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INCREASING THE EFFECTIVENESS OF LARGE GROUP FORMAT CBT VIA THE APPLICATION OF PRACTICE-BASED EVIDENCE

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Abstract. Within Primary Care, clients presenting with mental health problems are most likely to report the presence of an anxiety disorder. Referrals to mental health services can result in waiting lists due to the prevalence of individual models of intervention. A service delivery innovation to this organizational impasse has been White's group-based "Stresspac" approach. The current project attempted to increase the effectiveness of such service delivery via the application of practice-based evidence (PBE) guidelines. Clients completed a battery of psychometric tests prior to engaging in and on completion of a six-session group cognitive-behavioural intervention. A satisfaction survey was completed on termination of the group. Two groups were completed, the second of which was conducted using a PBE derived selection criterion. The application of the PBE selection criterion appeared to increase the effectiveness of the intervention provided, with clients in both groups being widely satisfied with the group approach. The active employment of PBE in the design and implementation of services appears to offer the opportunity for increasing the range, format and effectiveness of psychological interventions offered.

Keywords: Practice-based evidence, group CBT, "stresspac".

Introduction

A common dilemma in psychological practice in the NHS is the pressure of responding creatively to the demands imposed by Primary Care (PC) waiting lists, in combination with the requirement to deliver interventions that have been illustrated to be safe, successful and cost-effective. Clients suffering from unmanageable symptoms of anxiety represent the most common and likely referral to PC mental health services (Espie & White, 1986). Services can, as a result, be chronically swamped with clients seeking help with anxiety, whilst not possessing the organizational resources to respond to the scale of such need via the traditional individualized psychotherapeutic approach. A recent PC service innovation is Jim White's large-group CBT approach for clients experiencing anxiety disorders (Stresspac; White, 2000) – groups of up to 70 clients are not unheard of. The service philosophy underpinning the approach is that such provision liberates therapeutic resources, thus enabling clients with complex problems and presentations to have quicker access to the required one-to-one clinical input.

PBE in the psychological therapies (Barkham & Mellor-Clark, 2000) is a summary term to describe the process of conducting naturalistic studies that examine the effectiveness of

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interventions provided without attempting to meet the daunting and stringent requirements of efficacy research. PBE exists on the quality continuum in a position of strong external validity, but weak internal validity (Barkham & Mellor-Clark, 2000). The quality continuum suggests that practice-based evidence (effectiveness research) and evidence-based practice (efficacy research) reciprocate to provide broadband guidance as to the appropriate type, duration and mode of service intervention for the various psychological disorders.

Research process, intervention and client characteristics

All clients were labelled by GPs as experiencing clinically relevant anxiety, presenting via GAD, mild PTSD, agoraphobia, mild OCD and panic disorder with such an eclectic diagnostic mix being the norm for such groups (White, 2000). The six-session intervention was delivered by two experienced CB therapists, off NHS premises and in the evening to increase uptake and reduce stigma. The content of the group was focal psychoeducative CBT for anxiety, with behavioural homework tasks between sessions evaluated throughout with personal diaries tied to topics covered (White, 2000). Clients can bring along other people to the group for personal support should they wish. The groups were evaluated by clients completing a range of psychometric measures pre and post intervention. Psychometrics employed were the Beck Depression Inventory-II (Beck, Steer, & Brown, 1995), Brief Symptom Inventory (Derogatis, 1993), Inventory of Interpersonal Problems-32 (Barkham, Hardy, & Startup, 1996) and the General Health Questionnaire (Goldberg, 1978), with a client satisfaction questionnaire completed on termination of the group. The first group was conducted as a general trial of the group with 14 clients (mean age 41; 8 males and 6 females) completing the evaluation process. As is evident from Table 1, the results of the evaluation suggested that, although the first group did not appear to be detrimental to clients' mental health, clients did not report the anticipated broad reductions in psychological distress. Clients did, however, report being generally satisfied with the approach. The PBE hypothesis reached was that levels of depression reported in the first group might interfere with the clients' abilities to benefit from the group. A selection criterion for the second group was identified that participants should not exceed 27 on the BDI-II. This criterion was based upon extant local PBE that illustrated a BDI-II of 27 to be the mean score for PC referrals in the district (Kellett & Newman, 2003), with clients above the PC mean therefore likely to be unsuitable for a PC intervention. The intervention was repeated with a group of PC referrals meeting the selection criterion ($n = 18$, mean age 43, 10 males and 8 females; all BDI-II scores < 27).

Results

Comparison of the psychometrics for group one and group two is provided in Table 1. Wilcoxon's signed ranked test (non parametric) was employed to assess the impact of intervention in each group. As is evident from the table, when the PBE selection criterion was introduced, the effectiveness of the group approach appeared to increase. The generalized anxiety scale of the BSI displayed a statistically significant reduction in the selection criterion group, despite being very similar at intake for both groups. The Global Severity Index (GSI) of the BSI illustrated statistically significant reductions in the intensity of psychological distress in the selection criterion group. Although the focus of the group was anxiety management, the selection criterion group also had statistically significant reductions in depression as measured

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Table 1. Results of group intervention following introduction of selection criteria

Measure	Group 1 Assessment Mean (*SD*)	Group 1 Termination Mean (*SD*)	*z*-score (*p*)	Group 2 Assessment Mean (*SD*)	Group 2 Termination Mean (*SD*)	*z*-score (*p*)
BDI-II	27.58 (14.20)	24.30 (14.67)	1.19 (0.23)	16.16 (5.65)	11.14 (8.71)	1.92 (0.05)
BSI: Somatization	1.30 (1.02)	1.31 (1.03)	0.80 (0.42)	1.05 (0.90)	0.67 (0.68)	1.37 (0.17)
BSI: OCD	2.12 (1.05)	2.00 (1.14)	0.35 (0.72)	1.60 (0.85)	1.39 (0.76)	1.42 (0.15)
BSI: Interpersonal sensitivity	1.18 (1.28)	2.19 (1.30)	0.61 (0.53)	1.17 (0.81)	1.18 (0.98)	0.41 (0.68)
BSI: Depression	1.91 (1.08)	1.53 (1.19)	1.96 (0.05)	0.91 (0.82)	0.67 (0.69)	1.45 (0.14)
BSI: Anxiety	2.06 (1.08)	2.10 (1.25)	0.49 (0.62)	2.08 (1.00)	1.35 (0.69)	3.15 (0.00)
BSI: Hostility	1.21 (1.18)	0.95 (0.76)	0.27 (0.78)	0.89 (0.64)	0.97 (0.93)	0.32 (0.75)
BSI: Phobic Anxiety	1.71 (1.12)	1.56 (1.31)	0.13 (0.89)	1.50 (1.17)	1.08 (1.15)	1.79 (0.07)
BSI: Paranoid	1.68 (1.08)	1.95 (0.96)	0.46 (0.64)	0.71 (0.86)	0.67 (0.87)	0.38 (0.70)
BSI: Psychoticism	1.63 (0.99)	1.50 (1.22)	1.54 (0.12)	0.84 (0.83)	0.51 (0.70)	1.55 (0.12)
BSI: Global Severity Index (GSI)	1.72 (0.78)	1.66 (0.96)	0.17 (0.86)	1.17 (0.57)	0.93 (0.57)	1.91 (0.05)
BSI: Positive Symptom Distress Index (PSDI)	2.38 (0.59)	2.37 (0.63)	0.01 (0.99)	2.03 (0.48)	1.70 (0.51)	1.86 (0.06)
BSI: Positive Symptom Total (PST)	36.25 (11.07)	34.46 (16.46)	0.21 (0.83)	30.22 (10.37)	28.37 (11.59)	0.88 (0.37)
Inventory of Interpersonal Problems – 32 (IIP-32)	1.54 (0.43)	1.60 (0.65)	0.05 (0.95)	1.22 (0.53)	1.17 (0.75)	0.28 (0.77)
General Health Questionnaire – 12 (GHQ-12)	23.61 (10.70)	14.23 (8.26)	3.06 (0.02)	19.90 (7.75)	9.27 (5.14)	4.06 (0.00)

by the BDI-II. The GHQ-12 data were statistically significant for both groups, but the selection criterion group comparatively reported greater improvements in general psychological well-being. When the GHQ-12 data were scored using the caseness technique, caseness fell by 22% in the first group compared to a 55% fall in the selection criterion group. Both groups were similar in illustrating that the large-group format CBT approach did not appear to have any marked impact on interpersonal functioning as measured by the IIP-32. This is consistent with White (2000) service philosophy that places emphasis on symptom management rather than altering interpersonal processes as the means of improving general mental health. In terms of satisfaction, both groups reported similar high levels of satisfaction with the intervention across individual items. Sixty-seven per cent of the selection criterion group agreed that the intervention had significantly helped them overcome their problems in comparison to 36%

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of the initial group. The drop-out rate for both groups was 10%, with a total of three clients requiring further individual intervention following review at 3-month follow-up.

Discussion

The current paper has attempted to illustrate the role that PBE can play in the evaluation and evolution of clinical services in PC. The data presented appear to suggest that once the PBE selection criterion was introduced the effectiveness of the group programme appeared to increase. Satisfaction results are difficult to interpret due to fact that although clients can state their satisfaction with, in present context, a short-term group-based approach, clients are typically unable to rate satisfaction in comparison to their knowledge and/or experience of another psychotherapeutic approach. Satisfaction surveys could, at times, therefore appear to be measuring ignorance and/or naivety rather than satisfaction. The lack of psychometric evaluation at follow-up represents a major study weakness.

As the NHS attempts to change its organizational culture by examining the effectiveness of interventions provided, rather than blindly trusting that such interventions do actually work, PBE may fulfil a pivotal role. The current project's PBE selection criterion was made possible through the establishment of a locally based routine audit and evaluation system. This in turn enabled relevant population specific information to be used in service decision-making and planning. It is probable that the closer the source PBE information is to the population on which the decisions are being made, the greater the chances of clinical success. The evolution of clinical governance as a valued and useful tool rather than an organizational exercise depends on not only producing PBE, but truly putting such PBE to work in the design and implementation of psychological services (Kellett & Newman, 2003).

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