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Short communication

An evaluation of large group CBT psycho-education for anxiety disorders delivered in routine practice

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Abstract

Objective: To determine the clinical utility and acceptability of a brief CBT psycho-educational course delivered in an NHS psychotherapy service.

Methods: All patients referred, found suitable for CBT, and who had an anxiety disorder, were invited to enrol in a psycho-education course, delivered in an outpatient mental health clinic by two mental health nurses with post-registration training in CBT. There were up to 24 patients in each course. Outcome measures used were CORE-OM and Fear Questionnaire administered pre-course and at 12-week follow-up and Client Satisfaction Questionnaire administered post-course.

Results: One-hundred and ninety one patients were referred. Of these 120 remained in contact with the service to the follow-up meeting. Ninety-seven patients were discharged at the follow-up point and 92 requested further individual psychotherapy. A number of patients made a clinical and reliable change as measured by CORE-OM and Fear Questionnaire. One-hundred and two patients completed the CSQ-8 reporting high satisfaction with the intervention.

Conclusions: The intervention appears to be helpful for a number of patients and largely acceptable for most patients that attend.

Practice implications: Large group psycho-educational interventions for anxiety disorders could be increasingly used as a method of delivering low intensity treatments within a stepped care model of the treatment of anxiety disorders. The intervention is relatively simple to deliver and potentially could be delivered by primary care clinicians.

Keywords: Anxiety disorders; Psycho-education; Stepped care; Cognitive behaviour therapy

1. Introduction

Cognitive behavioural therapy (CBT) has been shown to be an effective psychological therapy for a wide range of mental health problems when compared to control groups in randomised trials [1]. There are well documented limitations to the accessibility of CBT for patients attending NHS services [2]. Typically, CBT is provided by specialist secondary or tertiary services and as such suffer from high demand relative to availability. This problem has become more acute with the drive towards evidence-based mental health care and the increasing scope for the utility of CBT. Consequently waiting times for CBT have grown with many services reorganising their delivery systems to accommodate a rising tide of referrals. Sheffield Psychotherapy Service operates a screening system whereby new patients are seen for an initial consultation within a few weeks of referral. Patients who are thought likely to benefit from CBT are then placed on a waiting list for a course of individual treatment. This time from screening to treatment has been as much as 18 months in Sheffield, not an uncommon period when compared to other similar services [2].

There is a growing body of evidence to support the use of alternative delivery systems, which acknowledge that not all patients require the same type and intensity of treatment [2]. For example, some patients may be helped by reading self-help books [3,4], or using a computer programme [5]. Others could benefit from a brief psycho-educational group [6] and others may require individual psychotherapy. In an environment of limited resources then it makes sense to provide all the time and expertise a patient needs, but not more. A stepped care approach represents an attempt to maximise the effectiveness

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of decisions about allocation of resources in therapy [7]. Such an approach supports efforts to introduce clients to low intensity interventions before 'stepping-up' to higher intensity treatment such as individual therapy delivered by a specialist practitioner.

In the light of the increasing demand for CBT, the emerging evidence for alternative delivery systems, and finite resources, a brief psycho-educational course was designed and delivered. The aims of this intervention were:

- To evaluate the acceptability of such an intervention to clients.
- To evaluate the clinical effectiveness of the psycho-educational intervention within the service it was delivered.

2. Methods

2.1. Participants and setting

All patients referred to the Psychotherapy Department, assessed individually by a cognitive behavioural therapist and their presenting problems determined as suitable for CBT, and where, in the assessing therapist's clinical judgement, they had an anxiety disorder, were invited to enrol in the psycho-education course. This might have included problems such as panic disorder (with/without agoraphobia), specific phobias, social anxiety, generalised anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder or hypochondriasis. There were up to 24 patients in each course. The course was delivered in an outpatient mental health clinic. One course was delivered in the evening, the remainder during office hours. All courses were facilitated by two mental health nurses with post-registration training in CBT.

2.2. Intervention

The course comprised four 90 min classes with a 20 min break mid-session. Classes were held weekly and participants could enrol more than once, or attend sessions in any order. The content of each class was as follows:

- Class 1—introduction to course, course rules and expectations, confidentiality, introduction to CBT, development of fear, physiology as a maintenance factor in anxiety problems, fight/flight response and homework.
- Class 2—review/questions, behaviour as maintenance factor, helpful/unhelpful strategies, escape, avoidance, exposure therapy, habituation, hierarchy development, principles of exposure and homework.
- Class 3—review/questions, thoughts as maintenance factor, cognitive therapy, thinking errors, negative automatic thoughts, challenging thoughts, behavioural experiments and homework.
- Class 4—review/questions, helpful and unhelpful medications, defining problems, target setting, review of course, verbal and written evaluation, follow-up arrangements and homework.

2.3. Measures

A number of outcome measures were routinely collected from clients attending the classes.

CORE-OM [8] administered pre-course and at 12-week follow-up. This is a 34-item self-completed measure of psychological distress that provides a mean overall score (range 0–4) and four domain scores (well-being, problems, functioning and risk). For this study only the overall score was considered.

Fear Questionnaire [9] administered pre-course and at 12-week follow-up. This is a 24-item self-report questionnaire that provides four scores: main phobia, global phobia, total phobia and anxiety-depression. The total phobia score, used in this study, is composed of agoraphobia, social phobia and blood-injury subgroups and results in a total score between 0 and 120.

Client Satisfaction Questionnaire (CSQ-8) [10] administered post-course enquiring about the client's experience of attending the course, and their perception of its usefulness. There are eight items on a 0–4 scale, and a possible total score between 0 and 32.

The availability of normative data for CORE and the Fear Questionnaire allows for the calculation of clinical/non-clinical cut-off scores. Therefore, individual patient scores can be identified as being within the clinical or non-clinical population range.

2.4. Statistical analysis

Service utilisation and client demographic data was collected from routine audit data.

The routinely collected pre and post CORE-OM and Fear Questionnaire data was grouped by measurement point and analysed to detect clinically significant and statistically reliable change. The former is defined as a change in score from within the clinical range pre-treatment, to a score in the non-clinical range post-treatment. Statistically reliable change is a change in score greater than could be attributed to the unreliability of the measure itself [11]. For the Fear Questionnaire, a cut-off of 34 was calculated and a change of 16 was calculated as statistically reliable. For CORE the figures were 1.55 and 0.48, respectively. CSQ-8 data was collected and percentages of responses were calculated.

3. Results

A total of 191 patients were referred to the psycho-educational intervention over the space of 1 year, including 108 females and 83 males. The mean time from initial assessment to attending the course was 2 months (range 0–10 months). Of these 140 attended the first session and 120 remained in contact with the service to the follow-up meeting. The mean number of classes attended was 2.5 (S.D. 1.6).

At 12-week post-intervention, 92 patients requested further individual cognitive behavioural psychotherapy, 97 were discharged from the psychotherapy service and 2 moved to a later course. Of those patients discharged, 23 reported themselves as recovered, 9 wanted no further therapy for other

Table 1
Clinically significant change on CORE-OM between individual assessment and 3-month follow-up ($n = 44$)

Clinically significant change	Reliable change			Total
	No reliable change	Reliable improvement	Reliable deterioration	
Failed to achieve CSC despite sufficient initial score	11	6	1	18
Started better than criterion for clinically significant change	9	3	3	15
Clinically significant change	0	11	0	11
Total	20	20	4	44

Table 2
Clinically significant change on Fear Questionnaire (Total phobia sub-scale) between individual assessment and 3-month follow-up ($n = 55$)

Clinically significant change	Reliable change			Total
	No reliable change	Reliable improvement	Reliable deterioration	
Failed to achieve CSC despite sufficient initial score	21	2	0	23
Started better than criterion for clinically significant change	21	2	0	23
Clinically significant change	3	6	0	9
Total	45	10	0	55

Table 3
Client Satisfaction Questionnaire (CSQ-8): mean response scores and percentages indicating each response ($n = 102$)

Questionnaire item	Mean	4	3	2	1
How would you rate the quality of the service you received?	3.18	27.4% Excellent	62.8% Good	9.8% Fair	0% Poor
Did you get the kind of service you wanted?	2.88	10.8% Yes definitely	66.7% Yes generally	22.5% No not at all	0% No definitely not
To what extent has our service met your needs?	2.51	5.9% Almost all met	42.2% Most met	49% Only a few met	2.9% None met
If a friend were in need of similar help would you recommend our service?	3.43	45.1% Yes definitely	52.9% Yes I think so	2% No I do not think so	0% Definitely not
How satisfied are you with the amount of help you received?	3.05	21.6% Very satisfied	61.8% Mostly satisfied	16.6% Indifferent	0% Quite dissatisfied
Have the services you received helped you to deal more effectively with your problems?	2.96	11.8% Yes a great deal	73.5% Yes somewhat	13.7% No did not help	1% No made it worse
In an overall sense, how satisfied are you with the service you have received?	3.06	22.5% Very satisfied	60.8% Mostly satisfied	16.7% Indifferent	0% Quite dissatisfied
If you were seeking help again, would you come back to our service?	3.37	43.1% Yes definitely	51% Yes, I think so	5.9% No I do not think so	0% No definitely not

reasons and 59 made no further contact with the service. Six patients were referred to an alternative mode of psychotherapy (e.g. psychoanalytic psychotherapy, cognitive analytic psychotherapy or systemic psychotherapy), following further assessment of their needs at the follow-up appointment. As measured by the CORE-OM, 11 patients made a clinically significant and statistically reliable change from a total of 44 patients for whom data was available. Fifteen patients had CORE scores below the clinical cut-off prior to treatment and, therefore, could not make clinically significant improvement. Three of these made statistically reliable improvement and three showed statistically reliable deterioration (see Table 1). The Fear Questionnaire total phobia score found that 6 patients achieved clinical and reliable change from a total of 55 who provided data at both measurement points. Twenty-three patients had scores pre-treatment that were below the clinical cut-off although two of these made statistically reliable improvement (see Table 2).

A total of 102 patients completed the CSQ-8 at the final class or at the follow-up appointment. The mean CSQ-8 score ($n = 102$) was 24.44 (S.D. 3.47) from a maximum possible score of 32. Table 3 describes the patients' responses in detail.

4. Discussion and conclusion

4.1. Discussion

The psycho-educational intervention appears to be a helpful intervention for a number of patients that attend. Results from this pilot suggest that patients can achieve a clinical and significant improvement in symptoms of psychological distress

by attending such an intervention. The intervention appears to be largely acceptable to the majority of patients that provided an evaluation by completing the CSQ-8.

There are a number of limitations in the reported findings. The low number of pre–post measures available greatly reduces the generalisability of the findings. Only those patients that completed the course and attended the follow-up appointment completed the questionnaires and so contributed to the reported results. This data collection strategy may bias the results to those clients that selected to attend the intervention and found it helpful. The intervention was introduced to be a clinically useful service to patients attending a busy psychotherapy service with a very long waiting time for therapy. As such the design was intended to be as open as possible to patients. A consequence of this clinically based decision would appear to be that a number of selection biases were introduced at various points in the patient journey through the intervention. For example, data on those patients assessed, deemed to have a problem that may be suitable for CBT but who were not offered the educational intervention was not recorded.

In order to establish the effectiveness of this intervention, future research should attend to these design weaknesses ensuring that patients are randomly assigned to either the educational group or treatment as usual (in this case the waiting list), that demographic information on all patients is collected, that all patients are followed up and pre–post data collected by both treatment completers and those that drop-out. The intervention was delivered in a specialist tertiary service setting by nurses qualified and experienced in cognitive behavioural therapy for anxiety disorders. The utility of the intervention in other service settings such as primary care with less well qualified staff would establish the effectiveness of psycho-education groups that may be more accessible to patients sooner after they first seek help.

4.2. Conclusion

The results of this pilot study are encouraging, suggesting that there is a need for further research to establish the clinical and cost effectiveness of large group psycho-education for anxiety disorders. Future research should attempt to investigate the effectiveness of this intervention in a randomised controlled trial.

4.3. Practice implications

Stepped care models of service delivery would suggest that educational interventions such as the one reported may play an important role in future mental health services for people with common mental health problems. NICE guidelines for the management of depression and anxiety explicitly recommend the use of minimal intervention strategies such as psycho-education and self-help [12,13].

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