'good' score. Some limitations are difficult to overcome, such as ensuring a recruitment method that means participants reflect the population from which they are drawn or that confounding variables such as medication use or further therapy between intervention end and follow-up are controlled. However it was rarely the case that full details on participant demographics compared to the population were reported or confounding variables were controlled for, or even described, in analysis. Other limitations are arguably easier to overcome, such as ensuring an unbiased randomisation procedure or blinding data collectors to intervention in randomised trials but again a substantial number of randomised studies failed to do so.

A further limitation for many of the studies reviewed here is that follow-up periods were often less than a year. Only one study reached two years and a further three reached a year. However it must be considered that remaining in contact with participants for long periods is difficult and for studies with a follow-up, the attrition rate varied from 4% to 60%. It is also difficult to control for confounds, such as further treatment, once an intervention ends, meaning conclusions as to effectiveness become increasingly weak.

Study size also made drawing conclusions difficult in many cases as eight studies had fewer than 100 participants at commencement, meaning several were underpowered. This difficulty was always noted by the authors but highlights the need for larger scale studies in this area.

Considering the outcomes measured in the reviewed studies, it was notable that the measures used to quantify them varied widely. Only the BDI was used in

more than three studies and many measures were used only once. This served to make any formal meta-analysis impossible which might be argued also weakens the conclusions of this review, although it does suggest opportunities for further research. It was also notable that few studies used clinician rated instruments to evaluate outcomes, again weakening the conclusions reached when evaluating clinical change.

In defence of the studies reviewed, it should be considered that the Downs and Black tool itself has some limitations. Although it was designed to evaluate both randomised and non-randomised trials, questions related to allocation only apply to randomised studies and so limit its application for non-randomised studies where benefits such as external validity for research into existing practice-based interventions cannot be given much weight (Deeks et al., 2003). Additionally in this review, studies were only reviewed by the author, meaning inter-rater reliability is unavailable, perhaps weakening the conclusions of studies' quality.

Recommendations for future research

The findings from this review suggest several areas for further research that might be implemented by services operating stepped care models such as IAPT.

Firstly it was notable that the interventions offered in the reviewed studies, whilst all stating they were based on CBT with some psychoeducation, varied somewhat in content. This was not surprising as the majority of the studies targeted specific disorders and tailored their approach accordingly. That said, with the increase in brief PGCBT for anxiety and depression and the need for services to choose effective treatments, it would be helpful for studies to be explicit in the intervention delivered, not only in terms of content but with regard to the specifics of delivery, for example whether participants took a treatment manual home or whether homework completion was understood by participants as essential or optional. Similarly, future studies might explore the implications of who delivers treatment.

Most of the studies here employed experienced CBT therapists or psychologists as clinicians, whereas in practice many services will use PWP's for brief PGCBT and although staff with similar qualifications and experience, such as nurses or occupational therapists often deliver psychoeducational groups in other areas of healthcare, the impact of clinician training is not yet known for brief PGCBT.

As noted, sample sizes were often small. The number of patients treated by IAPT since its inception is considerable, over 350,000 up to April 2011 (IAPT, 2011). Whilst most patients will not have received brief PGCBT, many will and considerable outcome data exists for them as IAPT mandates collection of outcome measures at assessment and every treatment session (IAPT, 2012). As this data is standardised across services it would in theory allow for large scale comparison studies between interventions and services, albeit with the proviso that these would be more akin to retrospective service audits as opposed to pre-designed studies.

Also of interest would be to further understand who might gain most benefit from brief PGCBT and what mediates and moderates effectiveness beyond the findings from studies presented here. With the large number of patients accessing IAPT brief PGCBT, similar mechanisms might be searched for as part of routine clinical work.

A similar point, although not explicitly researched in any of the studies here, is the cultural acceptability of brief PGCBT. Patel, Chowdhary, Rahman and Verdeli (2011) noted that changing the nomenclature of disorders, such as 'burdened' for 'depressed' can be helpful as can modifying homework tasks to be culturally appropriate. In the area of language, White, Keenan and Brooks (1992) who developed one of the first large scale open access brief PGCBT interventions named it 'stress control' to lessen stigma. A similar approach was taken by the study reviewed here by Brown, Elliott, Boardman, Ferns and Morrison (2004) who named their similar intervention as a 'How to improve your self-confidence' workshop and suggested this increased the referral rate. Research into any brief PGCBT

intervention might usefully include some qualitative research into how the intervention is perceived and whether it appears culturally appropriate to participants. This may be of relevance to gender as it was notable that in 12 of the 14 studies that were open to both men and women had greater numbers of women. It is known that UK men are less likely to seek help (Oliver, Pearson, Coe, & Gunnell, 2013) and exploring whether brief PGCBT can be adapted to be more 'male friendly' could lead to more accessible treatments.

Research might also explore what components of brief PGCBT patients find useful and whether and how they continue to use them after treatment ends. It was notable that of studies reviewed here, only Seligman et al. (2007) confirmed that participants had retained knowledge of what they were taught at intervention end. If it cannot be demonstrated that patients actually leave brief PGCBT with new knowledge that they integrate into their lives, it may be that change is due to other factors such as the processes believed to operate in other forms of group therapy, such as universality, altruism, interpersonal learning and the instillation of hope (Yalom & Leszcz, 2005), something noted by Bockting et al. (2005) in their study reviewed here.

Conclusions

Although the findings from this review are tentative as they are based upon a small number of studies with a number of methodological issues and limitations in quality, there is limited evidence that GCBT delivered in a psychoeducative format and in eight or fewer sessions might be effective for both depression and common anxiety disorders.

The review also clarifies gaps in the current evidence base with regard to brief PGCBT and so may provide guidance to services such as IAPT who are likely to increase their use of brief PGCBT in the future. Further research is clearly needed, ideally using studies that replicate clinical practice, to enable what appear

to be promising interventions to be delivered to people who will benefit. It is also necessary to understand what people see as beneficial from the brief PGCBT they receive and, for those who find it beneficial in the longer term, how they maintain the gains they make.

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Part 2: Empirical paper

**Are gains made in IAPT psychoeducational groups maintained over time? A
qualitative study**

Abstract

Aims: This study investigated what patients found helpful from attending an IAPT brief Psychoeducational Group Cognitive Behavioural Therapy (PGCBT) intervention that delivered skills to manage symptoms of anxiety and depression. The study also explored whether and how patients integrated these skills into their lives after the group ended.

Method: Participants were patients who met caseness for depression and/or anxiety at initial assessment and met criteria for reliable benefit at group end. Fifteen participants entered the study about six months after their group finished. Participants were interviewed about their experience in the group and how they used this experience since. Data were analysed qualitatively using thematic analysis.

Results: Eleven themes were identified across three domains; expectations, group process, and content and change. Most people incorporated some CBT skills into daily life, either through deliberate use or less formal awareness of new ways to approach problems. However participants found the normative, cohesive and cathartic elements of the group more important in effecting change. Gains made at group end were maintained at interview, through limited use of CBT techniques and a realisation by participants that mental health problems were commonplace and therefore could be managed.

Conclusions: Further research is needed, replicating clinical practice, to determine what factors moderate and mediate outcomes in brief PGCBT and how interventions can be further tailored to encourage these factors to operate.

Introduction

According to the Department of Health for England and Wales in 2000, over a quarter of GP consultations were for mental health problems (Department of Health, 2000). The limited availability of effective psychological treatments gave rise to long wait times leading to problem escalation (Brown, Elliott, Boardman, Ferns, & Morrison, 2004) and a consequent burden on the public purse. To address this problem, the Improving Access to Therapies (IAPT) Programme was established to enable the NHS and third sector organizations in England to deliver then current National Institute for Clinical Excellence (NICE) guidelines for treating depression (National Institute for Clinical Excellence, 2007b) and common anxiety disorders (National Institute for Clinical Excellence, 2007a). As argued for by the influential Layard Report (Layard et al., 2006), the interventions were to be brief and delivered in primary care settings.

Cognitive Behavioural Therapy (CBT) was, and remains, the primary therapeutic modality within IAPT and the majority of interventions are low intensity, typically of 6-8 week duration. These include computerised CBT, bibliotherapy, one-to-one guided self-help and brief psychoeducative groups. Such groups aim to equip patients with knowledge to manage symptoms of anxiety and/or depression through learning and using skills and techniques derived from CBT, such as noticing and being able to challenge unhelpful thinking or recognising links between thoughts, emotions and behaviours and acting in ways to break unhelpful cycles. Brief psychoeducative group CBT (PGCBT), once protocols are in place, offers a cost saving over individual therapy (Radhakrishnan et al., 2013; Sochting, Wilson, & De Gange, 2010; White, 2010) and so is increasingly commonplace within IAPT, hence the need to be assured of its effectiveness in providing lasting change for patients.

Overall results from the first IAPT demonstration sites were positive (Clark et al., 2009) with over half of clients who had attended at least twice being classified as recovered on leaving the service. Gains were largely maintained, with half of clients

who responded to a request for clinical data four months or later (mean ten months) still meeting recovery criteria. Richards and Suckling (2009) further analysed one of the demonstration sites, reporting combined recovery and remission rates of over two thirds for anxiety and depression for patients primarily receiving low intensity interventions. Richards and Borglin (2011) found that of over 4000 patients given two or more treatment sessions within an IAPT service, over half met reliable improvement or clinically significant change criteria for depression and anxiety.

Regarding choice of therapeutic modality, there is a substantial body of evidence that CBT is effective for a range of disorders including anxiety and depression (Butler, Chapman, Forman, & Beck, 2006; Roth & Fonagy, 2005). Current NICE guidelines for depression (National Institute for Health and Care Excellence, 2009) and anxiety disorders (National Institute for Health and Care Excellence, 2011), drawn up after substantive reviews of effectiveness, recommend CBT based therapies as treatment approaches to be tried in the first instance. The above guidelines also recommend group CBT, although of 10-12 sessions, for these disorders and there is evidence of effectiveness for interventions of this length. Feng et al. (2012) in a meta-analysis of 32 studies of Group Cognitive Behavioural Therapy (GCBT) reported that overall GCBT significantly reduced depressive symptoms for a six month period post-group. Similarly Oei and Boschen (2009) showed GCBT to be effective for symptom reduction post-group in patients with panic disorder, generalized anxiety disorder, post-traumatic stress disorder and in patients with a primary major depressive disorder with clinically significant anxiety symptoms.

A recent development has been the inclusion of patients with anxiety disorders and/or depression in a single GCBT protocol. Erickson, Janeck and Tallman (2007) reported successful outcomes with a treatment protocol for patients with heterogeneous anxiety disorders and McEvoy and Nathan (2007) demonstrated the effectiveness of GCBT for patients with depressive and/or anxious symptoms

who attended the same group. In IAPT services who are tasked with minimising the time from referral to intervention, the benefits of offering a single group that can take patients with a multiplicity of symptomatology are clear.

The substantive investment into the IAPT programme means that evaluating the effectiveness of its current treatments is important in order to improve outcomes and maximise efficiency. As noted above, GCBT has been shown to be effective and there is qualitative evidence emerging that suggests broad satisfaction with IAPT approaches amongst patients (Delgado, 2010). However such approaches are not without their drawbacks. In the case of GCBT, Morrison (2001) suggested several challenges including monopolisation or confrontation from members and the development of sub-groups in larger groups. Whilst these can be managed by effective facilitation, Morrison also highlighted differing improvement rates potentially discouraging some attendees and problems in members articulating individual core beliefs making lasting change unlikely. These latter two points are highly relevant to short-term groups and Yalom and Leszcz (2005) argued that the processes needed for groups to become effective may not have time to become embedded before short-term group termination. They suggested that facilitators need to be explicit about the group's aims, in particular that what is achieved is a starting point to change that will need to be actively pursued after the group ends. Yalom and Leszcz (2005) also noted that short-term groups may be most valuable as means whereby patients can learn ways to manage symptoms as opposed to achieving fundamental shifts in cognitions, emotion management or interpersonal relationships. Together these points suggest that when short-term groups, particularly psychoeducative ones, are effective, patients understand the purpose and are able to integrate what they learn into their lives post-group (Whitfield, 2010; Wong, 2011).

The concept of the therapeutic alliance between therapist and patient, considered to be a key predictor of any successful individual therapy (Kuyken,

Padesky, & Dudley, 2009; Lambert & Barley, 2002) has been thought to operate within the group in a similar manner. Johnson, Burlingame, Olsen, Davies and Gleave (2005) defined three aspects; climate (a sense of constructive interpersonal investigation), cohesion (a sense of belonging) and empathy (a sense of being understood). Research suggests that patients who experience high levels of these constructs are likely to be more involved in tasks within the group and so gain more benefit (Ogrodniczuk & Piper, 2003) and, in the case of psychoeducative groups, a deeper integration of learning.

Most GCBT studies are quantitative in nature, using measures of symptom reduction to demonstrate effectiveness. Similarly services often report patients' satisfaction with groups using Likert scale or other simple questionnaires. IAPT services are required to comply with the IAPT data standard (IAPT, 2012) which mandates the collection of outcome and patient satisfaction measures (IAPT, 2011b). Whilst the data standard captures much outcome information and some measure of service satisfaction, the latter is recorded with five 5-point Likert scale questions and a space for comments on the service. What it does not gather are patients' experiences of their interventions, the processes operating within their groups and what they see as responsible for changes in symptomatology. This is of particular importance when designing psychoeducative groups as facilitators often have to present interventions to manage symptoms to patients with a range of presenting problems. As patients are often reluctant to share details of their problems until a group is well established (Yalom & Leszcz, 2005) it can be difficult to tailor sessions to largely undiscussed individual need, especially if facilitators have not previously assessed the patients in their groups. It might therefore be that, from the patients' perspectives, irrelevant content or unhelpful group processes are incorporated into every run through, even when outcome measures are suggesting that the groups are effective.

The present study is a series of interviews with patients who attended psychoeducative groups for both anxious and depressive symptomatology delivered within IAPT. It was designed to understand what patients take away and incorporate into their lives after the group ended. In order to allow them to assess the impact of the group experience, participants who had met service defined criteria for recovery at group end were recruited six months (plus or minus two months) after group end.

The study also explores whether patient experiences, both helpful and unhelpful, of treatment share commonalities that might impact on the outcomes achieved at both treatment end and in maintenance beyond treatment. The study is intended to increase understanding of what patients perceive as useful in such interventions and how this can be used to adapt them in future.

Qualitative methodologies allow for an in-depth understanding of a population's experiences and are often used when its views are not well known (Flick, von Kardoff, & Steinke, 2004). Thematic analysis, a method for identifying and interpreting patterns in qualitative data (Clarke & Braun, 2013) was chosen as it is a method not linked to a particular epistemological position or theory of language and meaning (Braun & Clarke, 2006). Participants in the study were interviewed using a semi-structured format and their responses analysed using Braun and Clarke's method. This allowed questions generated from initial participant interviews to be explored with later participants when it was noted that they were helpful to the aims of the study.

Quantitative data can be incorporated into qualitative studies to provide both descriptive statistics and to allow outcome analysis if the data are amenable to this. This can lend weight to the conclusions drawn and is particularly helpful when, as in this case, a study is analysing a process of change (Kelle & Erzberger, 2004). Participants were asked to complete at interview the measures of symptomatology they had been given whilst in their groups and these were analysed to see if symptomatology had changed since their group had finished.

Research questions

The main research questions were:

1. In retrospect, what did participants find helpful in being part of a psychoeducative group?
2. Were they able to transfer learning, both formal and informal, from the group into their lives and if so, how has this been useful to them?

Method

Setting

The setting was an IAPT service run by an NHS Foundation Trust covering a county near London. The trust ran an IAPT pilot site in 2007 that covered part of the county and the service was extended to the whole county in 2008. In 2009 the service began offering psychoeducative groups. These groups are of five or six sessions with typically 8-16 patients per group. They are usually facilitated by two Psychological Wellbeing Practitioners (PWP). PWPs are usually graduates with a background in Psychology or a related discipline. They undertake a post-graduate diploma in CBT-based low-intensity interventions during their first year in post.

Within the county the service is divided into four regions and participants were recruited from two regions. Within the last year these regions had both offered a series of five session psychoeducative groups for clients with symptoms of depression or the common anxiety disorders: generalised anxiety disorder, panic or phobia. This meant all participants had experienced the same material in their group although facilitators and group composition varied.

Recruitment

Participant inclusion criteria

In order for participants to have had sufficient time to have integrated what, if anything, they took from the group into their lives, potential participants were

identified as people where six months (plus or minus two months) had passed after their group finished. As the study was investigating what patients had found helpful in and from the group, potential participants were drawn from people who had shown clinically reliable benefit from their group, having come to it meeting caseness for depression and/or anxiety as defined by IAPT (2012). This is a Patient Health Questionnaire 9 (PHQ-9: Kroenke, Spitzer, & Williams, 2001) score of >9 for depression and a Generalised Anxiety Disorder Questionnaire 7 (GAD-7: Spitzer, Kroenke, Williams, & Löwe, 2006) score of >7 for anxiety. To determine clinically reliable benefit, this study followed the approach taken by Richards and Borglin (2011) in their two year prospective cohort study which evaluated a large IAPT service. They calculated reliable change criteria, as outlined by Jacobson and Truax (2001), as a six point drop on the PHQ-9 or a five point drop on the GAD-7 between the first and last session of an intervention. Potential participants therefore needed to have shown this change by group end.

Potential participants were excluded if they thought they might know the researcher, either personally or professionally, as the researcher had previously worked as a PWP in that service.

Recruitment pathway

As IAPT services are mandated to collect the minimum data set (IAPT, 2012) and store it on database software where each patient is assigned a unique identifier, it was possible to anonymously identify 48 potential participants who met the inclusion criteria discussed above. This group was passed to the clinical staff within the service who were asked to contact them using a brief protocol (Appendix 2). In summary this meant calling each person on their list up to three times to try to make contact before moving to the next person on the list. If contact was made they briefly introduced the study, determined if the person would consider taking part and checked the person did not know the researcher. To avoid staff contacting 'favourite'

patients first, the list of potential participants was randomly sorted by the researcher into a contact order before being passed to staff.

If the person wished to take part in, and was eligible for, the study, contact details were passed to the researcher. The researcher then contacted potential participants to further discuss the study. If they were happy to proceed, an interview time and venue was arranged. The participant information sheet (Appendix 3) was sent out to participants in advance of the interview and this was gone through again with them before the interview began. After being given the opportunity to ask questions, participants signed the consent form (Appendix 4) as part of the informed consent process. Figure 1 shows the participants' journey through the recruitment process.

Participants

Fifteen people (11 women, 4 men) were interviewed. Their mean age was 40 (range 20-68) at group end. Twelve gave their ethnicity as White British, one White – any other background and two as Indian. There was a wide range of occupations and educational attainment (Table 1).

Participant demographics were broadly in line with the demographics of the 33 potential participants who did not take part (24 women, 8 men, 1 unknown gender; mean age 40 (range 18-68) at group end; 24 White British, 1 White – any other background, 1 Indian, 7 ethnicity unknown). In turn this is similar across age and ethnicity to the 41 patients who completed the same intervention in the recruitment window but did not meet recruitment criteria (mean age 43 (range 21-76) at group end; 32 White British, 1 White – any other background, 8 ethnicity unknown). However the approximate 3:1 female:male gender ratio is not replicated, being closer to 1:1 (22 female, 19 male).

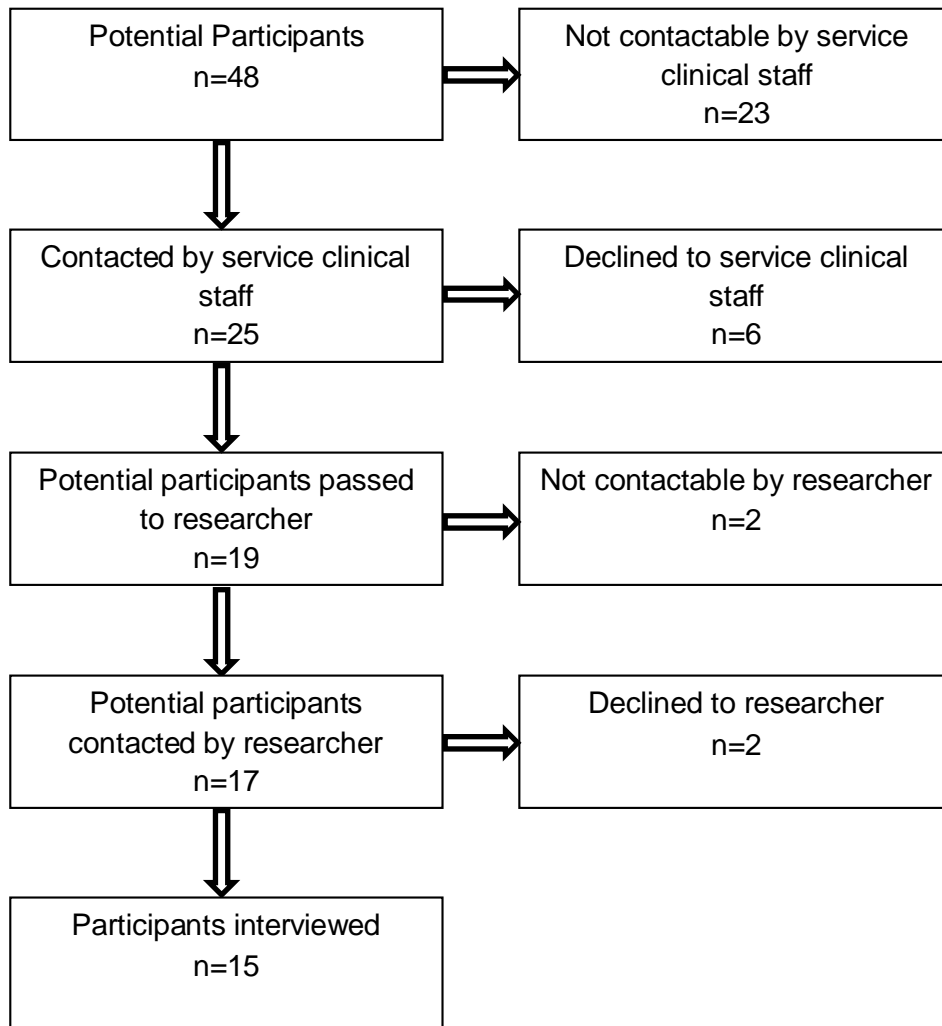


Figure 1: *Participants' journey through the recruitment process*

Distributions of PHQ-9 and GAD-7 scores at group start and group end for the 33 potential and 15 actual participants were examined. No significant differences were found (Table 2).

Ethics

Ethical approval was granted for the study by the NHS Health Research Authority, East of England Committee (Appendix 5), the Research and Development department for the Trust in which the research was carried out (Appendix 6) and the Joint Research department at University College London who sponsored and insured the study (Appendices 7 and 8).

Table 1: *Participant demographics*

ID	Gender	Age	Ethnicity	Employment status	Highest educational attainment	Participant perceived presenting concern
1	M	48	W. British	Employed	'O' level/CSE/GCSE	Depression
2	F	27	W. British	Unemployed	Degree	Anxiety with panic attacks
3	M	31	W. British	Employed	HND/Diploma	Stress
4	F	28	W. British	Employed	'O' level/CSE/GCSE	Panic attacks
5	F	20	W. British	Employed	'O' level/CSE/GCSE	Anxiety
6	F	40	W. British	Employed	Degree	Anxiety and low mood
7	M	68	W. British	Retired	'O' level/CSE/GCSE	Depression after bereavement
8	F	43	W. British	Disabled	'O' level/CSE/GCSE	Depression and relationship difficulties
9	F	44	W. British	Employed	'O' level/CSE/GCSE	Depression
10	F	34	W. British	Employed	NVQ/BTEC/HNC	Anxiety
11	F	50	Indian	Home Maker	'O' level/CSE/GCSE	Stress
12	M	47	W. British	Employed	Degree	Anxiety and insomnia
13	F	42	Indian	Home Maker	Degree	Depression
14	F	43	W. British	Employed	Degree	Anxiety and depression
15	F	60	W. - AOB	Unemployed	'O' level/CSE/GCSE	Depression due to chronic ill-health

Table 2: *Actual and potential participants' PHQ-9 and GAD-7 scores compared*

	Participants' medians and ranges		Mann-Whitney U Results		
	Potential	Actual	U	p	r
PHQ-9 scores pre-group	13 (4-24)	14 (7-22)	244.000	0.938	0.011
PHQ-9 scores post-group	3 (0-15)	5 (2-18)	215.000	0.463	0.106
GAD-7 scores pre-group	13 (5-20)	13 (6-19)	245.000	0.955	0.008
GAD-7 scores post-group	4 (0-17)	4 (0-13)	240.000	0.867	0.024

During the interviews two participants became distressed but after assuring them the interview could be terminated and checking they were happy to continue, both completed the interview.

All participants completed the measures of symptomatology and the researcher scored them before leaving. One participant met caseness for anxiety as measured by the GAD-7. This was discussed with the participant and he was advised as to how he could seek help.

Intervention

The service received self-referrals, GP referrals and referrals from Job Centres and other local organisations. Participants were all GP referred apart from one referred via the Job Centre. Once referred, patients spoke to a worker by telephone or in person who collected the IAPT data set (IAPT, 2011b) and, if appropriate for the service, offered an intervention based on presenting problems, symptom severity and past history of successful or unsuccessful therapies. If the patient was deemed suitable for a 'low intensity' intervention they would have been offered bibliotherapy, computerised CBT, a psychoeducative group or one-to-one guided self-help. The latter was usually only offered if the other approaches had been tried or the patient was unwilling to otherwise engage. The participants in this study all opted for the group available in their area of the county, although as discussed later, some would have taken one-to-one help if available.

This particular psychoeducative group was offered to patients with both symptoms of anxiety and/or depression and covered the following topics across the sessions with inter-session tasks suggested after sessions 1-4:

- 1 Introduction, What is anxiety and depression, what is CBT (hot cross bun model), goal setting, life-style changes (sleep, exercise, nutrition)
- 2 Behavioural activation
- 3 Graded exposure, breathing and relaxation, worry time
- 4 Challenging unhelpful thinking
- 5 Problem solving, planning for the future, reviewing CBT skills learned

After the group, participants were offered a review session with either a group facilitator or the worker who had assessed them for the group. This was either by telephone or in person.

At each session patients completed the measures of symptomatology from the IAPT data set (IAPT, 2011b).

Measures

The measures used in this study to determine eligibility and provide a quantitative description of the sample form part of the data collected by IAPT services (IAPT, 2011b) and are as follows:

Patient Health Questionnaire 9 (PHQ-9: Kroenke et al., 2001; Appendix 9). Used for determining depressive symptomatology and caseness, this is a nine item scale that asks how often over the last fortnight the individual has been bothered by each symptom such as 'little interest or pleasure in doing things'. Responses range from: 0 = "Not at all" to 3 = "Nearly every day" (scoring range of 0–27). A cut-off score of 10 is optimum for identifying depressive symptoms likely to be of clinical severity (Kroenke et al., 2001). Cronbach's alpha is 0.89 (Kroenke et al., 2001). It

has been validated in a UK depressed population (Cameron, Crawford, Lawton, & Reid, 2008).

Generalised Anxiety Disorder Questionnaire 7 (GAD-7: Spitzer et al., 2006; Appendix 9). Used for determining anxious symptomatology and caseness, this is a seven item scale that asks how often over the last fortnight the individual has been bothered by each symptom such as 'not being able to stop or control worrying'. Responses range from: 0 = "Not at all" to 3 = "Nearly every day" (scoring range of 0–21). A cut-off score of eight is optimum for identifying anxious symptoms likely to be of clinical severity (Spitzer et al., 2006). Cronbach's alpha is 0.92 (Spitzer et al., 2006). It has been validated by Löwe et al. (2008).

Interviews

Participants were interviewed for approximately an hour on NHS premises or in their own homes. Interviews were digitally recorded after confirming participants' consent to this. Participants were reminded that their responses were confidential and that an honest appraisal of their experience would be helpful in improving future groups. They were asked to complete measures of symptomatology and a form to capture demographic data (Appendix 9) but reminded this was not essential and their interview could be used without them. All participants completed the measures. They were reimbursed £10 for their time and travel expenses to and from the venue were refunded.

A semi-structured interview schedule covered the following topics (Appendix 10):

- 1 Participants' entry to the group and their preconceptions
- 2 Participants' experiences in the group
- 3 Changes for participants at group end
- 4 Participants' recall and use of techniques post group
- 5 Participants' reflections on the overall experience

6 Debriefing on the interview and invitation to review findings

During each interview the researcher also used follow-up questions to expand upon salient points raised by the participant. Interviews were transcribed verbatim and any material that might identify participants or workers in the service was removed. Recordings were destroyed once transcribed.

Research team

The research team comprised myself as researcher, a 46 year old Trainee Clinical Psychologist, and two supervisors. The supervisors are both Clinical Psychologists. One was a Professor of Clinical Psychology at University College London who acted as my internal supervisor. The other was Lead Clinician for the service where the research took place. He acted as my external supervisor. The team were all White British males.

Researcher affiliations

Prior to beginning clinical training I had worked in the service being researched and had facilitated psychoeducative groups, although not in the parts of the county where this research took place. I was curious at the time as to what patients had taken from the groups I had facilitated and whether they had used ideas post-group. My belief was that they found groups helpful for both the experience and content but, following qualitative research approaches, I attempted to 'bracket' these assumptions (Creswell & Miller, 2000) so as not to influence the interviews and analysis.

Analysis

Quantitative

Demographic data provided descriptive statistics for comparing the characteristics of the sample against the population from which it was drawn. Similarly measures of symptomatology were analysed to see whether scale scores

varied significantly between the sample and potential participants who did not take part (Table 2 above).

Measures of symptomatology collected at interview were also used to determine if, for each participant, the clinically reliable benefit seen on one or more measures of symptomatology at group end had changed.

Qualitative

Interview data were analysed using thematic analysis as described by Braun and Clarke (2006). The researcher took an essentialist stance; accepting that what the participants said reflected their actual experiences and ways of making sense of what they had learned (Dyson & Brown, 2006).

Initially, each transcript was read more than once to gain an overview of the data. Subsequently transcripts were examined line by line and ideas and units of meaning recorded using NVivo 10 software (QSR International, 2012) (Appendix 11). The codes were then assembled into subthemes that were related to the research questions or were particularly emphasised by a participant (Appendix 12). Once this was complete for all participants, the subthemes were collectively examined and integrated into superordinate themes. These themes were examined in light of the research questions and a thematic structure decided upon.

Throughout the analysis the raw data were repeatedly revisited and codes and subthemes modified if appropriate, in order to ensure that themes were grounded in the data and not in the researcher's preconceptions and prior assumptions (Flick, 2006). To further enhance credibility and validity in accordance with good practice guidelines suggested by Stiles (1999), the following steps were taken.

Following Creswell and Miller's (2000) concept of member checking, significant subthemes were sent to all participants who had agreed to review the findings from their own interview in the form of a brief summary letter and response

form to return (Appendix 13). They were asked to comment on the validity of subthemes, whether they wished to change the emphasis placed on subthemes and whether they wished to comment further on subthemes, their experience of the group or the interview process. Five participants responded. Four said the subthemes fully captured their views and one said the subthemes captured quite a lot of their views. No one suggested anything was missing or made any additions.

In accordance with Flick's (2006) suggestion to avoid individual researcher bias influencing the analysis, coding and subthemes constructed by the researcher were discussed with the internal supervisor during the analysis. After interviews were transcribed the internal supervisor read through transcript summaries with the associated subthemes. The internal supervisor then read through the superordinate themes and made suggestions for amendment and to revisit the raw data when themes seemed unclear or tenuous. Once the researcher and internal supervisor had an agreed set of themes, these were sent to the external supervisor for review and comment. Following this the final thematic structure was created.

Results

All 15 participants were able to recall considerable detail about the experience of the group they attended and the impact upon their lives during participation and since completion. Participants spoke freely with minimal prompting, and most seemed willing and able to reflect upon their experiences, giving both positive and negative opinions. All participants completed measures of symptomatology at the end of the interview.

Descriptive analysis of clinically reliable benefit

Descriptive data were used to evaluate whether the clinically reliable benefit seen on one or more measures of symptomatology when participants left the group was maintained. Clinically reliable benefit is defined here as a six point drop on the

PHQ-9 or a five point drop on the GAD-7 between the first and last session of an intervention and indicates a reduction in depressive or anxious symptomatology (Richards & Borglin, 2011). These results are shown in Table 3 and plots of scale scores for each participant at the three time points comprise Figure 2.

At group end all 15 participants had shown clinically reliable benefit on one or other measure, with 11 (73%) participants showing clinically reliable benefit for depressive symptomatology and 12 (80%) for anxious symptomatology. At interview this benefit was now shown for 13 (87%) participants with depressive symptomatology and for 14 (93%) participants with anxious symptomatology. Three (20%) participants had gained further benefit for depressive symptomatology between group end and interview and one (7%) had lost benefit. For anxious symptomatology three (20%) participants had gained further benefit between group end and interview and one (6%) had shown clinically reliable deterioration.

At group start 12 (80%) participants met caseness for depression. At group end 13 (87%) participants scored below caseness for depression and by interview all participants scored below caseness for depression. At group start 12 (80%) participants met caseness for anxiety. At group end 13 (87%) participants scored below caseness for anxiety and by interview 14 (93%) participants scored below caseness for anxiety. Two (13%) participants who had met caseness at group end no longer did so and one (7%) now met caseness.

Table 3: Clinically reliable benefit for each participant

	Participants														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
<i>PHQ-9</i>															
Score at T1 - group start	21	8	11	11	18	11	11	16	8	16	7	14	16	16	22
Score at T2 - group end	3	2	3	6	9	2	3	5	3	9	5	2	10	5	18
Score at T3 - interview	4	1	2	2	0	2	7	7	0	6	4	0	4	2	9
Clinically reliable benefit T1-T2?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No
Sub-clinical at T2 - group end	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Clinically reliable benefit T1-T3	Yes	Yes	Yes	Yes	Yes	Yes	No**	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Sub-clinical at T3 - interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Clinically reliable benefit T2-T3?	No*	No*	No*	No	Yes	No*	No	No*	No*	No	No*	No*	Yes	No*	Yes
<i>GAD-7</i>															
Score at T1 - group start	18	13	13	15	18	12	18	7	9	12	11	15	6	7	19
Score at T2 - group end	3	1	4	2	7	6	5	4	1	7	4	0	8	3	13
Score at T3 - interview	1	2	2	2	1	2	13	3	3	6	2	0	3	2	6
Clinically reliable benefit T1-T2?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes
Sub-clinical at T2 - group end	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Clinically reliable benefit T1-T3	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sub-clinical at T3 - interview	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Clinically reliable benefit T2-T3?	No*	No*	No*	No*	Yes	No	No***	No*	No*	No	No*	No*	Yes	No*	Yes

*T2 scale score below a point where further reliable benefit could be determined at T3

**Participant had lost clinically reliable benefit by interview

***Participant had shown clinically reliable deterioration since group end and met caseness for anxiety

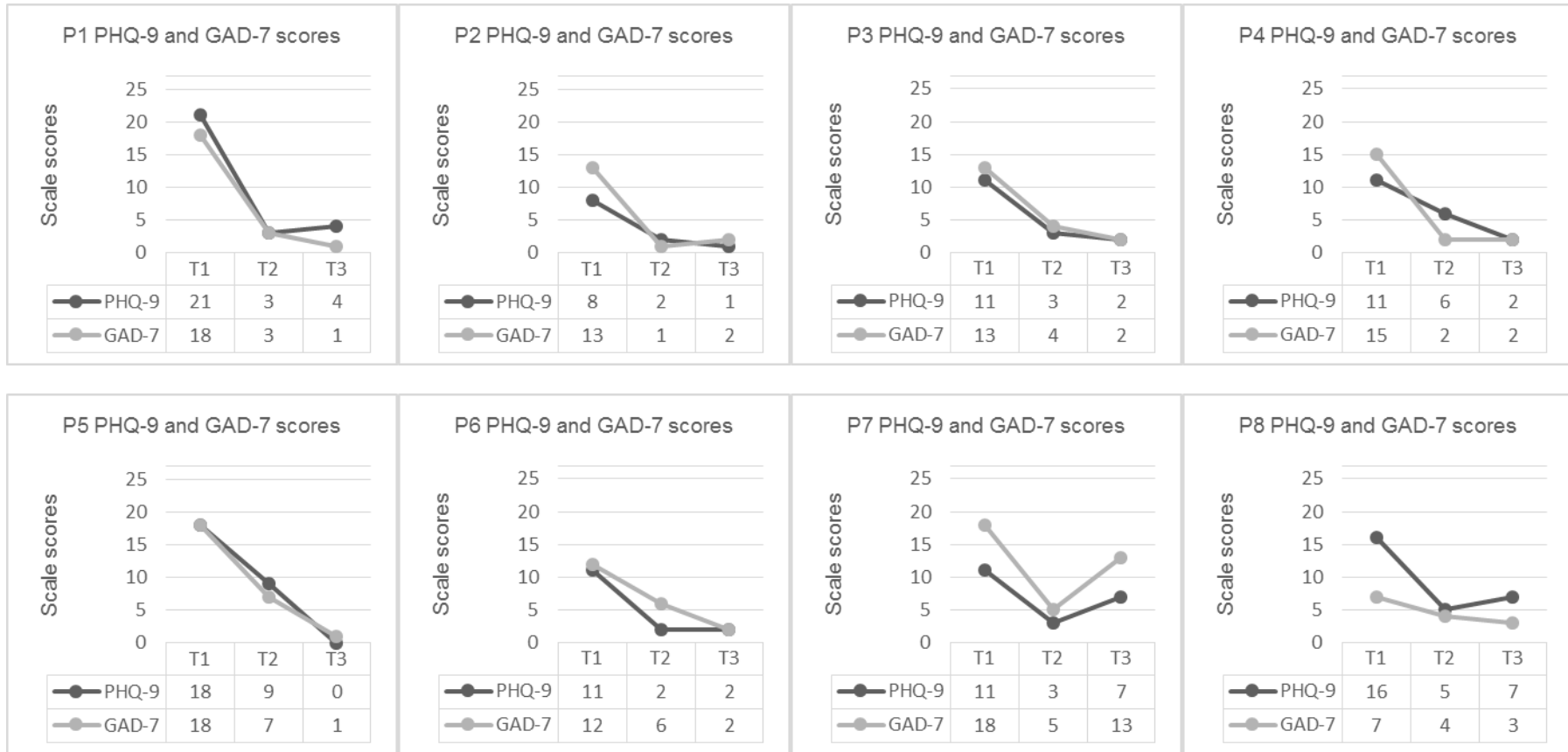


Figure 2: PHQ-9 and GAD-7 scores for participants at T1, T2 and T3

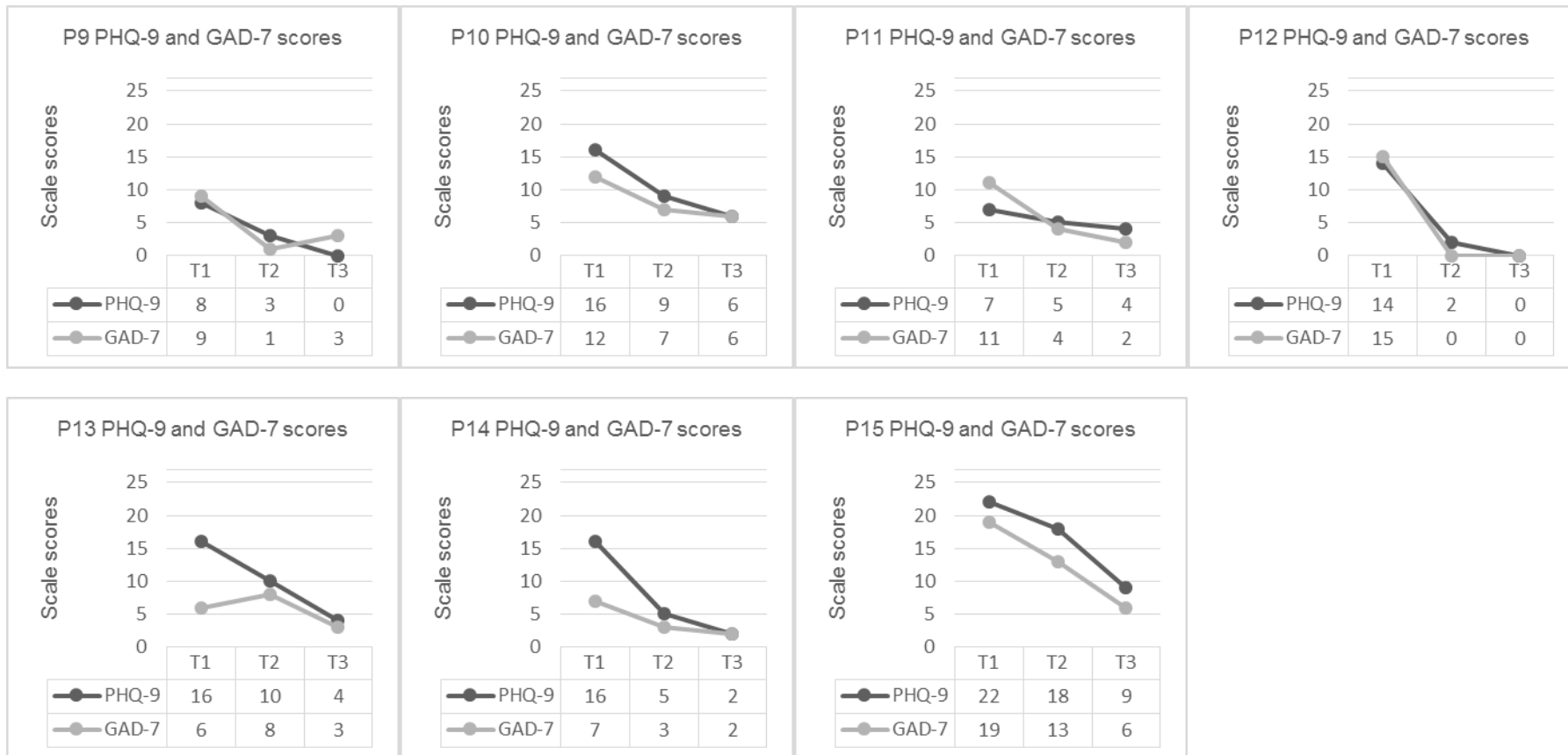


Figure 2 cont.

Qualitative analysis

Analysis of the 15 interview transcripts yielded 11 distinct themes covering the expectations about the group, the process and content in the group and reasons for change (Table 4). These are presented in the text with consideration of both frequency of participants' references to them and the stances they took. The prevalence categories are deliberately broad as it is unrealistic to accurately quantify what is a subjective process.

Clinical context

Six participants recalled either not being offered an alternative choice of treatment or being advised that an alternative could be offered if they found the group unhelpful. The other nine said they were offered something else such as computerised CBT or one-to-one therapy but preferred the group format. After finishing the group the majority of participants did not seek further help, but three chose to seek out more therapy, two opting for counselling and one for one-to-one CBT. One participant said she was expecting to be referred for one-to-one support after the group but was not contacted again. Eight participants missed one session.

Presentation of themes

Domain 1: Expectations. All participants spoke about their expectations prior to joining the group. As discussed above, six participants recalled the group being their only option but even those who made a choice to come to the group expressed both concerns and hopes about what it would offer. The majority of participants had some knowledge about what they might expect in terms of content and structure gained from their assessment session with the service but recalled being less sure about what other patients would be like and how the group could meet their needs.

Theme 1.1: Sitting and listening. Typically participants expected that they would be attending a class where active participation would be voluntary. This was seen as reassuring, as for most people the idea of having to speak out was

Table 4: *Domains, themes and subthemes*

Domains, themes and subthemes		Prevalence*
<i>Domain 1. Expectations</i>		
1.1.	How much will I have to reveal to others?	General
	Sitting and listening	Typical
	Unstructured group therapy	Variant
1.2.	What will other people be like?	General
	Meeting 'crazy' people	Typical
	People like me	Variant
	The other people are irrelevant	Rare
1.3.	Meeting my needs	General
	Learning new skills	Typical
	Finding help from others	Variant
	Being in the wrong group	Rare
<i>Domain 2. Group process and content</i>		
2.1.	Fitting in with other patients	General
	They were ordinary people	General
	Helpful common ground	Typical
	Not connecting to others' problems	Variant
2.2.	Sharing experiences and knowing each other	Typical
	It was helpful to talk	Typical
	We could have been closer	Variant
	Keeping apart	Rare
2.3.	Helpful and hindering factors in learning	General
	Learning from the facilitators	Typical
	Group structure	Typical
	Approachability of facilitators	Typical
	The facilitators' belief in the material	Variant
	Teaching pace	Variant
	Personalising the material to me	Variant
2.4.	Course content	General
	Finding something that helps	Typical
	It wasn't therapy	Typical
	New ideas and skills	Typical
	Reconnecting to common sense ideas	Variant
	Practicing skills may not be necessary	General
2.5.	Ideas for improvement	General
	More sessions	Variant
	More people like me	Variant
	Help us work together	Variant
	Help me stay in touch with others	Variant
	Reconvene to refresh the learning	Variant
<i>Domain 3. Change</i>		
3.1.	CBT as an agent of change	Typical
	Conscious skills use	Variant
	Not seeing ideas as relevant	Rare
	Internalising the method	Typical
	Building on what was taught	Variant
3.2.	Change coming from the group process	Typical
	Realising I was not alone	Typical
	Discovering my problems were not so bad	Typical
	Sharing experiences since	Typical
	Finding a new way to look at difficulty	Variant
3.3.	Areas of change	Typical
	Internal change	Typical
	External change	Typical

* General: applies to all or all but one participant, Typical: applies to over half the participants, Variant: applies to less than half the participants, Rare: applies to one or two participants. In some cases a theme encapsulates a range of opinion and this is discussed in the text

remembered as somewhat daunting. For some it made the group more appealing than other options.

I think it was just easier to kind of go somewhere and sit and listen to things they could tell me and I could quietly do things rather than having a big kind of personal chat. [P6]

A variant on this theme was a belief that the group would be unstructured and require people to self-disclose as a major component to the therapy. This was always recalled as being anxiety provoking and often given as a reason why one-to-one treatment might have been preferred.

I suppose I pictured that we'd be sat round in a circle, and everyone would be talking about their problems. And then there'd be somebody leading the class who would then say "Right, well, what we need to do with this issue is..." [P3]

I was a bit concerned that there would be some people who would sort of hog the limelight and that there would be people that would just be talking about their feelings the whole time. [P14]

Theme 1.2: What will other people be like? Participants had all wondered beforehand about the other people they might meet and they often recalled being anxious about what to expect in other group members and this in turn typically reflected a concern about how their own mental health was, or might be, viewed by others. Over half the participants admitted that they had been concerned that other group members would have mental health problems that would be visible to others.

At our first session of the group, somebody turned round, I think at the coffee break, and said, "I thought it'd be a load of nutters". And in fact it was just a wide range of people. So, to be honest I had no idea what to expect. You know, I wondered whether I was going to the right place, whether it would be as the lady said, full of the, it's not a very correct term but full of people with very severe problems. [P12]

It sounds funny but crazy people. You think you would meet crazy people. [P5]

A variant on this position was taken by some participants who had imagined they would meet people similar to themselves and this could be a positive experience.

I've had experience with quite a few people in either my family or a group of friends who have had problems. So, I don't think that I was expecting any one particular type of person to be there. [P6]

I suppose I kind of expected it to be people like myself, that were in high pressurised jobs, that were having full on lives, like me ... Taking this step is actually something that's going to support you and help you and I felt that that was better done where you hear how the people have done it and how they dealt with something. [P9]

A rare position taken was that the other people in the group did not matter to the participants; they expected to have little interest in what others were like or what could be gained from them.

If I'm honest with you I didn't really care if I'd been the only one that had it or everyone had it. I just didn't want to have it anymore. [P4]

Theme 1.3 Meeting my needs. Participants all recalled hoping that the group would meet their needs and almost all conceptualised that need as something appropriate for a psychoeducative CBT group. Typically people described wanting to learn skills or techniques to overcome anxious or depressive symptomatology.

I had had one to one counselling with a CPN for several months, and I felt like I didn't really get anywhere with it ... So I didn't want to go down that route again, because I thought I could just feel myself getting stuck in a rut. I wanted practical ideas, so the CBT group sounded ideal because I thought, that's what I want, I need things I can do to help. [P14]

However few participants, despite being briefed about the group at assessment, had a detailed idea of content.

She'd given me a bit of an idea but ...no, I hadn't expected kind of so many tools and different techniques. [P6]

A significant minority of participants spoke about hoping that help would (also) come from being with other people. This was often couched in the language of hoping to share common experiences.

Through work I'd gone on courses, you know, because you have to do bereavement counselling, HIV counselling, things like that. And I found that, in a group, to be very helpful, because you've got other people, their ideas bouncing. [P15]

Two participants recalled feeling they had been given the wrong option before the group began. Both described presenting problems, which although giving

rise to anxious and depressive symptoms, might have fitted better with another therapeutic option.

Well, I suggested maybe half a dozen one to one counselling type of thing.
[P7]

I was depressed in a way, but that wasn't the major thing. [P7]

Domain 2: Group process and content. This was the predominant area to which participants returned during interviews. There were clear views expressed about the other participants and how this impacted upon their own gains from the group. People also spoke widely about group structure and the delivery and content of the material. Many people offered ideas for improvement or change as they reflected on their experiences during and since treatment.

Theme 2.1: Fitting in with other patients. All participants had views as to how well they felt people came together as the group progressed. For most people it was a pleasant and helpful discovery that others were, in the main, ordinary people.

...one or two that you would actually pick out and go, "Yeah, I know why you're here". But literally only one or two, the rest of them, you could see them on the school run and you wouldn't know any different. [P10]

For several participants the diversity of age, gender and life experience came as a surprise, but only rarely did participants suggest this was unhelpful.

It's strange because there was all different ages. I think I was the youngest. There was a lot of older people, middle-aged, and it was all really comfortable to try and talk to them and they explained how they're feeling and you completely understand because you've been through it yourself.
[P5]

Seeing others as similar in some ways to themselves helped the majority of participants to find common ground with others and this in turn was seen as beneficial, usually for normalising their own experience through realising others had similar or worse problems.

I could sit there and whether it be a lady or a man you know, they'd say something and I'd think "Ah I know exactly what you're saying." And then another one might say, and I'm sitting there going "Yeah I've been there..."
[P1]

There were variants to this position. Several participants found it hard to see commonalities with others and this in turn made it difficult to draw upon others' experiences for their own benefit.

I felt quite indifferent about them. They were all there ... all had valid reasons, from what I remember, most of them were working, whereas I don't work. And they were trying to just juggle very busy lives with their issues, and I didn't feel that, I guess because I'm not employed I felt I didn't have some of the issues that they had. And so I couldn't relate to this ... their work causing the issues that were causing them to be there, because, for me, that factor wasn't there at all, I wasn't stressed because of work, I wasn't depressed because of work, I was there for something completely different. [P13]

Theme 2.2: Sharing experiences and knowing each other. Participants often described feeling alone and uncertain when first joining the group but this typically evolved into feeling comfortable in being there, through the discovery that it was helpful to talk to others. Often this led to shared experience that enabled participants to think about ways to manage their own problems, whether through discovering new ways to cope or simply through an opportunity to connect socially to others.

I was trying to conceal it and see how other people coped. And, in a way they were coping, they were giving strategies which I think were very helpful in the way that you wouldn't have thought of doing yourself if you hadn't attended the group. [P11]

To actually have somewhere to be for actually a time, for a set time, actually gave me a focus, for those few weeks, and there was a couple of people in the group that were really nice, because it was nice weather, you'd go outside and have your cup of tea and stand outside. [P10]

A variant on this theme was expressed by several participants who felt their group could have been more cohesive and in turn this would have been beneficial.

I remember thinking if I don't talk, I'm not going to get anything out of it and I was one of the main people that did talk in the group. But I remember thinking a lot of the people didn't speak much at all and I thought if they're not really talking, how are they getting anything out of it. I was surprised at how quiet some of the people were. [P8]

An infrequent but notable perspective was taken by a few participants who felt that they wanted to stay apart from others. However it seemed that this was due to a belief that they did not 'fit' with the group rather than a belief that to know others would be unhelpful.

But also part of me in there held back a bit because I had probably by the end of the first session or second session maybe had decided that I'm not as bad as some of these people in here ... And I felt that mine was quite a sort of almost, you know, Mickey Mouse situation. [P13]

Theme 2.3: Helpful and hindering factors in learning. Participants all recalled aspects of the learning process that they found more or less useful. This came across as both recollected more clearly than the material they had been taught and of seemingly greater importance. Much discussion was related to how the facilitators delivered the material, with most participants happy with the process.

I thought they were really exceptional, really nice girls that through their own knowledge and through the way they were taught how to run the sessions, they were really informative and really good, really helped a lot, from my point of view. [P11]

Because it was just explained very simply, very eloquently. [P2]

The group structure was usually described as resembling a class, presentation or seminar and this was a welcome and comfortable approach for the majority

So it is just bullet-pointed which is the best way, and then they talk about it, and they ask a question, and we're given time to ask a question. So yeah, and I liked that, and I liked the whole brainstorming thing as well, getting everybody involved. [P3]

There were a few dissenting voices.

I am a great believer in you sort out quite a lot of problems yourselves with a bit of guidance. I think it was a little bit too led, and I think ... I think some of the people might've found that format quite threatening, in a way. [P12]

The majority of participants found the facilitators approachable on a one to one basis and this was often cited as being helpful in reinforcing what was learned.

Because I think just specifically one of the tools I really couldn't understand and we kind of had a little chat during the class and we just sort of said, take it offline and think about it afterwards, which we did and five minutes of one to one and I was back on track again. [P9]

Within this theme several participants noted that the facilitators seemed to believe in, and perhaps use, CBT ideas themselves and this was a powerful reinforcer of the credibility of the content.

They said they had used them all in their training, they'd actually put them into practice to work out how they would work and so therefore they could tell you about the anxiety triangle and how to sort of do the simulation thing and all the rest of it. Yeah, knowing they at least have put them into practice helped. [P10]

The pace of teaching was recalled as influencing the learning by several participants but there was no clear consensus as to an ideal. For some it was too fast; for others there was too much repetition and revisiting material discussed earlier.

It does seem as though they've got to cram an awful lot of information into that short amount of time. So perhaps that's the reason why I mean I myself didn't grasp all of it. [P1]

We went back over what we'd learned the week before for the first half an hour of this session. I thought we did this last week. Yet we did more examples of what we'd already done the week before. And I thought OK have a little recap because people forget but the recap was too long [P4]

Several participants recalled moments within the course that felt uniquely personal to them; these were often emphasised as one of the key learning points they had taken away.

The main one that [group facilitator] told me was because we often got together afterwards and we were standing there talking and she was saying "Do you know a lot of it is out of your control, that's the way you've got to look at it, it's not your problem, it's your company's problem. It's not your problem it's theirs". And that's what I'll use. [P1]

Theme 2.4: Course content. Participants all commented on aspects of the content, reflecting on their recall and understanding of the material, although often recalling precisely what had been taught was difficult and seemed less relevant to participants than their perception as to whether the group had simply felt beneficial or not. That said most participants could recall a specific example of a CBT technique and, with a few exceptions, suggested it had been, or still was, helpful.

I think everything they said, you could put into practice at, maybe not at that specific time I was attending the classes, but to take away with me. [P11]

The understanding that the course had been skills acquisition rather than therapy was made explicit by the majority of participants and seemed to be welcomed by most.

This is about giving you some tools to go off and try and help yourself, basically, which, at the end of the day is, you know, is what we need, to be able to support ourselves. [P9]

Typically participants described at least some of the techniques as new ideas or skills and usually recognised some helpful benefit.

I remember the circles where behaviour leads to physical leads to emotional links. You know they all go round and round and I do bear that in mind because I think to myself sometimes with my panic attacks, I used to feel really sick when I first started getting them. And I used to associate and the nauseous feeling with the panic attack. So even if I'd eaten too much, and I felt sick because I was full, I would automatically think "Oh my god I'm having a panic attack, not just you've eaten too much that's why you feel sick". So that kind of chart, the hot cross bun, there you go, just remembered it, that helped me remember actually no you're not having panic attacks don't let what you're feeling physically turn into mentally... [P4]

However this subtheme was polarised, with a small minority suggesting the new ideas were of little or no relevance to them.

But as for what I would use from what they told us, although I've listened to what they said, I don't actually use it on a day to day basis. [P1]

A minority of participants, when discussing the course content, were explicit in noting that the ideas were not new to them. They framed them as common sense; lost because of their current difficulties.

... the CBT process, which I found to be something that I did have in me, and I'd kind of forgotten to use it. I think it's something that people normally use. And it had gone. [P12]

All participants recalled being given suggested tasks or skills to practice between sessions. Typically they noted that it had been made clear that these were optional and no one recalled being encouraged to try them. Even so, just over half the participants said they made a conscious effort to try most of the tasks, although everyone said not all had felt relevant and there was a notable sense of it feeling more akin to a chore than a way to reinforce helpful learning.

I was terrible. No, I would do it and look at it. It's a bit like being back at school. I'd probably sit in the car just before the session and fill something in. That was ...I would do it when I wasn't working but when I got back to work, I didn't really have time to. [P6]

A small minority of participants attempted few if any tasks between sessions and these were always individuals who had felt strongly that the group at best only tangentially offered material directed towards their perceived needs.

They used to give us homework to do as well, which I'm afraid I didn't do much of it. Some of it I couldn't make head nor tail. Some of the things I didn't enjoy doing at all. [P7].

Theme 2.5: Ideas for improvement. When considering if the group could be changed in any way, all participants were enthusiastic in offering suggestions. There was no majority opinion as to a specific change but ideas did coalesce into several discrete categories. No one thought the group was too short and a substantial minority suggested adding further sessions. This was usually expressed as a want to consolidate learning rather than add extra knowledge but also seemed to be a recognition for some that the supportive nature of the group ended too soon.

After six (sic) sessions, it doesn't feel like it's enough. I feel that they've given you enough information but I think you still, at the end, you still need that push so you don't give up and you don't stop it, just after you finished the session. [P5]

A small minority of participants concluded that attending a group where people presented with a wide range of problems was less helpful than if the group had comprised more people with similar issues. This seemed related to how they conceptualised their problem as it was a view expressed by people who saw themselves as having a bounded problem, such as panic or a health or workplace issue, as opposed to low mood or anxiety.

I've been on parenting courses and we're in a group of people, parents, they may or may not work, but the children are the common factor, and it was almost reassuring to hear that one person's child's behaviour wasn't that dissimilar from what my children might have been doing. So if I'd been in a group for the CBT course where I felt I was possibly with people that were more on an equivalent level ... you know, comparable, possibly I would've drawn not strength, but more, just drawn more parallels from it and been able to sort of correlate the situations and that might've helped. [P13]

A substantial number of participants suggested the group structure or process might have been altered to help them feel more comfortable at the start although there was a recognition that talking in a 'mental health' setting might be

uncomfortable for them or others. Ideas included ice-breakers, small group working and intriguingly changing the seating structure from rows to a circle or 'round table' format. The latter idea was mentioned by several participants as a way to maintain the class feel but lessen the school room element of it.

If the tutors could come across and say, "Okay, you might feel very, you know, isolated at the beginning, but give it time and you'll, you know", so if something could be done on that first day, to make you feel more comfortable. [P15]

I think a circle would've been better, because you know, you come in, so everyone's kind of progressed towards the back. And you couldn't see people, so you were looking at the back of somebody's head. [P12]

Just under half the participants said they would have liked the opportunity to stay in touch with other people. Whilst no one suggested this was discouraged, it was never suggested by the facilitators but would have been welcomed by some as they felt they had connected on a personal level with other people.

Yeah. I think they should have. Yeah. I think that would have been a really good idea because, like I said, I got on really with a few people but obviously, I don't know who they are, where they come from or anything like that. [P5]

Whilst those who recalled having a one to one follow-up session with a PWP in person or by telephone seemed to find it helpful, there was a significant number of people who suggested it would be helpful if group members could be brought back together for something akin to a 'top up' session, to see how others had coped since and perhaps draw strength from shared successes.

I've got a lot from this, I feel much more positive than I did at the beginning, you feel like it's a shame that it's kind of ending. With regards to the actual tools that I got to come away with, I certainly felt that I got something from it. But yeah, I think it would've been good to have had a few more sessions. Or to have kind of a revisit session, so give it a couple of months and then come back. [P9]

Domain 3: Change. This was the third substantive area addressed in the interviews. All bar two participants thought they had changed in at least some way during the group or since it finished, with a majority attributing at least some of this change to having gone through the group. However a substantial minority also

ascribed positive change to shifts in life circumstances, such as difficulties with employers or family resolving or physical health improvements.

Theme 3.1: CBT as an agent for change. Over half the participants credited something in the course content for helping them change. For a minority of these people it was less a skill or technique but more a single idea such as realising that behaviour can influence mood or noticing a link between stress and poor sleep. Fewer than half the participants were continuing to consciously use a taught technique but some people did give concrete examples of use. Only one person had seen the idea of graded exposure as helpful and had not gone on to use it further but there were some people still actively using cognitive restructuring or behavioural activation.

I think about it. I don't write it down but I think about it.. I've become quite good at that. When I'm leaving work I'll say, "Right, that evening I'm going to do this", or, "This Saturday, I am going to ...", and I'm quite good at sticking to it, which, it's quite, what's the word? When you feel about quite good about actually achieving something that you set out to do, even if it's just mow the lawn. [P14]

I do have a black book at work, which ... a notebook, if I'm feeling, if I've got problems, if I feel I'm worrying about something too much, or getting myself bogged down with things, I write it in there, look at it, read it and think, look, is this really that serious? And just try and apply what I've learned to that. [P3]

A rarely expressed view was that nothing in the course in terms of CBT content was helpful but bearing in mind the participants were course completers who had shown symptom reduction, it is perhaps important to note that even within this group, for some, the material was not seen as appropriate to them or they felt they needed more support to implement ideas.

I do remember lots of other things that we did that weren't really relevant to me or my problems but I still remember them. [P4]

Because I thought it's all right while I'm doing it but when I leave, I forget about it all, I won't bother with it. [P8]

Something that became apparent in many interviews was that participants often suggested they did not use, or even recall, a technique but then went on to

describe how their life had changed in a way that appeared to involve the use of CBT ideas. Usually this was in terms of noticing links between behaviour, thoughts and mood or recognising and challenging unhelpful ways of thinking.

Some evenings I sit here, he's gone to bed and I get that horrible feeling in my chest and I think, you know what, just get on and do something else because it will go away. It's not going to be there for the next four days. [P2]

For a substantial minority of participants there was a recognition that to build upon what they had learned would need both practice and generalisation to other situations in order to be truly helpful. It appeared that these were also the participants who described the course as the most helpful and something to which they would return, either through conscious use of the ideas or through revisiting the materials they had taken away.

I've still got all the notes to the course, and I still every so often, if I feel that things are sort of sliding slightly then I'll always go back once a week, or whatever, just go through things and just, "Yeah, I'm doing this, I'm doing that" – just sort it out. [P3]

I was very interested in seeing what tools were given to me because I really didn't understand how I could manage this depression, because it was very much a slow progress, progression into it, I really didn't understand how or what it was that I could do to change that ... I was very interested to see what they were going to give me that was going to be the magic and make it all go away, which obviously it isn't, you need to put the work in. [P9]

Theme 3.2: Change coming from the group process. Whilst the psychoeducative content of the group was helpful for many, either through deliberate use or unrealised integration of ideas, the participants often spoke of other aspects they had taken from the course that they also saw as helpful. This was often linked to realisations about themselves that had come about through meeting others and listening to their experiences. With few exceptions, participants recounted how finding they were not alone with their problems was normalising at the time and had allowed them to face difficulty since with a realisation that other people would also struggle and so they were, as often said, 'normal'.

[Talking about depression] Before I had a very narrow view on it and now I feel that actually, as studies show, it really does affect a lot more people than we recognise and really, whereas once I saw it as a sign of weakness, I've

taken the word weakness away from it, I've just taken it as a, this is a condition, that can happen, but can be resolved or certainly one can recover from it. And possibly be a stronger person as a result of it. So that's something. [P11]

Alongside but distinct from the normalisation that belonging to the group gave, was the realisation for many participants that others were worse off than themselves and that this was helpful in suggesting to them that they could overcome difficulty.

Some of the people in the group did shock me at their, like, personal appearance. You could tell that they were in such a state that they didn't really care. I think that helped a lot because it made me realise I'd never sunk to that level as well. And I know it's horrible to sit and judge somebody, to think "Oh well you're dirty, you smell or whatever". But when you're looking at your own issues, the depression and everything else, and you know that you're not at rock bottom, it's kind of easier to pull yourself up a bit more. [P2]

A small minority of participants disagreed.

I suppose that made me feel a bit more depressed, to be honest. [P8]

It was evident that a majority of participants had, through being in the group, changed how they talked to family, friends and colleagues about their mental health. This was seen as helpful, in that rather than be rejected or judged negatively, they had found increased support and understanding. This had, in some cases, been seen as a helpful way to stay well or to help others.

And I've got a neighbour, she was shocked. I confided in her and whatever, because she had a similar background to me. And she phones me constantly to make sure I'm okay and sends a text [P15]

I talk to people. It's surprising because in my job, I talk to people all the time. I'm always talking to people. And it's a crazy amount of people that say, and who are embarrassed to say, "I've got this problem." I meet so many people that are exactly the same as me who are in my situation. And I say, "Look, go to your doctor, talk to him about it and try and get into these sessions because you don't realise how much help and to realise that it's normal to feel like this." [P5]

Participants also spoke of the group experience helping them to reframe their difficulties. For a minority of people this seemed to move beyond normalisation to a new and more positive way of looking at themselves and their role in their own and others' lives.

Because I would've thought of other people's feelings all the time instead of thinking, "I can think like this and I don't need to worry about what people think, because I think I'm doing the right thing". Before, you think, "Oh I can't do that because so and so will think differently", and you know, I think it's made me into a stronger person, thinking I'm a stronger person in my own right, I can make decisions. And I wouldn't have done that. I don't know if it's due to age as much as, you know, attending the class which gives you the extra confidence. [P11]

Theme 3.3: Areas of change. Most participants considered the areas of their lives beyond symptom reduction that had changed. This covered two broad areas; change in the self and external change. With regard to the former, the participants who reflected on this described a spectrum of views, ranging from seeing themselves as thinking and behaving in ways new to them, to viewing themselves as having returned to a way of thinking, feeling and behaving that had become lost, with the majority of people noting aspects of both.

I think I'm a lot different, I think I'm a lot calmer, I'm a lot less... I'm a lot less stressed about planning everything. [P2]

I think things that you do when you're so-called 'well', you do it automatically without thinking, and I think it was just like re-training the brain to go back into that mode. [P12]

Half way there I would say. I'm not fully there because I've grown up as well. But yeah, I'm back to living a normal life, should I say, and being happy. [P5]

It was noticeable that whilst the majority said they believed the group had been helpful in creating change within themselves, a substantial minority of participants had noted change in other areas of their life that had happened at the same time which they directly cited as a reason for their symptoms lessening. Many saw this resulting from their experiences in the group, such as thinking or behaving differently.

I told my boss and my manager that I was doing the workshop, I said because I was getting stressed out about things. So I think for a while maybe things slackened off with work, things were not quite as hectic. [P3]

However several also described changing circumstances that they did not link to the group processes. These were often in the areas of work.

But while this has all been going on that manager has been removed from the company and they moved him elsewhere and he's doing the same at this other company. But things have greatly improved at my workplace. [P1]

I felt more relaxed because, obviously, I'd not been at work and I was away from that situation rather than being on this downhill treadmill that I just couldn't get off. [P6]

Discussion

This study explored the views of patients of an IAPT service who had completed a five session psychoeducative CBT group targeted at people with symptoms of anxiety and depression to determine whether gains made during the intervention were maintained approximately six months post-intervention and if so, how this came to be. The primary methodology was qualitative, using thematic analysis (Braun & Clarke, 2006) to interpret interviews given by 15 participants. Additionally as the service had collected quantitative data as mandated by IAPT (2012), measures of symptomatology were collected at interview and used to determine numbers of participants still showing reliable clinical change or remaining below caseness thresholds.

The quantitative analysis cannot be used to draw any conclusion as to the effectiveness of the intervention for patients in general as the participants were explicitly selected because they had shown reliable clinical benefit on a measure of depressive symptomatology, the PHQ-9, or anxious symptomatology, the GAD-7. Even for this sample, conclusions drawn from the quantitative data as to the effectiveness of the intervention must be tentative as participants attended different groups, albeit based on the same manualised content, and confounding variables such as medication use, levels of symptomatology and nature of disorder were not considered. Bearing these caveats in mind, it was encouraging to find that at interview, only one participant had lost reliable clinical benefit, and no participants met caseness, for depression. For anxiety, one participant had lost reliable clinical benefit and had returned to caseness. Six participants gained reliable clinical benefit

between group end and interview for either anxious or depressive symptomatology but this relatively low number is due to the majority of participants having scored so low on the scales at group end to make further reliable change impossible.

This extremely low rate of relapse is substantially better than that seen in other studies of IAPT in general (Clark et al., 2009) or GCBT in the context of depression (Feng et al., 2012) or GAD (Fischer & Durham, 1999) but as said cannot be generalised to suggest this particular group protocol would be effective for other individuals. Nonetheless the results of the thematic analysis illuminate how and why these positive changes came about for these particular people.

All participants found some positive experience during their time in the group and many were able to carry this forward into their lives since. This was despite many participants clearly recalling negative expectations of what the group would be like beforehand, often with concerns about the level of personal information they would have to share. Interestingly this sense of wanting to be able to conceal their difficulties from others had shifted for most people by group end, indicated by the themes of wanting to be closer to others and finding talking in the group helpful. This is not a new finding and applies to many therapeutic groups (Holmes & Kivlighan Jr, 2000) but it was interesting to see it operating in what most participants rightly saw as a skills based course rather than a therapeutic group. It maps onto several of the therapeutic factors outlined by Yalom and Leszcz (2005); catharsis, group cohesiveness and the development of socialising techniques. This willingness to engage with others in discussing mental health issues continued post-group for many participants and is arguably a mechanism by which gains were maintained.

For many, being able to talk to others about one's mental health presupposes a belief that to experience mental health difficulties is a common experience. The group helped the majority of patients achieve this through their changed perspective of who a typical patient who accessed their service might be. The initial idea of coming to a group run by a mental health service was unsettling to

people, with concerns that others would be mentally 'ill'. It might be interpreted that this spoke of participants' fears that they too were 'ill' in a way they found hard to accept. By group end, most participants had concluded that others were, in the main, 'ordinary people'. This seemed to be a relief and allowed them to reframe their difficulties as part of typical human experience. This too is not a new finding; Yalom and Leszcz (2005) described it as universality and argued it operates in all therapeutic groups so it is not surprising to find it here. It is also in line with social comparison theory (Festinger, 1954) that has been suggested to operate in therapeutic groups, where those who show gains make helpful comparisons with other group members who are doing well, seeing them as role models (Dibb & Yardley, 2006).

A third key realisation, related to the two above, was the discovery for many that they were not alone with their problems and associated symptoms. Intellectually most participants already knew this but by meeting others this was brought home in a way that helped them draw strength from shared experience. It was evident in the interviews that participants who were able to relate their experiences to those of others, even when they did not match exactly, were more positive about the group experience. The few who struggled to find common ground also struggled to take helpful concrete ideas for managing difficulty or effecting change from the group. This fits with findings by Kellett, Clarke, and Matthews (2007) who suggested that the patients who benefit from brief GCBT are those who found the group the most supportive.

A further realisation for many participants was that their presentation was less severe than others in the group. Once again this maps onto Yalom and Leszcz's (2005) principles, appearing to have given participants a sense of hope. It has been documented in similar interventions (Kellett, Clarke, & Matthews, 2007; Wong, 2011) and here was carried forward by participants into their lives post-group and may have contributed to participants' motivation to use some skills taught in the

group. It is perhaps worth noting that a reverse process might operate for people who conclude that their problems are more severe than others. In a short intervention, there may not be enough time for the instillation of hope or the development of a sense of normalization for such individuals, leading to poor outcomes (Yalom & Leszcz, 2005). Again, social comparison theory also explains these results, suggesting those who benefit from a belief that they are better off than others use this knowledge to enhance self-esteem (Festinger, 1954; Paquin, Kivlighan III, & Drogosz, 2013), whereas for those who compare themselves negatively to others, the reverse process occurs.

For many of the participants interviewed here though, the group processes in operation were experienced as positives and developed rapidly. This might be conceptualised as the conditions seen as important for good outcomes; climate, cohesion and empathy (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005) as operating in this particular group protocol; something that should in theory lead to a more rapid integration of learning (Ogrodniczuk & Piper, 2003). However the accounts by participants of their recollection and use of material only partially support this and rather give weight to the argument of Kellett et al. (2007), that in brief GCBT the key factors in achieving positive outcomes are similar to those discussed above.

The recognition by the majority of participants that aspects of the group structure and delivery method both helped and hindered learning was unsurprising and it was clear by their suggestions for improvement that many people had considered in depth what would be most helpful to them. Using the facilitators to help personalise the material and having confidence that they themselves used skills was notably important and suggests mechanisms whereby facilitators can counteract the lack of individual client formulation, often seen as a weakness in GCBT (Morrison, 2001) and contribute to the helpful processes of normalisation and universality. It was apparent that participants who suggested narrowing the group

focus to patients with similar problems to their own often had more apparent difficulty generalising others' ideas or use of techniques to their own situation.

It was notable that although most participants recalled some of the material, few recalled it in great detail and less than half made explicit use of techniques despite having made and maintained impressive reductions in symptomatology. Offsetting this to some degree was the finding that more participants described thinking or behaving in ways since the group that reflected CBT techniques. It might be tempting to conclude that the protocol was so effective that little overt practice, notable in the very limited attempts at homework, was required for fundamental cognitive and behavioural change but to do so contradicts widely accepted models of how cognitive behavioural therapy effects change (Brewin, 1989; Craske, 2010). Rather it seems reasonable to conclude that the therapeutic factors of group membership primarily drove change and participants, as they began to derive benefit from them, were able to gain a sense of mastery over their problems and symptoms; a helpful therapeutic outcome in itself (Whitfield, 2010; Yalom & Leszcz, 2005). As suggested by Borkovec, Newman, Pincus and Lytle (2002) this in turn perhaps allowed participants, through shifting attention from their perceived 'weakness' or 'failure' in being unwell, to access and employ patterns of thinking and behaving that were not entirely new ways of being (Longmore & Worrell, 2007) but a return to, as some had noted, helpful 'common sense' ways of functioning.

This resonates with participants' often expressed idea that they had not received therapy as such; rather they had attended a class or course. Presenting the material in this way was usually appreciated and may have helped with engagement and outcome. As suggested by Brown et al. (2004) and White (2010), interventions that appear less stigmatising may be easier to engage, aiding normalisation and suggesting to participants that their difficulties are manageable without the requirement for extensive self-disclosure; even though, as discussed

above, connecting with others and talking about mental health was subsequently experienced as helpful.

It was encouraging to find that although many participants noted change in external events as coinciding with their recovery, they were able to recognise that their changed views of their own difficulties and ability to manage them could either help them effect such external change or help them cope in future. As found by Coon, Thompson, Steffen, Sorocco and Gallagher-Thompson (2003) and Gopinath, Katon, Russo and Ludman (2007) self-efficacy both improved with brief GCBT and mediated intervention effects and a similar process may have operated here, although no causal determination can be made from this study.

Overall the findings from this study overlap with findings from other qualitative studies of brief GCBT, albeit with different patient groups. For example Laberg, Tömkvist and Andersson (2001) reported normalisation, building interpersonal relationships and self-efficacy as key processes described by participants in a GCBT intervention for eating disorders. Wong (2011) noted group cohesiveness and having a space to express negative emotions and discuss mental health as important in GCBT for depression in the Hong Kong Chinese community and Day, Thorn and Kapoor (2011) identified group cohesiveness, universality and normalisation from others including facilitators as themes in GCBT for pain management. The latter two studies also identified a higher level of CBT skills use but the interventions were both of 10 week duration.

Finally it is worth noting that, even with some dissatisfactions expressed by participants, their overall experience of the group and effect on life since was positive. Bearing in mind the participants had been selected because they had improved this might be expected but it adds weight to findings that IAPT interventions are well received (Delgadoillo, 2010). Although the primary reasons for change as articulated by the participants were weighted more towards group processes rather than content, it does not mean the format of the group is

fundamentally flawed as had it been presented as more overtly therapeutic it would have been harder for participants to engage with and so likely less effective in such a brief time frame.

Methodological limitations

Although qualitative research is primarily aimed at in-depth understanding as opposed to generalisation, conclusions have been drawn here that might be used to understand and adapt similar groups in future. Therefore matters of representativeness must be considered.

The sample, by imposing the criterion that participants needed to have made gains was clearly not representative of all group attendees and by extension not representative of all IAPT patients or those who choose not to access IAPT services. The recruitment protocol also excluded people who could not be contacted by phone during working hours and the service covers a relatively affluent county, meaning a likely very different sample from an inner city. All the excluded groups may have held very different views on what is effective or not in brief PGCBT. Similarly the participants were well motivated and enthusiastic to take part but they only comprised two thirds of those who were contacted. The ones who declined may also have held differing views or perhaps had lost the gains they made post-group and so felt reluctant to give their views on what they may have seen as an unsuccessful intervention.

The age range and ethnic mix of the sample broadly matched that of the pool of potential participants and in turn that broadly matched all patients who undertook the group in the same time frame. It is unlikely that it matches the ethnic mix and age range of the general population in the region and it clearly does not match the gender ratio of even those who undertook the group but did not meet eligibility criteria. Once again this limits the generalisability of the findings to other cultural, ethnic or gender groups.

A further limitation is the dependence upon participants' recall of events that took place approximately six months ago, a likely source of bias (Giorgi & Giorgi, 2003) that perhaps meant the interviews did not fully capture what participants would have recollected about the group at the time of attending. For instance several participants spoke of attending six sessions when session data records reveal they attended five. Nonetheless the study was explicitly interested in what participants recalled and used since. So although participants' memories of events or content may not have exactly matched what occurred, it can be argued that these memories have been used to construct their version of what transpired and it is this they now draw upon rather than an objective truth (Flick, 2004).

Finally, the responses given by participants will inevitably have been mediated by how they wished to present themselves in the research: to the interviewer, to the service and to themselves. As discussed above, people may present as 'well' when they are not (Shedler et al., 1993), both to themselves and others, along with wishing to appear socially acceptable in their responses (Dyson & Brown, 2006). Whilst these processes do not invalidate the findings here, they should be taken into account when considering the implications for further research and service design.

Recommendations to services

Beginning with assessment for the group, it may be helpful in increasing engagement if patients are given a clear outline of what to expect and what they may find helpful, not only in terms of content but in how being in a group has benefits beyond what is taught. That is not to say the idea of it being a course or class should be deemphasised. Rather assessors might stress the idea of working with other 'ordinary' people as being helpful, even though it may be experienced as anxiety provoking at first. Running alongside this is a need for facilitators to be explicit in explaining that the content cannot be tailored to the individual, rather they

are general ideas that can be applied across many areas of difficulty. Time in sessions might be usefully employed in encouraging those who have tried a technique to report back and then map their experience onto the different situations of others in order to promote generalisation.

Similarly, recognising change when it has occurred for a patient should be highlighted to reinforce improvement. This might be through recognising what a patient may share with the group and encouraging the other members to consider if they might use what worked to effect similar change, or by reviewing measures of symptomatology each session and exploring with people, in group or more privately, what seems to be helping when improvement is noticed.

Ensuring there is enough space for participants to talk one-to-one with facilitators if needed is helpful, both to allow concerns to be addressed and to build in opportunities for patients to feel they are understood as individuals with unique problems and needs. As already said, brief PGCBT is not geared for individual formulation work but even small moments of personalisation will help with engagement and subsequent benefit, as was often noted by participants here.

Whilst there are understandable pressures on services to maximise throughput and reduce costs and groups may appear an attractive way to achieve both, a careful consideration of who will both benefit from and contribute to the group should be made; something that the IAPT data set (IAPT, 2011b) does not adequately capture. Whilst participants in this study did not express direct dissatisfaction with other group members, there was a belief that in some groups there was little interaction and this was usually seen as unhelpful. That does not mean that 'quiet' individuals should be excluded, rather it suggests that facilitators should ideally have some idea of the characteristics of attendees before the group begins and bear these in mind in endeavouring to create an atmosphere that encourages interaction. Helpful suggestions made by participants here were small group working, such as sharing ideas with a neighbour rather than to the whole

group in early sessions, ice breakers, seating arrangements that encouraged participation and ways for people to contribute non-verbally, such as writing ideas on post-it notes to place on display boards. These may appear simple ideas but from the results of this study it is the group processes that most effect change so encouraging cohesiveness to in turn promote empathy, normalisation and install hope and subsequent helpful cognitive and behavioural shifts may increase successful outcomes.

Services might consider whether these processes can be strengthened through the involvement of service users. Although not asked directly if hearing from past group members would have been helpful, it was clear that for many participants, discovering they were not alone was important in effecting change. Services might consider if inviting past group members back to speak or facilitate at the early sessions might be helpful. In a related area, whilst it is difficult to recommend if content should be removed or changed as the sample was small and their utilisation of ideas was somewhat limited, services might consider routinely consulting participants about the material they receive in order to discover what patients typically see as helpful and what they themselves might wish to add or remove.

All the preceding recommendations might be incorporated without increasing group length, something that, whilst a popular proposal suggested by participants, is one that services may well be unwilling to consider. Therefore further research is needed to both explore if changes proposed above might be effective and to widen the evidence base into the effectiveness of brief PGCBT.

Recommendations for further research

This study highlights a number of potential areas for future research. Although gains made post-group were extremely well maintained six months later, findings here cannot be used to assess the effectiveness of brief PGCBT delivered

by IAPT. Larger scale quantitative studies with longer term follow-up would be helpful in order to compare these interventions with outcome studies from longer GCBT or individual therapy where relapse rates over longer time periods are already known. It would also be useful to include clinician rated measures of symptomatology and recovery as IAPT data are self-report and subject to bias, such as wishing to appear well (Shedler, Mayman, & Manis, 1993).

Whilst this study reported the views of participants who benefited from a brief PGCBT intervention and drew conclusions as to what they found helpful, it can say nothing about two other groups, those who completed the groups but did not benefit and those who dropped out. Exploring in depth what they found as unhelpful would be equally useful in modifying group protocols and delivery, as would eliciting the views of patients who rejected the group out of hand. There may be factors specific to ethnic, cultural or gender groups that make brief PGCBT either unacceptable or ineffective. One finding from this study directly suggests an avenue to explore; that of gender. The pool of potential participants was comprised of people who had shown reliable clinical benefit on measures of symptomatology and was approximately 75% female. The group of people who had not shown reliable clinical benefit was approximately 50% female, suggesting men do not gain so much benefit from this group format as women, albeit in a small sample. It is known that men devalue emotional experience more than women (Fischer & Good, 1997) and this may, even if they acquire as many CBT skills, limit what they gain from the group processes that appeared to benefit participants in this study. Further consideration of how groups might be structured so as to overcome such moderators of effectiveness would be helpful.

Considering moderating and mediating factors, this study has suggested concepts such as self-efficacy may be increased by and mediate effectiveness of the group. Outcome studies that explicitly evaluate the role of such concepts would again be helpful in understanding how and why change occurs and for adapting

interventions to maximise gains. With regard to the latter, McPherson, Evans and Richardson (2005) raised the intriguing idea that IAPT measures of symptomatology fail to capture important concepts such as quality of life and, when these are accounted for, the positive outcomes for IAPT (2011a) are less impressive. With the large numbers of patients receiving interventions it would certainly be possible to investigate this, using either qualitative or quantitative methods.

Finally all the above suggestions evaluate or explore IAPT brief PGCBT from the patient perspective. Whilst this is essential, as was found in this study, the interaction between facilitators and participants was seen as important for people's positive outcomes. Researching how facilitators perceive the group and the factors associated with outcomes would be helpful in understanding the processes that operate in groups from a different yet very valuable perspective.

Conclusion

This study found that, for participants who completed an IAPT psychoeducational CBT group for anxiety and depression and gained clinically reliable benefit, gains were maintained approximately six months later. The reasons for this positive outcome are twofold. Knowledge of and utilisation of CBT skills was clearly helpful, even when people were not explicitly aware of this. More importantly as mechanisms to effect change were the therapeutic processes of group membership and the subsequent experience for participants that mental health problems were common, normal and could be managed.

The findings indicated areas for further research, not only into the effective processes operating in such groups, but as to how these processes can be modified to engage and benefit people who did not find the group helpful. The large numbers of patients now being treated by IAPT offer an excellent opportunity for this to be undertaken.

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Part 3: Critical appraisal

Introduction

This appraisal critically evaluates the empirical study, focussing on the background to the research, the choice of methodology and theoretical position taken; all of which informed the assumptions as to what might be found. It continues by considering the conceptual issues and practical and methodological limitations to the research. It concludes with a consideration of the research process on participants and the researcher.

Background

After completing my undergraduate degree and some further postgraduate study, I worked for a year as a data assistant for one of the 11 IAPT pilot sites. In training and encouraging clinicians in the systematic collection of far more patient data than they had hitherto been used to, I became aware of how these data could be used to provide evidence of intervention effectiveness and yet how little it revealed about the mechanisms of change.

I then worked for two years as a Psychological Wellbeing Practitioner (PWP) in an IAPT service and, towards the end of my time in post, began delivering brief psychoeducative groups based on cognitive behavioural therapy (CBT) to patients who exhibited symptoms of depression or anxiety disorders. Our outcomes were good and yet when recovered patients attended for post-group reviews they often seemed to have made little active use of the course content, despite showing impressive reductions in symptomatology. However they frequently said that the group had been useful and had contributed to their improvement. I was curious as to how this came about but the service was not geared up for research that could address this question.

Having worked in IAPT during the early phases, I was familiar with criticisms that interventions were too short and delivered no more than a toolkit of techniques that offered 'sticking plaster therapy'. Listening to my recovered patients from the

group I wondered if this was what I had delivered to them and had a nagging concern that they would soon relapse; even though we were seeing relatively few re-referrals. Consequently when the opportunity arose to conduct my own research I wanted to address both the question of what was gained from such groups and whether it was integrated into people's lives in a way that suggested gains could be maintained. I was hopeful that, in researching questions I had been asking for some years, I would be able to bring enthusiasm and curiosity to a project that, when viewed in its role as a piece of work assessed for an academic qualification, might feel burdensome and unwelcome at times.

Reasons behind the methodological choices

My original idea for the project conceived it as a quantitative piece of work, ideally recruiting a large enough sample of former IAPT patients who had been through brief Psychoeducative Group Cognitive Behavioural Therapy (PGCBT) to allow for an analysis of factors that correlated with improvement and maintenance of gains. Whilst this research might still be valuable and has yet to be carried out, I realised that it did not answer the question that I wanted it to; what is it that patients think they gain from PGCBT?

The small scale research projects I had been involved in had varied from entirely quantitative to mixed methods with brief semi-structured interviews. The latter had helped me bridge the gap from a positivist mind-set gained as an undergraduate to an appreciation of truth as a subjective concept. Taking this stance made the choice of a qualitative methodology an appropriate way to answer my question and once this conclusion was reached, it became a matter of selecting a specific method.

Considering qualitative methods in light of teaching I had received and the studies I had read, I realised that to answer the research question I needed to know what patients had experienced and how they had thought about it, rather than how

they expressed this or what had led to their development of ideas. Consequently I sought out a method that could help me analyse data that was not tied to a theory of language or underpinned by predefined concepts of explanation of meaning as other qualitative approaches often are (Flick, 2006).

Thematic analysis (Braun & Clarke, 2006), seemed to offer exactly this, appearing flexible and straightforward in application to data of the kind I expected to collect. In addition as it is not tied to a particular theoretical framework, I also saw it as being able to stand alongside the small amount of quantitative analysis that I planned to include in the study; the re-measurement of symptomatology with scales used in treatment (IAPT, 2011).

The researcher's position with regard to the research

As a neophyte researcher, especially so with qualitative methods, I turned to the literature to help me discover 'how to do it'. It became apparent that this could not begin to be answered until I had understood my own epistemological and personal stances (Dyson & Brown, 2006; Flick, von Kardoff, & Steinke, 2004). Consequently reflecting on my position with regards to objective versus subjective truths, I concluded that whilst I accepted that my participants' recollections would be necessarily subjective, I would see them as the most accurate accounts they themselves could provide. I was taking an essentialist position (Dyson & Brown, 2006) with regard to the data.

I expected to take a different stance to the analysis as rather than assume that 'themes would emerge', I accepted that, although the thematic analysis would be data rather than theory driven (Clarke & Braun, 2013), they would be constructed as the analysis proceeded. Although credibility checks could be used to make this a collaborative process with both other members of the research team and participants (Creswell & Miller, 2000; Stiles, 1999), the results would primarily be my subjective interpretation of what had been said. Therefore although I intended to

'bracket' my assumptions during analysis (Creswell & Miller, 2000), I spent some time in considering what they were and how my past experience had formed and shaped them.

Having facilitated IAPT PGCBT interventions with successful outcomes, I believed that they were beneficial and when working as a PWP, I firmly believed that the techniques taught were useful and if practiced could offer helpful ways to manage anxious and depressive symptoms. I had used some ideas in my own life, for instance cognitive restructuring (Beck, 1995), and coming into Clinical Psychology training I was very positive about the effectiveness of CBT.

As my training progressed, although very open to other therapeutic approaches, I still believed CBT had much to offer in terms of content but had become more aware of the importance of process in therapy. Participating in a long-term therapy group I had begun to question whether I overvalued the importance of simply learning techniques and to consider instead that change might be mediated through group processes (Yalom & Leszcz, 2005).

Bringing these two strands together, my expectation before I began to collect data was that participants would attribute their gains made to learning useful ideas in a supportive environment and maintain gains through conscious use of ideas that they found relevant. I was surprised by the finding that group processes seemed so important in not just facilitating gains but in maintaining improvement. This was something that was clearly articulated in the first interviews I conducted so in working with the transcripts I was pleased to see that this does not lead me to defend my prior assumption against this theme. Rather, in reviewing my journal where I made notes on the interviews, it is apparent that I am pleased to be finding something surprising to me. This meant I needed to be both aware of this as a finding worth pursuing and equally aware that it was not a conclusion that could be reached before all interviews were completed and analysed. To put it another way, I

discovered that I still needed to 'bracket' my new assumptions as the research progressed.

Research preparation

As I had designed this study myself, rather than join a pre-existing project, I thought it important to spend time not only planning the research but engaging with the service where it took place. In some ways this was relatively easy; I had worked there as a PWP so had contacts in place. That said, I was returning in a new role and was aware that as the study was to be submitted for an academic qualification, I had as much to gain from it as the service, if not more. I hoped I would be remembered favourably which might help engage staff but was alert to the possibility that underneath this might be some resentment from staff in that they felt they had to do a favour for an old colleague.

I also wondered if the PWPs in place might find the study threatening as I was asking them to recruit their former patients who I would then ask about their experiences. To address both these issues, I was proactive in attending team meetings to go through the research process. I was careful to explain how only I would know who ultimately took part; a subset of people who had expressed an interest to their recruiting PWP. This approach seemed helpful, with staff expressing interest with the study, but recruitment was slow and it was only when one particular staff member was able to take responsibility for recruitment that I gained the participants I needed.

On reflection I believe that the recruitment process I had devised that asked each PWP to contact a few people and so minimise workload was unhelpful in itself, beyond any concerns PWPs may have had about contacting former patients. With approximately 15 recruiters there was considerable diffusion of responsibility and so recruitment fell foul of the bystander effect (Latané & Nida, 1981) as busy PWPs assumed someone else would probably meet my needs. In future research I will try

to either recruit personally, or if not possible, actively support and encourage a smaller recruitment team.

Had I not been familiar with the content and delivery of the brief PGCBT intervention I would have endeavoured to attend a group in progress to help shape my research questions. As it was, I reread the material and spoke to staff at the meetings I attended about questions they thought might be useful to include at interview. Alongside this I read the literature around the area and constructed an interview schedule that strove not to reflect mine and others' assumptions as to what might be found. An opportunity missed at this point was to involve service users in the shaping of the research. Whilst there is no IAPT service user group in the service, thinking now about the study design, I could have searched for one in other IAPT services or considered asking some potential participants if they wished to advise on the research rather than be interviewed. Thornicroft and Tansella (2005) argued convincingly for service user involvement and had I done so, I am certain that this would have shaped the research question and informed the interview process in fruitful ways. This in turn may have generated ideas for intervention and service improvement and further research beyond those the study highlighted.

Reflections on data collection

When I made contact with potential participants I was clear in stating that I was a Trainee Clinical Psychologist from University College London. I did so again when we met for interview; however these often took place in NHS premises. I do not know if this meant participants were aware that I worked in the NHS but it might be presumed that they did. Consequently it is possible that participants gave more favourable accounts of their experiences to someone they saw as working in the organisation that treated them. To counteract this I was careful to state that to be uncritical meant ways to improve services might be missed and their responses would remain anonymous and could not influence any further treatment they might

have. In discussing their experiences I tried to appear neutral and to give equal time to both negative and positive recollections. On reflection, I am conscious that even suggesting a service or treatment can be improved carries an implicit message that it already has some merit and in future will consider other ways to encourage without introducing bias. Set against that, participants were able to be both critical of some aspects of the intervention and their experiences and positive about others, suggesting that this bias was minimal.

Appraising my interview style, my main criticism would be that at times I appeared to ask leading questions, usually after summarising a set of statements.

For instance:

I: Yeah. So do correct me if I've got this wrong but it sounded like that some of the things made sense but with the busy life that you have and the stress that you were under at the time, actually trying those things out was just a bit too much to do at the time?

P: Exactly. Yes.

I: Can you remember anything and you may not be able to but can you remember anything they said that really doesn't make any sense?

This is from an early interview and was noted by my supervisor who reviewed initial transcripts for such issues. Ideally the first few interviews could have been used as pilots and not included in analysis but the small sample size precluded this. That is not to say that any interviews were fundamentally flawed and awareness of leading questions and similar issues was considered during analysis.

Frequent summarising and requests for clarification or expansion upon points are good practice in interviews and I believe I used this effectively. It was pleasing to note that participants were also able to ask me for clarification when they did not understand something, suggesting perhaps that they were comfortable with the process and myself.

This positive engagement felt at times akin to my clinical work, particularly as I had worked with IAPT patients as a PWP and again on placement in my Clinical Psychology Training. Whilst I did not offer my own opinion as to the usefulness of

CBT or brief groups, on occasion I was asked directly. I managed this through suggesting we return to it after the interview if the person so wished and in one instance this resulted in a conversation as to what treatment might be helpful if symptoms of panic returned. I do not think this detracted from the value of that particular interview but it does highlight the issue of how participants view a researcher who is also a clinician. I thought it unethical not to introduce myself in my role of Trainee Clinical Psychologist but in future I might go further and discuss with the participant how we think it might affect how I ask questions and how they might respond.

A further reflection on the practicality of interviewing was the struggle I had at times to remain focused on areas I felt important to explore when participants wished to talk about matters pertinent to them. Often these were items I had expected to cover later in the interview and I became increasingly comfortable in 'going with the flow'. I believe this promoted engagement and encouraged participants that what they had to say was relevant and valued. Occasionally participants spoke about issues so far removed from the area under discussion, such as funding for physical healthcare, that I had no choice but to close them down. In future it might be helpful to explain to participants at the start that to go 'off topic' is common and if it happens I might have to refocus in order to ensure their insights are recorded and that I do not keep them beyond the time agreed.

I also noted when transcribing my interviews that I had a tendency to either ask multiple questions in one talking turn or restate the question in several ways.

For example:

Did you get a chance to, or talk to facilitators outside of ... I suppose outside of the sort of, all of you sitting there together, whether it was at coffee-breaks, or before, or afterwards, or do you think you could have done if you'd needed to?

It is something I had noted in recordings of my therapeutic work and comes, I believe, from a fear that I will not be understood. Of course it has the opposite effect

to what I intend. I was pleased to note that as interviews progressed I became better at simply stating a question and allowing the participant to respond or ask for clarification. I can see a possible danger in moving too far into a closed questioning style but in this study I think I was, although not perfectly, at least sufficiently open in my style to avoid overly leading or closing down avenues of enquiry.

As data collection progressed, I included areas from earlier interviews that seemed significant as is often done in various qualitative methods. This has led me to think about an apparent tension between collecting data without prejudice and analysing as data collection proceeds. The former might be achieved with interviews by completing collection before transcription but the latter approach allows interview technique to be evaluated as well as highlighting promising ideas to be pursued, as is the case in grounded theory (Flick, 2006). In future research, I will keep this tension in mind as I see it helpful in ensuring as far as possible that the researcher is neither blind to ways to build positive feedback into data collection, nor overly driven by a priori hypothesising.

Considerations in the analysis and interpretation of data

In an ideal world I would have transcribed all my interview data myself but delays in gaining participants meant I had to partly use a transcription service for a fast turnaround. However all interviews were listened to carefully on receipt of the transcript before commencing analysis and I followed the approach of Braun and Clarke (2006), simply coding discrete data items without placing a relative value upon them at this point. I was still taking an essentialist stance and only when patterns in the data became obvious, through noting how certain items recurred more than others, were tentative themes constructed (Rosenthal & Fischer-Rosenthal, 2004).

Taking this data-driven approach was a new experience for me that I experienced as both liberating and anxiety provoking. The former as I was used to a

hypothetico-deductive approach to (quantitative) research so to be 'free' to see what the data revealed was undeniably exciting. With this came a concern that in a sense I, rather than an observable phenomenon or statistical test, was responsible for, and needed to stand behind, the results and conclusions. It was helpful at this point to revisit the epistemological ideas that underpin qualitative research and remind myself that the results and conclusions offer validity derived from participants' subjective experiences and the expectation is not to produce findings that necessarily offer broad generalisability.

As the findings are partly subjective and, although credibility checks were in place, primarily my work, I have considered if the analysis was biased in some way or could have been improved. I believe that by considering my prior assumptions as to what might be found before I began I was able to lessen some bias there are other possible sources.

One is that approximately a third of the potential participants who were contactable declined to be interviewed. It is not known why but their accounts may have varied from the ones I heard. Similarly the participants I spoke to were happy to be interviewed. The remuneration was small so it is unlikely that they participated for reward; rather they had something they wished to say and overall it was of positive experiences and outcomes. Almost all had maintained gains made at intervention end which may explain why they took part, perhaps wishing to demonstrate to themselves and others that they had remained 'well' or even to give something back to a service they saw as helpful.

Whilst it is difficult to research people who do not wish to participate, if I were to run a similar project again, I would think in more detail about what was said to potential participants at first contact. I had asked PWPs to follow a script based on the participant information sheet (Appendix 2). The wording was deliberately neutral but it did refer to people being contacted because they had made gains and so may

have inadvertently suggested to people who had relapsed that they had nothing to contribute whereas their views would have added much richness to the findings.

A second potential source of bias stems from the fact that the analysis was conducted using a software package NVivo 10 (QSR International, 2012). I found this very helpful in organising and retrieving units of data but somewhat constraining in constructing themes and subthemes at first. There was a danger at that point that I may have shaped my analysis to suit the software (Kelle, 2004); something I believe I avoided through holding this in mind and revisiting and redrafting thematic structures as soon as they appeared to fit the package rather than the data.

The impact of research upon researcher and participants

Most participants enjoyed the interview experience and several commented on how it had helped them realise how much the group had been responsible for change in their lives. As discussed above, this may have been responses given to a researcher they saw as involved in the NHS, but as they arose at the end of the interview and were often expressed with some surprise, I believe it was a genuine revelation to participants.

This was a positive for me as well, as I had wondered if participants wanted to present themselves as 'well' to avoid considering that they may still be experiencing difficulties. Reflecting on this now, I do not believe this was the case; rather I see the interview as offering people a space to reflect on their use of the group and reengage with the ideas of normalisation, cohesion and catharsis that had been helpful as well as reengage with CBT ideas. The measures of symptomatology collected after the interview reinforce this position, as although they are self-report, they gave a clear indication that gains had been maintained.

For myself, engaging with a new research methodology was challenging and interesting, necessitating a consideration of where I stood with regard to evidence and how it is produced. Consequently, even if I never conduct similar research in the

future, I am certain that I will approach others' research findings, both qualitative and quantitative with fresh eyes.

The findings have also given me much to consider in being part of and designing group interventions in the future. I remain positive about CBT and believe its ideas can be delivered in low intensity formats for many people but am more aware of group processes and will strive to ensure they can be foregrounded in my groups in future.

Conclusions

This study highlights the importance of group processes even in groups not seen as 'therapeutic' per se and suggests these can help maintain gains made. Whilst there are many other questions that could be addressed around this area, I hope the findings presented here prove useful to IAPT and similar services but to any clinician who offers brief psychoeducative groups.

From a personal perspective, conducting the research has not only evolved me as a researcher but suggested ways where I can improve as a clinician, something I did not expect when I first came to it, for which I will always be grateful.

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Appendices

Appendix 1: Downs and Black quality appraisal questions

Appendix 1: Downs and Black quality appraisal questions

Question	Scoring
Reporting	
1. Is the hypothesis/aim/objective of the study clearly described?	Yes=1, No=0
2. Are the main outcomes to be measured clearly described in the Introduction or Methods section?	Yes=1, No=0
3. Are the characteristics of the patients included in the study clearly described?	Yes=1, No=0
4. Are the interventions of interest clearly described?	Yes=1, No=0
5. Are the distributions of principal confounders in each group of subjects to be compared clearly described?	Yes=2, Partially=1, No=0
6. Are the main findings of the study clearly described?	Yes=1, No=0
7. Does the study provide estimates of the random variability in the data for the main outcomes?	Yes=1, No=0
8. Have all important adverse events that may be a consequence of the intervention been reported?	Yes=1, No=0
9. Have the characteristics of patients lost to follow-up been described?	Yes=1, No=0
10. Have actual probability values been reported for the main outcomes except where the probability value is less than 0.001?	Yes=1, No=0
External validity	
11. Were the subjects asked to participate in the study representative of the entire population from which they were recruited?	Yes=1, No=0, Unable to determine=0
12. Were the subjects who were prepared to participate representative of the entire population from which they were recruited?	Yes=1, No=0, Unable to determine=0
13. Were staff, places, and facilities where the patients were treated, representative of treatment the majority of patients receive?	Yes=1, No=0, Unable to determine=0
Internal validity - bias	
14. Was an attempt made to blind study subjects to the intervention they have received?	Yes=1, No=0, Unable to determine=0
15. Was an attempt made to blind those measuring the main outcomes of the intervention?	Yes=1, No=0, Unable to determine=0
16. If any of the results of the study were based on "data dredging", was this made clear?	Yes=1, No=0, Unable to determine=0
17. In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?	Yes=1, No=0, Unable to determine=0
18. Were the statistical tests used to assess the main outcomes appropriate?	Yes=1, No=0, Unable to determine=0
19. Was compliance with the intervention/s reliable?	Yes=1, No=0, Unable to determine=0
20. Were the main outcome measures used accurate (valid and reliable)?	Yes=1, No=0, Unable to determine=0

Question	Scoring
<i>Internal validity - confounding (selection bias)</i>	
21. Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?	Yes=1, No=0, Unable to determine=0
22. Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time?	Yes=1, No=0, Unable to determine=0
23. Were study subjects randomised to intervention groups?	Yes=1, No=0, Unable to determine=0
24. Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?	Yes=1, No=0, Unable to determine=0
25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?	Yes=1, No=0, Unable to determine=0
26. Were losses of patients to follow-up taken into account?	Yes=1, No=0, Unable to determine=0
<i>Power</i>	
27. Did the study have sufficient power to detect a clinically important effect	Yes=1, No=0

Appendix 2: Recruitment protocol for PWPs

Are gains made in IAPT psycho-educational groups maintained over time? A qualitative study

Recruitment protocol

Dear PWPs,

Participants for the study will have been identified from PC-MIS and will meet the following criteria:

1. Met caseness for depression and/or anxiety at initial assessment.
2. Received a low intensity psycho-educational group 6 months (+ or - 2 months) ago.
3. Met criteria for reliable improvement at group end.
4. Did not go on to a further IAPT intervention.

All possible participants will then be allocated to the PWP who recruited them into the group and/or carried out the post group follow-up. This may mean you have more contacts than a colleague but a 'friendly face' introducing the study will aid recruitment.

The contact list you are given will also have been randomised into a 'contact order'. Please proceed as follows:

- Contact each person in turn by telephone
- If you cannot make contact, move onto the next person
- Once you reach the end of the list, please try again at a different time or day. For example you might run through the list at 9:30 on Monday, again at 4:00 PM and then on Wednesday
- After 3 failed attempts to contact someone (made on 2 or more separate days) please remove them from the list

Contact is made

NB If someone other than the named person answers, please follow the same 'script' you would use when contacting a new patient e.g. call back if the person says 'they will be home at...', explain it is confidential if the person asks what it is about.

Introduce the study as follows (the wording is a guide, but you can read it as a script if you wish):

The study aims to find out what people thought about the group they attended. The researcher is also interested in whether people continue to use things they have learned in the group in their daily lives.

The results will be used to help services improve how they run similar groups in future to best meet patients' needs.

You completed questionnaires about your symptoms whilst you attended the group. By the end of the group your symptoms seemed to have noticeably reduced. This meant you were a suitable candidate for the study. The researcher would like to speak to you and other people

who have said they are interested. He will interview you on your own and in private for about an hour in one of the premises used by [removed to preserve confidentiality] NHS Foundation Trust or a suitable meeting place. He will digitally record and transcribe the complete interview removing any details that might identify you. He will also ask you to complete the same questionnaires you were given when you were in the group. This will allow him to see if your symptoms have changed since the group finished.

You will be given a payment of £10 for your time and will also be refunded for travel costs you incur in travelling to and from the interview.

Person declines

Simply thank them for their time, reassure them it will make no difference to their treatment with any service and explain they will not be contacted about this study again.

Person agrees

Tell them my details:

1. Charlie Wykes, Trainee Clinical Psychologist
2. I used to work at [removed to preserve confidentiality] doing the job you are doing from December 2008 to September 2010.
3. If from point 1 or 2 they think they know me explain that regrettably they cannot take part and thank them as if they had declined.

Then find out their preferred way for me to contact them and tell them you will pass contact details on to me. A phone number and 'best time to call' would be best but email is OK as long as they are told it cannot be guaranteed as secure. If you can establish if I can explain who I am to someone other than the participant who answers the phone, that would be fantastic.

Person has more questions

The participant information sheet appended below should answer most of them but if not, note the question, email me with it (without identifying them) and I will answer ASAP. You may also say that if they agree to take part I will always answer any questions they have.

Passing details of potential participants on to me

Once you have a telephone number or email, please note it down on paper. I will place a 'collection box/envelope' in reception for each team and regularly call in to pick this up and make my contacts

What's in it for me?

The satisfaction of being involved in research! But if that's not enough, I will provide 'PWP only' biscuits and chocolates and should any of you want to talk about Clinical Psychology training I'll be happy to chat about it.

Contacting me

My contact details are: charles.wykes.10@ucl.ac.uk or [removed to preserve confidentiality] (personal mobile)

PARTICIPANT INFORMATION SHEET

Patients' experiences of groups for anxiety and depression (student research project)

I would like to invite you to take part in a research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through this information sheet with you and answer any questions you have. This should take about 20 to 30 minutes.

You are welcome to talk to others about the study if you wish and please ask me if there is anything that is not clear.

Introduction

Many people experience periods of worry or low mood during their lives. Research shows that some people can be helped to manage these periods through attending groups. In recent years groups have been widely used to give people ideas and techniques to manage mood and worry that they can continue to use after the group finishes.

What is the study for?

The study aims to find out what people thought about the group they attended. I am also interested in whether people continue to use things they have learned in the group in their daily lives.

The results will be used to help services improve how they run similar groups in future to best meet patients' needs. The study is being carried out as part of my Clinical Psychology Doctorate at University College London.

Why was I invited to take part?

You completed questionnaires about your symptoms whilst you attended the group. By the end of the group your symptoms seemed to have noticeably reduced. This meant you were a suitable candidate for the study and so you were asked by [removed to preserve confidentiality] NHS Foundation Trust if you were interested in taking part. As you said you were interested I contacted you. I will also speak to other people who have said they are interested, with the aim of finding 15-20 participants for the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you agree to take part, I will ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This will not affect the care you receive with [removed to preserve confidentiality] NHS Foundation Trust or any other healthcare provider.

What will happen to me if I take part?

I will interview you in private for about an hour in one of the premises used by [removed to preserve confidentiality] NHS Foundation Trust or a suitable meeting place. I will digitally record and transcribe the complete interview removing any details that might identify you. I will also ask you to complete the same questionnaires you were given when you were in the group. This will allow me to see if your symptoms have changed since the group finished. To check whether I have fully understood your experiences, I may invite you to read through the conclusions I come to about your interview before I write up the study.

Will I receive payment and travel expenses for taking part?

You will be given a payment of £10 for your time and will also be refunded for travel costs you incur in travelling to and from the interview. If you travel by car you will be refunded at the NHS public transport rate of 24 pence per mile. If you travel by public transport your costs will be refunded as long as you can produce receipts that cover the journey. I would recommend you bring any receipts to the interview with you and if this is not possible, retain them so I can organise a reimbursement as soon as possible afterwards.

What are the possible disadvantages and risks of taking part?

Interviews are a common way to find out about people's experiences. I will not be taking any samples or specimens from you. You will not have to change any medication or treatment you are taking. You will have to travel to the interview venue and give up time for this and an hour for the interview itself. However I will arrange the interview at a time you choose and you can rearrange or cancel the interview at any time.

Occasionally people find that by being interviewed or by thinking about their experiences they feel distressed. If this happens in the interview I will stop and explain how you might seek support if you wish. After the interview finishes I will leave you a document that similarly explains how you can access support in the future.

In the unlikely event that from what you tell me I think you or someone else is at great risk, I will stop the interview and discuss with you how we can best keep the person safe.

What are the possible benefits of taking part?

The interview will give you a chance to let your opinions on groups for anxiety and depression be taken into account. Groups like the one you took part in are fairly new and your views will be important in influencing how they are delivered in the future. You may also find it personally helpful to discuss the ideas you took away from the group and how they fit in with your life now.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time without giving a reason. Any information you have given will be destroyed and no record kept about your participation or withdrawal.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer should be addressed to me. In the first instance I will discuss this with you. If however you are not satisfied with my response you will be welcome to speak to my supervisors whose details are shown below. If they are unable to resolve your complaint, you should then contact [removed to preserve confidentiality] NHS Foundation Trust's Customer Relations Team whose details are shown below.

Will my taking part in the study be kept confidential?

Recordings, transcripts and notes on your interview will be stored securely throughout the study period. Recordings will be kept on encrypted electronic media until transcription and transcripts and notes will not include your or any other person's name. Any presentations or discussions about the study and the written report will also not include your or other person's name although they may include anonymous direct quotations to illustrate participants' ideas. Only [removed to preserve confidentiality] Foundation Trust will know who agreed to be contacted about the study and they will not know whether you then agreed to take part.

Only the research team (I and my supervisors, Dr Nick White and Professor Chris Barker) will have access to the data. All recordings will be erased immediately after they have been transcribed. All transcriptions will be kept securely for 20 years after publication and then destroyed, according to standard research guidelines.

What will happen to the results of the research study?

The results will be written up to meet the academic requirements of my Clinical Psychology Doctorate and a copy kept at University College London. A presentation and summary of the research will be made available to [removed to preserve confidentiality] Foundation Trust and the study will be published in an academic journal. The study will eventually be available online via UCL discovery at http://discovery.ucl.ac.uk/view/theses/UCL_Thesis.html

Who is organising the research?

The Research and Development Committee at [removed to preserve confidentiality] Foundation Trust agreed that the study could take place, subject to ethical approval by the NHS. I am supervised by Dr Nick White, Clinical Lead for the Enhanced Primary Mental Health Service/Improving Access to Psychological Therapies at [removed to preserve confidentiality] Foundation Trust. This is the service that you saw when you took part in the group.

As a trainee Clinical Psychologist, I am studying at University College London and this study is supervised there by Professor Chris Barker in the Department of Clinical, Educational and Health Psychology.

Who has approved the research?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES East of England – Cambridge East Research Ethics Committee.

Further information and contact details

If you would like more information or wish to discuss the study either now or afterwards, the following people and organisations will be happy to help you.

Researcher - Charlie Wykes

[removed to preserve confidentiality]

Research Department of Clinical, Educational and Health Psychology

University College London

Gower Street

London WC1E 6BT

Supervisor – Dr Nick White, Clinical Lead for EPMHS/IAPT

[removed to preserve confidentiality]

**Supervisor - Professor Chris Barker, Joint Research Director in the Department of Clinical Psychology,
University College London**

Research Department of Clinical, Educational and Health Psychology

University College London

Gower Street

London WC1E 6BT

[removed to preserve confidentiality] NHS Foundation Trust Customer Relations Team

[removed to preserve confidentiality]

[complaints@\[removed to preserve confidentiality\]](mailto:complaints@[removed to preserve confidentiality])

[removed to preserve confidentiality]

Appendix 3: Participant information sheet

PARTICIPANT INFORMATION SHEET

Patients' experiences of groups for anxiety and depression (student research project)

I would like to invite you to take part in a research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through this information sheet with you and answer any questions you have. This should take about 20 to 30 minutes.

You are welcome to talk to others about the study if you wish and please ask me if there is anything that is not clear.

Introduction

Many people experience periods of worry or low mood during their lives. Research shows that some people can be helped to manage these periods through attending groups. In recent years groups have been widely used to give people ideas and techniques to manage mood and worry that they can continue to use after the group finishes.

What is the study for?

The study aims to find out what people thought about the group they attended. I am also interested in whether people continue to use things they have learned in the group in their daily lives.

The results will be used to help services improve how they run similar groups in future to best meet patients' needs. The study is being carried out as part of my Clinical Psychology Doctorate at University College London.

Why was I invited to take part?

You completed questionnaires about your symptoms whilst you attended the group. By the end of the group your symptoms seemed to have noticeably reduced. This meant you were a suitable candidate for the study and so you were asked by [removed to preserve confidentiality] NHS Foundation Trust if you were interested in taking part. As you said you were interested I contacted you. I will also speak to other people who have said they are interested, with the aim of finding 15-20 participants for the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you agree to take part, I will ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This will not affect the care you receive with [removed to preserve confidentiality] NHS Foundation Trust or any other healthcare provider.

What will happen to me if I take part?

I will interview you in private for about an hour in one of the premises used by [removed to preserve confidentiality] NHS Foundation Trust or a suitable meeting place. I will digitally record and transcribe the complete interview removing any details that might identify you. I will also ask you to complete the same questionnaires you were given when you were in the group. This will allow me to see if your symptoms have changed since the group finished. To check whether I have fully understood your

experiences, I may invite you to read through the conclusions I come to about your interview before I write up the study.

Will I receive payment and travel expenses for taking part?

You will be given a payment of £10 for your time and will also be refunded for travel costs you incur in travelling to and from the interview. If you travel by car you will be refunded at the NHS public transport rate of 24 pence per mile. If you travel by public transport your costs will be refunded as long as you can produce receipts that cover the journey. I would recommend you bring any receipts to the interview with you and if this is not possible, retain them so I can organise a reimbursement as soon as possible afterwards.

What are the possible disadvantages and risks of taking part?

Interviews are a common way to find out about people's experiences. I will not be taking any samples or specimens from you. You will not have to change any medication or treatment you are taking. You will have to travel to the interview venue and give up time for this and an hour for the interview itself. However I will arrange the interview at a time you choose and you can rearrange or cancel the interview at any time.

Occasionally people find that by being interviewed or by thinking about their experiences they feel distressed. If this happens in the interview I will stop and explain how you might seek support if you wish. After the interview finishes I will leave you a document that similarly explains how you can access support in the future.

In the unlikely event that from what you tell me I think you or someone else is at great risk, I will stop the interview and discuss with you how we can best keep the person safe.

What are the possible benefits of taking part?

The interview will give you a chance to let your opinions on groups for anxiety and depression be taken into account. Groups like the one you took part in are fairly new and your views will be important in influencing how they are delivered in the future. You may also find it personally helpful to discuss the ideas you took away from the group and how they fit in with your life now.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time without giving a reason. Any information you have given will be destroyed and no record kept about your participation or withdrawal.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer should be addressed to me. In the first instance I will discuss this with you. If however you are not satisfied with my response you will be welcome to speak to my supervisors whose details are shown below. If they are unable to resolve your complaint, you should then contact [removed to preserve confidentiality] NHS Foundation Trust's Customer Relations Team whose details are shown below.

Will my taking part in the study be kept confidential?

Recordings, transcripts and notes on your interview will be stored securely throughout the study period. Recordings will be kept on encrypted electronic media until transcription and transcripts and notes will not include your or any other person's name. Any presentations or discussions about the study and the written report will also not include your or other person's name although they may include anonymous

NHS Foundation Trust header removed to preserve confidentiality

direct quotations to illustrate participants' ideas. Only [removed to preserve confidentiality] Foundation Trust will know who agreed to be contacted about the study and they will not know whether you then agreed to take part.

Only the research team (I and my supervisors, Dr Nick White and Professor Chris Barker) will have access to the data. All recordings will be erased immediately after they have been transcribed. All transcriptions will be kept securely for 20 years after publication and then destroyed, according to standard research guidelines.

What will happen to the results of the research study?

The results will be written up to meet the academic requirements of my Clinical Psychology Doctorate and a copy kept at University College London. A presentation and summary of the research will be made available to [removed to preserve confidentiality] Foundation Trust and the study will be published in an academic journal. The study will eventually be available online via UCL discovery at http://discovery.ucl.ac.uk/view/theses/UCL_Thesis.html

Who is organising the research?

The Research and Development Committee at [removed to preserve confidentiality] Foundation Trust agreed that the study could take place, subject to ethical approval by the NHS. I am supervised by Dr Nick White, Clinical Lead for the Enhanced Primary Mental Health Service/Improving Access to Psychological Therapies at [removed to preserve confidentiality] Foundation Trust. This is the service that you saw when you took part in the group.

As a trainee Clinical Psychologist, I am studying at University College London and this study is supervised there by Professor Chris Barker in the Department of Clinical, Educational and Health Psychology.

Who has approved the research?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES East of England – Cambridge East Research Ethics Committee.

Further information and contact details

If you would like more information or wish to discuss the study either now or afterwards, the following people and organisations will be happy to help you.

Researcher - Charlie Wykes

Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
London WC1E 6BT

Supervisor – Dr Nick White, Clinical Lead for EPMHS/IAPT

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[removed to preserve confidentiality]

Supervisor - Professor Chris Barker, Joint Research Director in the Department of Clinical Psychology, University College London

Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
London WC1E 6BT

[removed to preserve confidentiality] NHS Foundation Trust Customer Relations Team

[complaints@\[removed to preserve confidentiality\]](mailto:complaints@[removed to preserve confidentiality])

[removed to preserve confidentiality]

Appendix 4: Participant consent form

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Centre Number: [removed to preserve confidentiality] NHS Foundation Trust R & D Department

Study Number: REC Reference 12/EE/0380 UCL Reference 12/0147

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: Patients' experiences of groups for anxiety and depression (student research project)

Name of Researcher: Charlie Wykes

By completing and returning this form, you are giving us your consent that the personal information you provide will only be used for the purposes of this project and not transferred to an organisation outside of UCL. The information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998

Please initial box

I confirm that I have read and understand the information sheet dated.....
(version.....) for the above study. I have had the opportunity to consider the information,
ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time
without giving any reason, without my medical care or legal rights being affected.

I understand that if I disclose something that, in the opinion of the researcher, means I or
someone else is at risk of harm, the researcher may have to break the confidentiality of
the interview in order to make sure the person is kept safe.

I understand that anonymous direct quotations of what participants say during the interview
may be used in the report to illustrate participants' ideas.

I agree to take part in the above study.

Name of Participant _____ Date _____ Signature _____

Name of Person _____ Date _____ Signature _____
taking consent

When completed: 1 for participant; 1 for study site file; 1 (original) to be kept by researcher.

Consent Form version 1.4

31/10/2012

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Appendix 5: NHS REC committee approval



Health Research Authority
NRES Committee East of England - Cambridge East
Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone:
Facsimile:

13 November 2012

Professor Chris Barker
Professor of Clinical Psychology
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
London WC1E 6BT

Dear Professor Barker

Study title: Are gains made in IAPT psycho-educational groups maintained over time? A qualitative study
REC reference: 12/EE/0380

Thank you for your letter of 31 October 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

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

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity - Arthur J. Gallagher International		30 July 2012
Interview Schedules/Topic Guides	Version 1.1	06 June 2012
Investigator CV - Professor Chris Barker		27 February 2012
Other: CV for student - Charles Frederick Wykes		25 May 2012
Other: Email Confirmation from Chris Barker		04 November 2012
Participant Consent Form	1.4	31 October 2012
Participant Information Sheet	1.4	31 October 2012
Protocol	Version 1.1	02 July 2012
Questionnaire: Outcome questionnaires	Version 1.0	
REC application	Submission code: 103155/348620/1/74	02 August 2012
Referees or other scientific critique report from Oliver Mason		17 February 2012
Response to Request for Further Information email From Charlie Wykes		31 October 2012
Summary/Synopsis - Flowchart	Version 1.0	17 May 2012

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/EE/0380	Please quote this number on all correspondence
-------------------	---

With the Committee's best wishes for the success of this project

Yours sincerely

**Dr Daryl Rees
Chair**

Email:

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Emailed to: Professor Chris Barker ;
David Wilson
Professor Tim Gale
Mr Charles Wykes ;

Appendix 6: NHS Foundation Trust R and D department approval

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Professor Chris Barker
Professor of Clinical Psychology
Research Dept of Clinical, Educational and Health Psychology
University College London
Gower Street
London, WC1E 6BT

R&D Department
[removed to preserve
confidentiality]

Tel.
Fax.
e-mail

7th December 2012

Dear Professor Barker,

Research Study: Are gains made in IAPT psycho-educational groups maintained over time? A qualitative study.
Rec reference: 12/EE/0380

I have received the documentation in support of the above project. Following a review by The R&D Department, I am pleased to tell you that the study now has R&D approval on behalf of [removed to preserve confidentiality] NHS Foundation Trust.

Approval is given on the understanding that you will notify the R&D Office of any further amendments to the study design, that you will carry out the study as specified in the final version of the protocol, and that you will comply fully with the [removed to preserve confidentiality] R&D Policy (copy sent by e-mail).

With kind regards

Tim Gale Ph.D.
Manager, Research and Development Department
Visiting Professor, Dept Psychology, UoH

Appendix 7: Sponsorship letter from University College London



Joint Research Office

Students' Research Lead
Joint Research Office
(part of the Research Support Centre)
1st Floor Maple House (Suite B)
149 Tottenham Court Road
London W1T 7DN

Postal Address: Joint Research Office, UCL,
Gower Street,
London
WC1E 6BT

Professor Chris Barker
Professor of Clinical Psychology
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
London WC1E 6BT

Date: Wednesday, 28 November 2012

Dear Charles,

Sponsor's Approval

Title: Are gains made in IAPT psycho-educational groups maintained over time? A qualitative study
Project ID: 12/0147
REC Ref: 12/EE/0380
UKCRN ID:

As sponsor, I am pleased to confirm that the necessary governance and sponsorship checks are satisfied. Thank you for providing the letter dated 13 November 2012 confirming a favourable/no objection Ethics opinion.

Sponsorship runs concurrently with that of the above stated ethics approval. UCL sponsorship is independent of Ethics and may be withdrawn at any time if the terms are not met.

Site approval.

You must get written site/local approval before you start your research at particular site/sites. In the case of each site forward the respective SSI and the Local approval letter to the sponsor.

Please read carefully the following terms and requirements of this approval and contact this office should you require further clarification.

During your study

- Your research must be conducted in accordance with the Department of Health's Research Governance Framework for Health and Social Care (2nd edition 2005) and all members of the research team must be aware of their responsibilities under the Framework.
- Comply with the Data Protection Act, Caldicott Principles and Trust Information Governance Policy in addition to that of UCL and the site.

1 of 3

Green light letter Students, CK 30 Jan 2011 v1.10



UCL Hospitals is an NHS Foundation Trust comprising: The Eastman Dental Hospital, The Heart Hospital, Hospital for Tropical Diseases, National Hospital for Neurology and Neurosurgery, The Royal London Homoeopathic Hospital and University College Hospital (incorporating the former Middlesex and Elizabeth Garrett Anderson Hospitals).

- Respond to, and maintain communication with, the sponsor throughout the duration of your study.
- Maintain an investigator file to store all study/trial documentation to be made available for sponsor monitoring and or audit.
- Notify this office, in writing, of any change in the research team, or suspension or premature closure of the study, substantial and non-substantial amendments. Copies of all letters to and from Ethics regarding this study must be sent to this office.
- Notify, in writing, the sponsor of serious adverse events, incidents and complaints.

At the end of your study

- Complete the end of study declaration at <http://www.nres.npsa.nhs.uk/applications/after-ethical-review/endofstudy/#endofstudyDefining> or NRES declaration of the end of a study form v1.0 and send it to @ucl.ac.uk

You should send a lay summary (maximum 2 A4 sides) of the final research report to the sponsor at the end of the study. You may enclose this with the end of study declaration or send it to the sponsor subsequently @ucl.ac.uk

There is no standard format for final reports. As a minimum, you should inform the main sponsor and the REC whether the study achieved its objectives, the main findings, and arrangements for publication or dissemination of the research, including any feedback to participants.

We wish you all the best for your research.

Yours sincerely,

Mr David Wilson

UCL sponsor representative
 UCL research co-ordinator
 Information and database Officer
 UCL/UCLH/Royal Free Biomedical Research Unit

Appendix 8: Certificate of insurance from University College London



30th July 2012

TO WHOM IT MAY CONCERN

We, the undersigned Insurance Brokers hereby certify that we have placed the following Insurance:

VERIFICATION OF INSURANCE

Unique Market Reference: B1252110103012

Type: No Fault Compensation for Clinical Trials and/or Human Volunteer Studies

Insured: University College London

Period: From: 1st August 2012
To: 1st August 2013 Both days inclusive at Local Standard Time.

Interest: This Policy will indemnify/cover the Insured in respect of their Legal Liabilities arising out of the Insured's activities and as more fully disclosed within the Policy Wording.

Limit of Indemnity: GBP 15,000,000 Any One Claim and GBP 15,000,000 in the Aggregate, including costs and expenses

Excess: GBP 2,500 Each and Every Claim, including costs and expenses

Underwriter: 100.0000% Newline Syndicate 1218

This document is for information only and does not make the person or organisation to whom it is issued an additional Insured, nor does it modify in any manner the Contract of Insurance between the Insured and the Insurers. Any amendment, change or extension to such Contract can only be affected by specific endorsement attached thereto.

Should the above mentioned Contract of Insurance be cancelled, assigned or changed during the above policy period in such manner as to affect this document, no obligation to inform the holder of this document is accepted by the undersigned or by the Insurers. The information provided is correct at the date of signature.

Authorized Signatory
Gallagher London.

Appendix 9: Quantitative measures and demographic capture form

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Patients' experiences of groups for anxiety and depression (student research project)

Name of Researcher: Charlie Wykes

IAPT minimum data set measures

Patient Identification Number for this trial:

The questionnaires on this page are about how you have been over the last TWO WEEKS.

Over the last TWO WEEKS, how often have you been bothered by any of the following problems? Please circle just ONE number for each.	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over eating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thought that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total				

Over the last TWO WEEKS, how often have you been bothered by any of the following problems? Please circle just ONE number for each.	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total				

Demographic information

It would be helpful if you can answer the questions below. However you do not have to answer anything you do not wish to.

Age: _____

Gender: _____

Current Occupation: _____

Please tick the educational qualifications you have

- | | |
|----------------------------|-----|
| No formal qualifications | [] |
| 'O' level/CSE/GCSE | [] |
| NVQ/BTEC/HNC | [] |
| 'A' level | [] |
| HND/Diploma | [] |
| Degree | [] |
| Postgraduate qualification | [] |
| I do not wish to say | [] |

Please tick the ethnic group you consider yourself to belong to

- | | |
|----------------------------|-----|
| White British | [] |
| Irish | [] |
| Any other White background | [] |
| White and Black Caribbean | [] |
| White and Black African | [] |
| White and Asian | [] |
| Any other mixed background | [] |
| Indian | [] |
| Pakistani | [] |
| Bangladeshi | [] |
| Any other Asian background | [] |
| Caribbean | [] |
| African | [] |
| Any other Black background | [] |
| Chinese | [] |
| Any other ethnic group | [] |
| I do not wish to say | [] |

Appendix 10: Interview schedule

Patients' experiences of groups for anxiety and depression (student research project)

Interview schedule

Preamble: Thank you for agreeing to be interviewed today. Before we begin I want to make sure you understand what taking part will mean for you and that you are happy to be interviewed. I am going to go through an information sheet and consent form with you. (Go through the PIS/consent form). Do you have any questions? (Answer questions).

I am going to be asking you about your experience of the group therapy you took part in. I will also about whether you have made use of what you learned since the group ended. This will help services improve similar groups they run in the future.

We will speak for about an hour but if you wish to stop at any time, either for a break or to finish, please let me know. If you do not want to answer a question we can leave it and go on to the next one. Are you happy to begin?

1. **Can you tell me a little about the difficulties you were having before you joined the group?**
 - a. How long had they been occurring?
 - b. Did you try any other types of therapy or treatment before the group?
2. **Can you tell me why you chose to take part in the group?**
 - a. Did your therapist give you other options for support?
 - b. (if no) Would you have chosen something else if it had been offered?
 - c. Did you attend all sessions?
3. **What had you imagined the group would be like?**
 - a. Was the reality close to or far from this? In what ways?
4. **Did you find common ground with other participants?**
 - a. In what ways?
 - b. Was this helpful?
 - c. How?
 - d. Normalisation. Of self or others?
5. **Did you find common ground with the facilitators?**
 - a. In what ways?
 - b. Was this helpful?
 - c. How?

6. **Was there space for you to talk/be heard?**
 - a. Was the 'mix' of participants right?
 - b. Was there enough time to become comfortable there?
 - c. Was it easy to say 'I don't understand'?
7. **What did you get out of the group?**
 - a. Was this what you had wanted?
 - b. Was it what you expected?
8. **Did you feel things had changed for you by the end of the group?**
 - a. In what ways?
 - b. What in particular had changed?
 - c. Were these positive or negative changes?
 - d. What do you put them down to?
 - e. Did events outside group contribute to change? How?
9. **What techniques or skills to help you manage difficulties do you recall?**
 - a. What at the time seemed helpful or unhelpful?
 - b. In what ways did they help or not help?
 - c. Did these techniques feel 'personalised to you? Why/why not?
 - d. Where there other things you wanted help with that the group did not provide?
10. **Did you continue to use ideas or techniques after the group ended?**
 - a. What did you plan to do?
 - b. Why did you intend to do this?
 - c. Did you continue to use ideas or techniques
 - d. What did you do (or not do)
 - e. How did you do this (or why didn't you do this)
 - f. For how long?
 - g. Would going over them again help?
11. **Did you take other things from the group beyond techniques?**
 - a. What were they?
 - b. Did this come from facilitators or members?
12. **Has the group changed your life noticeably?**
 - a. Is this emotionally and/or practically?
 - b. Is this a 'comfortable' way of being?
 - c. Do you still practice ideas and techniques from the group?
 - d. Why have they changed life in the way you suggest?
 - e. Was change a return to normal or a new way of being?
 - i. In what ways?

13. Have you sought further help?

- a. What have you done?
- b. Did the group experience make a difference to the therapy you chose or explored?
- c. How?

14. Looking back, what would you change about the group?

- a. Balance of participants?
- b. Facilitators
- c. Length?
- d. Structure?
- e. Anything else?

Debrief: We have come to the end of the interview and I have just a few more questions. I will be in touch in the next few weeks with a summary of what we have discussed today. I will do this to make sure I have understood what you said correctly and to see if there is anything else you would like to add.

- What would be the best way to contact you for this?
- Would you like a summary of the study once it is finished?
- If so, how would you like this sent to you?
- Are there any important questions you think I should have asked today?
- Do you have any questions or comments you would like to make now?

Close: Remember you can contact me or the other people I told you about on the PIS. If you have any travel expenses I can pay those for you now (pay expenses). Finally, thank very much for taking part, it has been greatly appreciated.

Appendix 11: raw codes exemplar

Submitted to examiner but removed to protect client confidentiality

Appendix 12: Subthemes exemplar

Participant subthemes

Name	
P1 themes added a few only	
Attended all - no missed	
Change in views of mental health	
MI as initial stigma	
Not alone (group)	
Recognise M - causes in others	
Understand MH problems in others	
Difficulties with others	
Men talked more	
Discharge - yes	
F I - No	
F J - in person	
Facilitators	
Facilitator able to relate	
Facilitator believed in Cs	
Facilitator too young	
Group composition	
Groups not C	
Group size good	
Group general positives	
Group not stigmatising	
Group Overall - good	
Hear what others say	
No pressure to talk	
Group length	
Group better if longer	
Session length	
Framework	
Key moments	
Material recall and use	
No change	
No change in views of mental health	
P1 other themes	
Positive outcomes	
Presentation	
Reasons for change	
Recommend group to others - ✓	
Referral journey	
Session feel	
Stay in touch with others - Yes	
Talk up and put in writing	

Appendix 13: Theme feedback and comment form sent to participants

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Saturday, 29 June 2013

Charles Wykes
[removed to preserve
confidentiality]

Research Department of Clinical,
Educational and Health Psychology
University College London
Gower Street

Dear,

Re: Patients' experiences of groups for anxiety and depression

Thank you for recently taking part in my research study. It was a pleasure to meet you and discuss your experiences.

When we met, you mentioned that you would be interested in giving your feedback on the themes I have identified from our meeting. Giving people who have taken part in our research an opportunity to comment is very helpful in making sure that we report an accurate reflection of people's experiences. It would be useful if you could comment on whether you think these themes are a valid interpretation of our conversation. I have included some quotes from our meeting to give you an indication as to how these themes were reached.

Giving this feedback is voluntary and we are still able to make use of your contribution if you decide not to. You can give your feedback by post using the enclosed stamped addressed envelope. I can also be contacted by telephone on [removed to preserve confidentiality] if you would like to discuss anything further.

Many thanks for taking part,

Charles Wykes

NHS Foundation Trust footer removed to preserve confidentiality

Patients' experiences of groups for anxiety and depression: Participant feedback form

Participant XXX summary

Below are themes that I drew out from our interview, including some illustrative quotes

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Theme:

Quote:

Participant XXX summary

How much do the themes listed capture what you said in the interview?

Please underline the number that best matches your answer.

0	1	2	3	4
Not at all	A little	Moderately	Quite a lot	Completely

Is there anything missing from the list of themes?

Is there anything that needs changing?

Do you have any other comments?