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AFREEN HUSAIN HUQ BSc Hons., MSc, MPhil.

**EXPLORING THE PERCEPTION OF
COGNITIVE BEHAVIOUR GROUP THERAPY
FOR OLDER ADULTS WITH DEPRESSION AND
/ OR ANXIETY.**

A thesis submitted in partial fulfilment of the requirements of the Open
University for the degree of Doctor of Clinical Psychology.

NOVEMBER 1999

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY COLLEGE

AWARD DATE: 5 November
1999

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This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed *Afreant King* (Candidate)

Date 21.09.99.

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Declaration of confidentiality

Every effort has been made to preserve the anonymity of the participants in the present study. Therefore, the names of the participants and any information which could identify anyone taking part have been changed.

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Introduction

Throughout its history, the field of psychotherapy research has faced controversy as theories have multiplied and practices have changed. The procedures and emphases in psychotherapy research have likewise evolved, with the most recent emphasis on understanding variables that lead to client improvement (Garfield & Bergin, 1994). Roth and Fonagy (1996) examined the evidence for the efficacy, effectiveness and cost effectiveness of different psychotherapies for specific disorders and recommend greater communication between researchers and clinicians to facilitate evidence based practice.

Mintz, Steuer and Jarvik's (1981) observation continues to be true that major psychotherapy outcome studies do not include older adults. There is either an upper age cutoff or too few older adults are recruited to undertake analyses by age. Considerable clinical writing advocates various adaptations of therapy for older adults (Grant & Casey, 1995). Thus, practitioners in the field are probably providing different aspects of therapy to their older adult clients from those described in manuals for adults. Older adults present some diagnoses and problems that are uncommon among other age groups seeking psychological care such as age related cognitive changes, loss and grief issues, changes in roles, physical health problems, dementia. Additionally, it has been argued that subclinical conditions such as minor depression and anxiety may be more consequential in older adults because the prevalence of many chronic medical conditions such as cardiac disease, lung disease, rheumatoid arthritis, stroke, cancer and sensory impairments, increases with age (Blazer, Burchett, Service & George, 1991; Zonderman, Herbst, Schmidt, Costa &

McCrae, 1993).

A major difficulty in published outcome research is the criterion that the studies must exclude dual or ambiguous diagnoses and must adhere to standardised therapy manuals. Such 'pure form interventions' have not been found by practising therapists to translate very well to the types of clients who present themselves for therapy (Goldfried & Wolfe, 1996). Moreover, the clients who are included in such trials are unrepresentative of the general population and drop out rates are often problematic making generalisation of the findings difficult. Measures of outcome often poorly reflect personal experience of the clients and are not well calibrated against real life implications (Sechrest, McKnight & McKnight, 1996).

In the following sections, the literature review will cover a discussion on the specific needs of older adults to set the scene for subsequent discussions on the evidence for the efficacy of cognitive behaviour therapy (CBT) followed by evidence for cognitive behaviour group therapy (CBGT) with older adults. Then the discussion will focus on the study of therapy process that has been neglected in the quantitative experimental studies just referred to. As a complement to quantitative method, the utility of qualitative approach will be considered to fill the gap, with a particular focus on interpretative phenomenological approach, and the problems of reliability and validity in qualitative work. A description of the service (CBGT) that formed the context for the present study will be given followed by the rationale for the present study and end with research aims and questions.

The needs of older adults

Older adults are generally under served by mental health services including psychological therapy services. They have frequently been viewed differently from younger adults despite having similar problems but also in some measure having different needs. Although there is debate within the British Psychological Society (BPS) whether older adults should be a separate specialty, they are in fact often seen differently and frequently neglected in therapy trials. According to the Community Care Team of the Kings Fund Centre (Kings Fund, 1986), older adults are a 'neglected and under-valued group in our society'.

Freud believed that older adults had too much life experience to explore and that this would result in interminable analysis. In addition, he supported the view that adults over 50 did not have the necessary elasticity of mental processes for psychoanalysis. His viewpoint has influenced succeeding generations of therapists. Perhaps partly as a result, until relatively recently, little scientific attention had been devoted to the study of psychotherapy with older adults. In some American research in the 1970s, many therapists were found to prefer in their clients the 'YAVIS' criterion i.e. 'Young, Attractive, Verbal, Intelligent, Successful' which Kosviner (1994) pointed out is not represented by those in need of psychological therapies presenting to the NHS. Although older adults have historically been regarded as poor candidates for psychotherapy, some recent research supports the use and efficacy of cognitive behaviour therapy (CBT) for older adults (Gatz, Fiske, Fox, Kaskie, Kasl-Godley, McCallum, & Wetherell, 1998). Other research will be reviewed in the next section.

A recent study described the application of CBT in the German Health Care

system as typified by a random sampling of 1,344 cases of which only three cases were 65 years and older (Linden, 1996), which again showed that older adults do not generally find their way into cognitive behaviour therapy.

Even with a high incidence rate of depression, it is probable that depressive disorders are under diagnosed among older adults by being masked as somatic complaints and disturbances of sleep and appetite, which are diagnosed either as transient symptoms or as dementia (Kaszniak & Allender, 1985). Older adults have slightly less than half the chance of being referred to psychological services as do younger people with comparable problems (Skelton-Robinson, 1995) despite growing evidence for the efficacy of psychological interventions for mental health problems in late life, some of which is reviewed here.

Limited by health problems, many older adults may lead a relatively sedentary life, which may be a contributory factor to the occurrence of depressive ruminations. Many of the depressogenic factors in their lives are both unchangeable and continuously present such as varied levels of functional disability related to physical and mental health. In the face of such unchangeable and inherently distressing life events, it could be argued that the most productive efforts that can be made to ward off depression are in the cognitive domain (Bradbury, 1991; Morris & Morris, 1991).

Yost, Beutler, Corbishley, and Allender (1986) suggested that group therapy for older adults is preferable to individual therapy as the group offers unique opportunities that are important but often unavailable for this population. For example, socialisation (to develop or rediscover social confidence), the experience of expressing one's altruistic needs (playing a valuable role in the lives of others),

and to be reminded of the universality of personal conditions and problems. For example, older adults are often forced to have fewer contacts due to ill health, lack of transportation, and the death of friends and family, which can result in a sense of personal isolation and the loss of opportunities to maintain social skills. Group therapy presents an opportunity to develop or rediscover social confidence as the response of other group members can serve as an important reinforcing factor. A group experience not only fulfils a need for socialisation in older adults but also one's altruistic needs. The experience of speaking up in group, being heard and allowed to contribute to others' ideas and play a valuable role in the lives of others can be empowering for older adults.

Furthermore, the sense of universality applies not only to specific common problems but also to the life stage that group member's share and the pooling of wisdom around common experiences provides not only practical help but also more importantly, a hope that problems can be overcome. In CBGT, such discussions are used to foster a sense of community and of intentional problem solving.

Overview of CBT for depression and anxiety with older adults

In recent years, several scholars of psychological interventions with older adults have presented meta-analyses of psychological treatments for depression (Scogin & McElreath, 1994; Teri, Curtis, Gallagher-Thompson & Thompson, 1994). These meta-analyses reported that psychological interventions do lead to improved mental health.

There is an optimistic flavour to the emerging data suggesting that cognitive behaviour therapy (CBT) is an effective treatment for older people with depression.

Scogin and McElreath (1994) concluded that group and individual therapy in older people with depression appear to be similar in effectiveness with a mean effect size based on BDI scores, of 0.78. This mirrors the findings of a meta-analysis of cognitive therapy in the general adult population with a mean effect size of 0.73 (Robinson, Berman & Neimeyer, 1990). As a guide to interpreting effect sizes, Cohen (1977) suggests that for the behavioural sciences, a value of 0.80 represent a large, 0.50 a medium, and 0.20 a small effect.

Koder, Brodaty & Anstey (1996) calculated mean effect sizes based on BDI scores and converted the effect sizes into percentages on seven comparison studies and found that cognitive therapy (CT) showed 66 per cent improvement compared to psychodynamic therapy, a 60 per cent improvement over behaviour therapy (BT) and an 89 per cent improvement over no-treatment or waiting list control. They concluded in their review that cognitive therapy with adaptations, is an effective intervention for depression in older people. However, they recommended strategies for further research to enable more accurate targeting of therapy because although empirical evaluation is at an early stage and appears optimistic, there are deficiencies and limitations in the current research methodology adopted in the published research.

A series of studies examined the effects of individually administered cognitive, behavioural and brief relational therapy on depression on community dwelling older adults. Gallagher and Thompson (1982) found that all three approaches led to comparable improvement, and that at subsequent follow ups, there was evidence for the superiority of cognitive and behavioural to relational approaches. In a similar study, Thompson, Gallagher and Breckinridge (1987) found

that all three approaches led to significant improvement, while a waiting list control group did not improve.

Cognitive therapy has been used in a self-administered mode to older clients in the community, some with major depressive disorder and some with subclinical depression. Scogin, Hamblin and Beutler (1987) compared cognitive bibliotherapy with weekly telephone calls to discuss therapeutic issues arising from the reading material, to an attention control group involving a waiting list group who received weekly telephone calls of a social nature and general information, and to a waiting list control group, and found that cognitive bibliotherapy was superior to both the attention and waiting list control groups. Scogin, Jamison and Gochneaur (1989) compared a cognitive bibliotherapy, behavioural bibliotherapy and a waiting list control group and found that both cognitive and behaviour therapy were superior to the waiting list control and the difference was maintained at two year follow-up. There was no difference between cognitive and behavioural therapy.

Fry (1984) found cognitive behaviour therapy superior to a waiting list control group for older community residents. Campbell (1992) found a significant decrease in depression after individual cognitive therapy (supplemented with elements of reminiscence therapy) in comparison to a psychological placebo and to an untreated control group. Gallagher-Thompson and Steffen (1994) found that individual CBT and psychodynamic therapy were the same in reducing depressive symptoms in depressed caregivers. However, CBT was more effective for those who had been caregiving longer with psychodynamic therapy more effective for those who had become caregivers more recently. Chambless, Sanderson, Shoham, Johnson, Pope, ChrisChristoph, Baker, Johnson, Woody, Sue, Beutler, Williams, &

McCurry, (1996) concluded that cognitive therapy for depression has been accepted as a well established treatment for depressed adults. The evidence with respect to older adults is that cognitive therapy and CBT are probably efficacious treatments for depressed older adults in the community, who are cognitively intact, have minimal comorbid psychopathology and are not suicidal. It was also noted that little adjustment of fundamental techniques appears to be required.

King and Barrowclough (1991) evaluated the use of cognitive restructuring and behavioural strategies with two male and eight female older adults with panic, agoraphobia or generalised anxiety disorder. Nine out of these ten clients reported decreased anxiety symptoms after therapy and eight out of nine were symptom free at follow-up. Some work has been done using various forms of relaxation, imagery or meditation with older community volunteers who have complaints of anxiety (DeBerry, 1982a, 1982b; DeBerry, Davis, & Reinhard, 1989; Sallis, Lichstein, Clarkson, Stalgaitis, & Campbell, 1983; Scogin, Richard, Keith, Wilson, & McElreath, 1992). There is, however, a lack of sufficient evaluations of treatments for anxiety in older adults using manualised or clearly described approaches in comparison to control groups or other treatments (Gatz et al., 1998).

Efficacy of group therapy with older adults

Research has indicated that cognitive therapy can be successful with older people (Yost et al., 1986). The group situation is often preferable to individual therapy, because the group offers unique opportunities that allow older adults to share their feelings and experiences which enhances socialisation as well as empowering them to helping each other and to recognise that they are not alone (Yost et al., 1986).

A few studies have investigated the efficacy of group psychotherapy with depressed elders. Steuer, Mintz, Hammen, Hill, Jarvik, McCarley, Motoike, & Rosen (1984) found patients in both cognitive behavioural and dynamic group therapy showed clinical and statistically significant reductions in clinician rated depression levels (Hamilton Rating Scale of Depression, HRSD) and self rated depression scores (Beck Depression Inventory, BDI). No difference between the groups emerged for HRSD, however, older patients in cognitive behaviour therapy (CBGT) as compared with dynamic therapy, reported lower scores on the BDI.

Beutler, Scogin, Kirkish, Schretlen, Corbishley, Hamblin, Meredith, Potter, Bamford & Levenson (1987) compared group cognitive psychotherapy with psychotropic medication. No between group differences were found between medication and placebo conditions but patients in cognitive therapy groups showed consistent improvement in self report (BDI) and blind clinician ratings of depression (HRSD) and significantly improved sleep efficiency.

Ong, Martineau, Lloyd & Robbins (1987) set up a support group for depressed elderly patients using psychodynamic and problem-solving techniques and found that this simple intervention reduced re-referral and admission rates. Yalom (1983) found that older clients treated within inpatient groups were more likely to pursue post-hospital treatment programmes.

Kuhner, Angermeyer and Veiel (1996) evaluated a CBGT for older patients who were pretreated for clinical depression on a psychiatric in/outpatient basis and found that by strictly matching group participants with non participants on illness related characteristics at pretreatment, the group intervention was mainly effective in preventing short term relapses during the six month period under treatment.

Klausner, Clarkin, Spielman, Pupo, Abrams and Alexopoulos (1998) compared the efficacy of goal focussed group psychotherapy and reminiscence therapy and found both groups improved in depressed mood and functional disability. But the goal focussed group had a far greater change in depressive symptoms and also improved in the areas of hope, hopelessness, anxiety and social functioning. Kipling, Bailey and Charlesworth (1999) reported a cognitive behaviour group therapy (CBGT) for memory difficulties in early dementia to be feasible and beneficial.

Very few published reports describe studies on anxiety disorders, although anxiety is increasingly recognised as an important issue for older adults (Blazer, George & Hughes, 1991). Stanley and Beck (1995) compared CBGT to a supportive, nondirective therapy group for older clients with generalised anxiety disorder and found both treatments were equal at reducing self report and clinician rated measures of worry, anxiety and depression.

The study of process in cognitive behaviour therapy

Research into the effectiveness of CBT has largely focussed on outcome. Outcome is important as it validates the therapy, however, it provides little information about how change occurs. With the effectiveness of psychotherapy generally regarded as established (Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, 1988), more attention is now being directed to discovering the ingredients responsible for its effectiveness. This shift in focus has resulted in an increased interest in significant events occurring during therapy, based on the assumptions that such events will contain the sought-for effective ingredients. One line of research into significant events is the study of their

therapeutic impact, that is the immediate effect on the client of a therapist intervention or session (Elliott, 1985), which exists as an intermediate step between therapy process and outcome (Orlinsky & Howard, 1986; Stiles & Snow, 1984).

The client's perception of therapeutic efficacy is an important dimension in psychotherapy outcome research (Kazdin, 1994; Strupp & Hadley, 1977). Moreover, client's views about the process of therapy and the factors involved in their change are useful to assess as Fuller and Hill (1985) and Llewelyn (1988) found that clients tend to see their therapists' interventions and the helpful events of therapy differently from their therapists.

Llewelyn (1985) devised the Helpful Aspects of Therapy (HAT) questionnaire, which is based on the questionnaire used by Bloch, Reibstein, Crouch, Holroyd, & Themen (1979), in their study of therapeutic factors in group psychotherapy. Each client completed the HAT form at the end of each therapy session. This asked participants to describe in their own words the event that occurred in that session of therapy, which was most helpful for the client, together with any other important event which could include unhelpful events.

Significant events, as identified by 40 clients over an average of 10 sessions each, were analysed, using the Therapeutic Impact Content Analysis System (TICAS) devised by Elliott, James, Reimschuessel, Cislo & Sack (1985), and contrasted with the events identified by their therapists. Trained coders rated the events according to their therapeutic impact. The findings indicated that while therapists (from a variety of theoretical backgrounds and using a range of therapeutic techniques) reported that the most helpful impact of therapy for clients was the gaining of insight, the clients

themselves reported the most helpful aspects of therapy to have been reassurance and relief gained, as well as help in solving their problems.

Llewelyn (1988) highlighted the need to become more aware of the ways in which events occurring in therapy are perceived differently by those who provide the therapies as professionals, and those who participate in therapy as clients. This awareness may stimulate more accurate appreciation of the ingredients of psychological therapy which have most helpful impact, and this in turn should lead to more effective intervention.

Elliott and James (1989) reviewed the literature on client experiences of psychotherapy and found that the helpful factors most frequently reported by clients across therapies were facilitative therapist characteristics, unburdening of distress, self-understanding and encouragement for gradual practice. Llewelyn et al. (1988) reported that the most commonly occurring helpful impacts across two types of therapy (CBT and exploratory, relationship-oriented individual therapy) were problem solution, awareness and assurance, with awareness largely attributable to exploratory therapy and problem solution to prescriptive therapy. The most commonly occurring hindering impact was 'unwanted thoughts' (where the client was made to think about uncomfortable and painful ideas or feelings in an unhelpful way), 'unwanted responsibility' and misdirection that was found to be more common in exploratory therapy.

Wiseman (1992) and Elliott and Shapiro (1992) used 'interpersonal process recall' (IPR), also known as 'brief structured recall' (BSR), to study clients' experiences of helpful impacts and events within psychotherapy sessions. IPR is a special interview procedure in which a therapy session is audio or videotaped and immediately played back for the participants. The informant is asked to remember

and describe the momentary experiences and perceptions associated with particular events in the conversation using the HAT questionnaire. IPR makes it possible for participants to recapture fleeting impressions and reactions, which would ordinarily be forgotten or merged into more global perceptions. They found that clients arrive at 'an alternate way of looking at themselves', a new understanding, problem clarification or reported gaining insight encompassing feeling understood and relieved.

Lietaer (1992) used content analysis on pre-post session reports of helpful factors in client-centred/experiential therapy and found categories dealing with relational climate (e.g., therapist empathy), specific therapist interventions (e.g., confrontation), or immediate outcome aspects of the process (e.g., insight into oneself). Whether the unit of therapy process is a change event, a session, or the entire treatment, an important question in understanding factors leading to change is the extent to which these factors are either common or specific to one particular approach.

Many researchers have confirmed the well established finding of a lack of systematic differences in the effectiveness of brief treatments for psychological disorders (Ablon & Jones, 1999). Lambert and Bergin (1994) categorised the various common factors into support, learning and action factors which is consistent with previous findings (Elliott & James, 1989). Gershefski, Arnkoff, Glass and Elkin (1996) found that clients reported both common and specific aspects of therapy perceived as helpful as in previous research as discussed earlier. As far as it can be ascertained, this kind of work on process has not been done with older adults.

Qualitative Research Methodology

Qualitative research has traditionally been criticised by mainstream psychology for failing to meet conventional scientific standards. Such criticism assumes a prescriptive view of what science is. In fact, it can be argued that science is a multifaceted activity that is well able to accommodate qualitative approaches to psychology. According to some writers and practitioners of science, a psychology that involved a move towards qualitative methodology would be more in keeping with contemporary definitions of what science is and what it can achieve (Smith, 1996a). It is an increasingly accepted view that work becomes scientific by adopting methods of study appropriate to its subject matter. Qualitative research can be said to be scientific to the extent that it uses appropriate methods and is rigorous, critical and objective in its handling of the data (Smith, 1996a).

Barker, Pistrang and Elliott (1994) espouses the notion of “methodological pluralism”, that different research methods are appropriate for different types of research question. For example, qualitative methods are good for questions of definition and description within a discovery-oriented framework, for instance, when the aim is to learn about a phenomenon that has not been previously researched. Quantitative methods are good for questions of covariation and comparison such as looking for relationships between variables.

Available literature on studies about the client’s experience in therapy have varied widely in terms of the phenomena addressed and the method of analysis applied to them (McCleod, 1990). Investigators in these studies have gained access to the client’s experience through written reports (Rogers, 1951), questionnaires

(Orlinsky & Howard, 1975; Strupp, Wallach & Wogan, 1964), interviews after a course of therapy (Mayer & Timms, 1973; Oldfield, 1983; Phillips, 1984, 1985), interviews with tape (audio or video) assisted recall of significant events in therapy immediately after the session (Elliott, 1984, 1986; Llewlyn, et al., 1988; Elliott & Shapiro, 1992; Rennie, 1992). The present study adopted the approach of obtaining client's tape replay assisted recollections of the experience of specific group therapy sessions and then conducting an interpretative phenomenological analysis (Smith, 1995, 1996a,b). In the absence of process research about the views of older adults in cognitive behaviour group therapy, an inductive approach was considered to be the most appropriate.

Interpretative phenomenological analysis

Interpretative phenomenological analysis (IPA) (Smith, 1996b), an innovative form of qualitative methodology, connects to a long intellectual history in the social sciences more generally. It draws upon two important theoretical touchstones, i.e. 'phenomenology' and 'symbolic interactionism'. Phenomenological psychology (Giorgi, 1995) can be said to be concerned with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself. Symbolic interactionism (Denzin, 1995), influenced by phenomenology, is concerned with individual meanings within a specific context. It considers that meanings are only obtained through a process of interpretation, that meanings occur in, and are made sense of, as a result of social interactions. The purpose of IPA is to explore the participant's view of the world and to adopt, as far as is possible, an insider's perspective (Conrad, 1987) of the

phenomenology under study. IPA also recognises that research is a dynamic process and that the researcher is also a part of the process. It is assumed that what a respondent says in the interview has some ongoing significance for him or her and that there is some, though not transparent, relationship between what a person says and beliefs or psychological constructs that he or she can be said to hold.

IPA is consonant with the theoretical position of grounded theory / analysis. Grounded theory methods provide systematic procedures for shaping and handling rich qualitative materials, for discovering significant aspects of human experience. Grounded theory methods bridge interpretative analyses with traditional positivist assumptions as they are used to discover research participants' meanings, provide an empirical enterprise, and a set of procedures to follow (Charmaz, 1995). However, it is IPA, rather than the more extensive grounded theory that is used here, since the latter generally requires theoretical sampling of a substantial number of participants and the building, elaboration and inductive testing of theory to an extent not possible within the limitations of the present study.

Reliability and validity in qualitative research

Evaluating the reliability and validity of qualitative research is an issue that has been exercising a number of psychologists (e.g. Henwood & Pigeon, 1992; Stiles, 1993). One view is that it is important that qualitative research should be judged against criteria appropriate to that approach. In other words, qualitative research should not be evaluated in terms of the canons of reliability and validity that have evolved for the assessment of quantitative research since these have different epistemological priorities and commitments. Traditionally, psychological measurement (concerned

with how to describe and understand the way a person functions by testing or assessment) has been governed by the classical test theory (Nunnally, 1978) that assumes that the score obtained on a measure (the observed score) comprises two components, that is the true score plus an error score. The two main criteria derived from this view are reliability (the degree of reproducibility of the measurement) and validity (whether the measure measures what it is supposed to measure).

A bridge between the concepts of reliability and validity is the generalisability theory (Cronbach, Gleser, Nanda & Rajaratnam, 1972; Levy, 1974; Shavelson, & Webb, 1981; Shavelson, Webb & Rowley, 1989). This concerns the broader problem of how to make a general statement from a specific observation (or test score) to other classes of observation (often known as the dependability of a score or test). It de-emphasises the concept of the true score in favour of the central activity of analysing sources of variations in the scores.

An enlarged definition of 'scientific' psychology will involve amending the criteria for assessing the reliability and validity of different types of research. A number of suggestions have been made in the absence of criteria that have yet to be agreed within the community of qualitative researchers. These include internal coherence, presentation of evidence, independent audit, triangulation, member validation and reflexive research practices (Smith, 1996a). These concepts will be returned to in the Methods and Discussion sections in relation to assessing the findings of the current study.

Description of the therapy as applied in the service context applicable to the present study

Drawing upon previous work that applied CBT and CBGT, a broad eclecticism (Beutler, 1983) can be maintained, and it is believed that a cognitive view of depression is useful even if not comprehensive. The aim is to identify and modify unhelpful ways of thinking and behaving in participants and to bring about desired changes in their lives. It focuses on enhancing existing skills and learning new strategies to minimise difficulties.

Beck's (1967, 1976) cognitive model of depression can be applied for making sense of distress. Ability to cope depends partly on perception of the illness. Individuals construct their own definitions and representations of illness and subsequent behaviour depends on the nature of this definition. Coping strategies include problem solving or emotion focused strategies (Leventhal, Nerenz, & Steele, 1984). Problem solving involves attempts to deal directly with the situation, in order to make it more manageable. This is done by seeking information and support, which may lead to developing a sense of control. Emotion-focused strategy is more concerned with managing emotions generated by illness. Other variables relevant to the coping process include somatic disease characteristics; personality traits and impact on adaptability; previous crisis experience and coping strategies; social network and prognosis.

The primary objective of such an approach is to reorient and adjust established beliefs and attitudes in people to make them more consistent with the demands of reality. The focus of change is client well being, a subjective internal

state. The importance of behavioural and affective change is also emphasised at the same time.

Of all cognitive therapies, the Beck, Rush, Shaw and Emery (1979) approach to depression has probably received the most attention in recent years. The Beck et al. (1979) approach allows a broad eclecticism and makes it compatible with many other approaches and conveys a sense of flexibility, which appeals to clinicians in general. Variations of Beck's approach have been explored for application in group formats (Covi, Roth & Lipman, 1982; Sank & Shaffer, 1984) and for older people, although it has largely been applied in an individual therapy format (Gallagher & Thompson, 1981; Koder et al., 1996). While these applications of cognitive therapy vary in the emphasis placed upon cognitive, behavioural and interpersonal variables, they also highlight the flexibility of cognitive therapy in addressing a wide range of different psychopathologies and age groups.

Cognitive behaviour group therapy (CBGT) fills a gap that many clinicians perceive between purely behavioural methods and dynamic psychotherapies. It is a task-oriented approach and highly structured which is safe and appropriate for people not functioning at their best (Yost et al., 1986). CBGT has a wide application but is most commonly used in the management of depression (Yost et al., 1986).

Use of this approach rests on the strength of current outcome literature, which continues its relatively strong support of the value of CBT in treating clients with a variety of clinical problems. This observation reinforces the selection of cognitive behaviour group therapy to help older adults cope with depression and anxiety.

Cognitive behaviour therapy (CBT) is a directive, time limited, structured

approach that emphasises the role of cognitive processes (Beck, 1967), social learning and the role of reduced reinforcement (Lewinsohn, 1974) in the origin and maintenance of depression and or anxiety. CBT uses a combination of cognitive strategies and behavioural techniques to induce changes in behaviour and ways of thinking. These interventions can be implemented in individual and group format. Beck's cognitive model of psychopathology has been evolving as a system into which theoretical concepts and techniques from other approaches have been incorporated to meet the demands of clinical work and to address theoretical and empirical challenges. Beck (1991) nominated cognitive therapy as the integrative therapy as he viewed cognitive change as a common factor operating across effective treatments and therefore asserted that the cognitive model can be used as the framework for the selection of techniques from a variety of other psychotherapies.

The cognitive behaviour group therapy (CBGT) in this study, was set up as a structured, agenda based therapy (the agenda for the first six sessions was therapist led and the participants led the agenda for a further six sessions, making up a 12 session therapy programme) along similar lines with the emphasis on modification of thoughts and behaviour that contribute to feelings of hopelessness and helplessness. The theoretical rationale for the group incorporated ideas from social vulnerability approach (Brown & Harris, 1978), Johnson-Laird's (1983, 1988) theory of mental models and Rossi and Freeman's (1993) impact model, which lends itself to an account of depression and anxiety that emphasises both the psychological and the social levels of vulnerability.

An important underlying premise of CBT is that all situations produce evaluative thoughts that then contribute to emotions and behaviour that may be

helpful or unhelpful and that depression / anxiety is partly caused by and maintained by unhelpful ways of thinking and behaving on the part of the individual. A CBGT, in seeking to identify and modify these unhelpful ways of thinking and behaving, is hypothesised to decrease depression/anxiety. The purpose is to understand the links between thoughts and feelings which affect behaviour that is helpful or not helpful, to bring to their awareness of unhelpful (irrational) beliefs and erroneous interpretation of their circumstances, leading to the production of 'vicious circles', and to encourage the development of new coping strategies to enable people to gain a more balanced view of their life situations.

A critical methodological challenge in effectiveness research is how to maintain integrity of an intervention while employing it in a heterogeneous population sample. The more complicating client factors one brings into play, the more difficult it is to keep to a manual structure while maintaining its relevance for all clients with whom one would like to apply the therapy. Faithful administration of a treatment protocol seems insufficient to transfer the benefits of efficacious treatments into effective ones because the therapist might become unresponsive to the needs of the client. Therapy must be delivered skillfully, to allow a certain amount of creative flexibility within the therapeutic framework, allowing for adaptations from standard protocol. However it is important to document such details in order that the modification can be validated (Woody & Kihlstrom, 1997). General health care delivery in the 1990s is striving for an outcome based evaluation of programmes. Questions are being asked such, as whether therapy works in ways that is measurably valuable to the individual, the clinician, and the care organisation.

Rationale for present research

There is now increasing evidence that cognitive therapy can be successful with older people (Thompson et al., 1987; Morris & Morris, 1991; Gatz et al., 1998). The effectiveness of cognitive therapy has been demonstrated in its application to group work with depressed adult outpatients (Morris, 1975; Shaw & Hollon, 1978). However, few studies on cognitive group therapy work with older adults in a naturalistic NHS clinic setting have been reported.

Nowadays, service evaluations have become a regular activity in the NHS. However, personal experience suggests that obtaining critical and honest comments from older people is particularly difficult as they tend to be reluctant to comment, let alone criticise the services they receive or tend to be more complimentary about any service that they do receive. A favoured approach is to administer questions through structured and semi-structured interviews instead of filling questionnaires (Boakes & Smyth, 1995; Hazell, Driver & Shalan, 1996). These authors suggest that the questions need to be short, to the point and easy to understand, carefully worded to gain insight, for example, asking if A is better than B (an alternative to the present system), and 'yes, no, don't know' format as these responses can be explored in a tactful and sensitive manner during the interview.

In order to begin to generate some information about what older people think of the process of CBGT, the present research aimed to interview older adults directly using the HAT questionnaire, to discuss with them in some detail their perception of the process of being in CBGT. To analyse the data thus generated, Interpretative Phenomenological Analysis was used. The outcome of the CBGT was also investigated using standardised measures, since it was important to place the client's

perceptions of process within the context of their overall self-reported progress.

Research Questions

1. Is there change in clients individually and as a group on standardised measures of depression and anxiety?
2. Is there any evidence of clients' use of CBT strategies taught in the sessions on the basis of the HAT-CBGT interviews?
3. What are the clients' perception of the helpful aspects of the CBGT?

METHODS

Participants

Older clients (65 years and over) with mainly depression/anxiety, referred to the weekly CBGT were invited to participate in the research. All ten participants attending the group therapy programme were willing to take part in the study. Selection to attend the group was based on clinical needs and preference for attending on a Monday or a Friday while sample size was based on what was practical at the time. There were two groups of five clients in each group (see 'Results' section for further details on the participants). For the purpose of data analysis and interpretation, the two groups were combined. The inclusion and exclusion criteria were the same as for the therapy, and were therefore as follows:

- Absence of gross cognitive impairment.
- Absence of florid psychotic symptoms.
- Absence of active suicidal ideation.
- Main complaint(s) of subjective feelings of depression/anxiety.
- Some basic reading/writing skills.
- Be able to tolerate being in a group and participate.
- Be able to attend on the day of the group therapy sessions (Mondays or Fridays).

Clients received clinical assessment to ensure they fit these criteria (see 'Measures' section for details of standardised measures used).

Design

A form of methodological eclecticism was used combining qualitative and quantitative methods of inquiry. This enabled a process of triangulation to be applied whereby two kinds of data were gathered to offer a comprehensive analysis of the impact of attending CBGT. The aim was to provide different sets of information about participants' perspectives and a description of results on standardised measures on clients. Each participant was followed through the group sessions and exploration of their experience undertaken at three stages. A multiple single case study design was employed. For the analysis of the helpful aspects of therapy as perceived by clients, the interpretative phenomenological approach (IPA) outlined by Smith (1996b) was used. Data were collected at three points in time within two weeks after the second, eighth and twelfth group therapy session.

Measures and materials

1. An audio cassette recorder was used for recording three of the group sessions (second, eighth and 12th) that the clients had attended, for the purpose of reminding participants of the particular group session during the Helpful Aspects of Therapy (HAT) administration. A decision was made not to employ an analysis of the first group session as it was felt participants needed the opportunity to familiarise themselves and become orientated to the programme.
2. The Helpful Aspects of Therapy questionnaire (HAT, Appendix-4) (Llewelyn, 1985, 1988) modified for cognitive behaviour group therapy (HAT-CBGT,

Appendix-5) was used as the basis for a semi structured interview. The HAT-CBGT was adapted in order to allow older adults to express their views about the therapy sessions. Items one to five in the questionnaire consisted of questions such as general impression of the session, anything that stood out to them, if they were interested/involved in the discussion, whether they felt able to talk, and whether they were uncomfortable. Item six asked about anything they found helpful in that session, with audio playback of the group session as a reminder instead of relying on spontaneous recall of the most helpful event in that session. The previous studies (Elliott & Shapiro, 1988; Llewelyn, 1988; Llewelyn et al., 1988) had used spontaneous recall of the most helpful event in the session immediately after the therapy session, and then the event was located from the taped session. The modification was considered to be necessary for this research in order to compensate for any memory problems in the participants. Item seven to ten were about why the identified aspect was helpful, how helpful it was, impression of the overall session and if anything important happened since the last group session.

Ideally the HAT should have been administered immediately after the group therapy session. However, this was not practical as there were five people from each group that needed to be interviewed by one researcher. Therefore, it was decided that the HAT was to be used as recall-based interview rather than instant recall.

The aim of this approach was to generate knowledge about process, explore what is helpful/unhelpful for the clients by generating a phenomenological description of their experiences, and to see if they showed evidence of having used

or having more awareness of cognitive-behavioural strategies discussed in the group therapy sessions.

3. There was analysis of older adults' general experience based upon the HAT-CBGT interview (see section on 'Data Management').

4. Standardised and published global measures, which are part of the routine protocol of ongoing assessment, one to two months before and after therapy, were used as follows:

- The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) was used for monitoring depression level. The BDI is a 21 item self report inventory of depression and has been shown across numerous studies to have high internal consistency (mean alpha coefficient of .81 for nonpsychiatric population), good test-retest reliability, and high correlations (greater than $r = .60$) with other measures of depression (Beck, Steer & Garbin, 1988). The BDI differs from other depression questionnaires by including many cognitive aspects since Beck differentiates between somatic and cognitive symptoms.
- The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983), was used for monitoring anxiety and depression levels, as it was designed to be used in samples with somatic comorbidity. The HAD scale has been found to be a reliable self assessment instrument for detecting depression and anxiety as well as being a valid measure of the severity of depression and anxiety. It has been validated amongst different populations (Moorey, Greer, Watson, Gorman, Rowden, Tunmore, Robertson & Bliss, 1991; Johnston, Earll, Mitchel, Morrison & Wright, 1996) and widely used in research. Evidence for

the homogeneity of the two subscales of the HAD are their high coefficient alpha values (anxiety =0.93, depression=0.90). The depression subscale (HAD-D) measures only features of anhedonia rather than depressed mood (hopelessness, guilt and low self esteem are not assessed). It is not affected by somatic symptoms that may be attributable to acute or chronic physical disorders or to the ageing process and has been found to be sensitive to change in the severity of depression in older adults (Flint & Rifat, 1996).

- The Mini Mental State Examination (Folstein, Folstein & McHugh, 1975) was administered as a measure of cognitive functioning using the widely reported cut-off point of 23-24 to indicate cognitive decline in older adults with limited education (Hodges, 1994).
- A subjective mood rating 11 point scale (where 0 is the “worst that you can feel” and 10 is the “best you can feel” with 5 in the middle) was used in the group therapy sessions before and after the group discussion, to help participants learn to monitor their mood and understand the links between thoughts, feelings and behaviour. This was not intended as an outcome measure however, and therefore, scores on it will not be presented in the ‘Results’ section (Appendix-11).

5. Handouts given to participants included the group therapy programme (Appendix-6), and the cognitive behavioural model for understanding depression and anxiety (Appendix-7). The structure of the group session including elements of CBT strategies introduced to the participants and a sample of the usual group session is given below.

The structure of the group therapy sessions

The group therapy was for 12 sessions of one hour duration on a weekly basis. Each session consisted of the following routine:

- a. Announcements, setting the agenda (the presentation of CBT model is given in Appendix-7).
- b. Rate how they are feeling now on a scale of 0 to 10 where 0 represents the worst that they can feel and 10 represents the best that they can feel.
- c. Mini lecture for the first six sessions on depression, anxiety and CBT model and coping strategies, and check how participants relate to it as individuals. From the seventh session onwards, the participants set the agenda for the sessions. What people remember from the previous session (not applicable to the first session).
- d. Share their personal experiences over the last week, in between the sessions (by taking turns) and relate this to the cognitive behavioural way of understanding depression/anxiety.
- e. They are encouraged to generate alternative coping strategies as a group.
- f. Summarise the session and reminder of tasks in between sessions.
- g. Rate again how they feel on the scale at the end of the session.
- h. Verbal feedback from the participants on the session.

List of the elements of CBT introduced to the participants

Following the introductory session where the CBT model (Appendix-7) was presented, the subsequent sessions incorporated the list (given below) of CBT elements as coping strategies to highlight alternative ways of resolving various problematic issues for the participants, both in the cognitive and behavioural domain.

Cognitive strategies taught during the CBGT: Identifying, testing and challenging negative automatic thoughts, beliefs, looking for possible alternative explanations, the advantages and disadvantages of thinking in a particular way, positive self statements to counter negative thoughts, distraction techniques such as pleasant images, memories, absorbing activities like puzzles, crossword, listening to the radio while doing the chores.

Behavioural strategies taught: Self monitoring, scheduling activities, graded task assignment, introducing a more realistic concept of mastery, self reinforcement, redefine success realistically, relaxation.

Procedure

Referrals to the group therapy were assessed and those who were motivated to join the group were invited to take part in the study and given an information sheet explaining the research and a consent form (Appendix-2, 3). They were asked if they wished to participate in the research, emphasizing that they were under no obligation to do so and that it would not affect their attending the group therapy. They were given the phone number of the researcher and informed they could approach her directly to discuss the research further.

The Interview: Following specific group therapy sessions, a date was arranged for the interview and took place within two weeks from that particular group session. Each participant preferred to be interviewed in their home. The interviews took from about an hour to two hours. The purpose of the research was explained and their

right to stop the interview at any time was emphasised. Permission was sought to record the interview on tape. Every effort was made for the interviews to take place within two weeks from the specific group therapy session.

It was made clear to the participants that the researcher/therapist was seeking open and honest feedback of their experience in the group therapy programme and that it was not a personal reflection of the researcher/therapist. Also, that the emphasis was not so much on an evaluation of the programme but on the details, identifying specific parts which are more or less helpful. At the end of the interview, the participants were thanked for their cooperation in this research. Any clinical issue that the participant had or raised during the home visit was discussed before the research interviews were commenced.

Data Management

A qualitative theme analysis (IPA as outlined by Smith, 1995, 1996a) was employed to explore the experience of the therapy and in particular, the perceived significantly helpful aspects or events. The verbatim transcripts of the interviews served as the raw data to be analysed using IPA method described below. The analytic process proceeded as follows:

1. Interview transcripts were read and reread a number of times, to ensure a general sense was obtained of the whole nature of the participant's accounts. During this stage, notes were made of potential themes and the process was informed by the researcher's experience of the interview itself.
2. Returning to the beginning, the text was reread and any emergent themes identified and organized tentatively.
3. Attention was then focused on the themes themselves to define them in more

detail and establish their interrelationships. The focus was on the psychological content of the phenomena under study and the data were now being condensed.

4. The shared themes were organized to make consistent and meaningful statements, which contributed to an account of the meaning and essence of the participants' experience, grounded in their own words.

Thus the analysis which follows was organized around themes which emerged from the transcripts, rather than constructs predicted in advance. In keeping with the phenomenological approach, these themes were then considered in relation to the available literature in the Discussion section.

Effectiveness analysis addressed the question of whether or not the intervention made any difference to the participants for better or worse based on the interviews, establishing a feedback mechanism and incorporated strategies that could minimise unhelpful aspects of therapy. Statistical tests specifically paired sample (related) t tests were used to ascertain whether there were any statistically significant changes in scores on the BDI, HAD, MMSE, over the course of the group. Individual change scores were also examined for clinically significant change.

Reliability and Validity of qualitative analysis

The traditional criteria of reliability and validity do not easily carry over to qualitative approaches as discussed in the literature review section. A number of scholars have suggested ways in which the credibility of qualitative studies can be

assessed. Conrad (1990) suggested that when considering a qualitative study, rather than looking at sample size, statistical power, or participant selection, the work should be measured by the applicability of the emergent concepts.

Smith (1996a) suggested several criteria to assess internal validity and reliability of qualitative research. Two important ones are internal coherence and presentation of evidence. Internal coherence refers to the need to concentrate on whether the argument presented in the study is internally consistent and justified by the data. In addition, to allow the reader to inspect the interpretation, sufficient verbatim evidence from the participants should be presented in the document. The aim of validity checks on qualitative work is to ensure that the particular account presented is a sound one warrantable from the data.

Inter-rater reliability: Using a Random Number Table (Coolican, 1990), three interview transcripts from the three stages were chosen and given to an independent rater, with a list of themes and the second rater was asked to match the themes to the sections of text delineated. Cohen's kappa coefficient of agreement between the raters was 0.74. Following further refinement of the categories, the second rater was asked to independently code a new set of text segments, and this procedure yielded a kappa value of 0.84.

Respondent validation: Individual feedback from the HAT-CBGT was summarised and posted to participants for their opinion with reply paid envelope enclosed, with a covering letter (Appendix-9,10). The feedback summary included a rating scale with ten boxes (zero, denoting 'Don't agree with any of it' to 100 percent, denoting

'Agree with all of it') with instructions to tick the box to indicate their level of agreement. Four out of 10 participants gave a response of 100 percent, three gave 90 per cent and three gave 80 percent level of agreement. Therefore the agreement percent ranged from 80 – 100 percent. This process is referred to again in the 'Discussion' section.

Ethical Considerations

(i) Potential ethical considerations arising from being the researcher and the therapist: Being the researcher/therapist fits well with clinical practice and the developing area of Action research, Ethnography, Single case methodology and current developments in psychotherapy process research (Rudi Dallos, personal communication). It also fits well with the scientist-practitioner model where the researcher/therapist allows participants to give feedback as part of an ongoing audit process. Eliciting feedback from participants in therapy is an integral part of clinical work. Carrying this out using a formal research approach which enables a practitioner to reflect regularly and scientifically on their ongoing practice is seen as essential to the development of effective treatments (Barker, Pistrang & Elliott, 1994; Elliott, 1985; Llewelyn, 1985).

Potential difficulties may arise from asking for feedback directly from clients, however. They may feel reluctant to give critical feedback to the therapist. It was hoped this could be minimised by reassuring clients that the feedback is not a personal reflection on the therapist but focussed on their experience of the therapy, where the therapist was also a participant. It was found in practice that clients were indeed able to give both positive and negative feedback.

Ethical Committee approval was sought and received and did not require modifications to the research methodology. The letter of approval from the ethics committee is given in Appendix-1.

(ii) Protection of participants: It was not anticipated that the semi-structured interview might cause any distress to participants as the interview was focussed on the helpful and unhelpful aspects of the group therapy programme. However, participants were reassured that they could stop any time they became uncomfortable during the interview and that the researcher/therapist was sensitive to any potential distress caused so that reassurance could be offered to ensure participants were not left in an emotionally vulnerable state at the end of the interview.

It was made clear that they could choose to drop out of the study any time and still continue with the group therapy programme. It was also made clear that the research was concerned with exploring the current group therapy programme so that it could be made more effective for the participants.

The participants would normally expect a home visit from their CPN outside of their participation in this research. This was unaffected by their participation in this research and the CPNs were also informed about the research and their participation in it. When they gave their consent to participate in the three interviews for this study, they were given the choice whether they preferred to be interviewed by the researcher/therapist in their own home or the hospital premises. All chose home.

RESULTS

The results are divided into four sections. Section one presents a summary of the participants. Brief individual case histories of the participants involved in the research are given in Appendix-8. Section two presents their responses on the MMSE, BDI, HAD scale before and after therapy. Section three presents evidence of awareness of and/or use of CBT strategies introduced in the group sessions. Section four presents the categories generated, using the interpretative phenomenological analysis, from the participants' interviews on their perception of the helpful aspects of therapy highlighting common issues.

Section One: Summary of the participants'

The participants' age ranged from 68 years to 81 years with a mean age of 73 years (see Table-1). Altogether there were three men and seven women. They were all on various medications for physical health problems in addition to psychiatric medication. Four of the participants had a diagnosis of paranoid delusions in the past of unknown aetiology but the current diagnosis (diagnoses) for the participants were mainly that of depression and anxiety. The participants were all drawn from an inner city catchment area that is renowned to be one of the disadvantaged area with high levels of unemployment, crime, poor housing and education, ill health and poverty. It should be noted that the names of the participants have been changed to preserve their anonymity.

Table 1. Summary of the background history of the participants.

Participants	Age	Country of origin	Employment Hx	Recent Psych Hx	Past Psych Admission	Current Physical health problems	Who they live with
P01 Anne	75	England	Machinist	Depression	yes (5)	Parkinson's disease, chronic high BP, hearing loss, prone to falls, dizzy spells.	Widowed, alone.
P02 Brigitte	78	Belgium	Tailoress	Anxiety + depression	no	Pain from arthritis, sciatica, obesity.	Widowed, alone.
P03 Claudia	74	German	Home help	Depression	yes (3)	Severe rheumatoid arthritis in knees, kidney Problems, high BP, wheelchair bound.	Married, husband.
P04 Dolly	67	British Guyana	Typist	Depression @ Mild paranoid ideas	yes (1)	None	Divorced, alone. Has a boyfriend.
P05 Ernie	75	Ireland	Painter & decorator	Depression + Anxiety	no	Kidney problems, chronic bronchitis, heart disease.	Married, wife.
P06 Farley	74	England	Engineer	Depression + Anxiety	yes (1)	Prone to urine infection, falls, dizzy spells, vascular dementia, prostate problems, high BP	Widowed, alone, has a girlfriend.
P07 Gill	81	England	Factory Worker	Depression	no	Heart disease, angina, chronic high BP, dizzy spells, loss of balance.	Married, husband.
P08 Heather	69	West Indies	Dressmaker	Depression	yes (1)	Back pain from arthritis.	Divorced but back with husband.
P09 Ivy	68	Ireland	Odd jobs	Depression + Anxiety	yes (1)	High BP	Widowed, alone.
P10 Jack	69	Jamaica	Factory worker	Depression	yes (1)	Lesion in the right lung.	Divorced, alone.

Section two: Outcome on the standardised measures

The obtained score for the participants on the MMSE remained stable for before and after therapy which suggests that there was no deterioration in their cognitive functioning over the time they were undergoing therapy. The mean score on the MMSE was 27.5 (s.d.= 3.6). With a cut-off point of 23-24 on the MMSE generally regarded as indicative of cognitive deterioration, there were two participants who scored below the cut-off point while the rest of the participants' scores were within the normal range (see Table-2).

Table-2. Obtained scores on standardised clinical outcome measures:

Measures	MMSE	BDI			HAD						
		*	Bef- ore	Aft- er	Diff.	Anxiety			Depression		
						Bef- ore	Aft- er	Diff.	Bef- ore	Aft- er	Diff.
1 Anne	22	14	8	-6	11	9	-2	6	6	0	
2 Brigitte	30	26	15	-11	18	16	-2	10	7	-3	
3 Claudia	28	16	10	-6	11	9	-2	9	7	-2	
4 Dolly	30	12	0	-12	12	6	-6	10	3	-7	
5 Ernie	30	15	6	-9	12	10	-2	5	7	+2	
6 Farley	20	20	8	-12	10	8	-2	7	6	-1	
7 Gill	28	16	12	-4	7	8	+1	11	10	-1	
8 Heather	27	11	5	-6	11	5	-6	6	1	-5	
9 Ivy	30	20	10	-10	11	8	-3	10	6	-4	
10 Jack	30	10	6	-4	3	3	0	2	2	0	

* The MMSE score is given once as it did not change when measured again post therapy.

Table 3. Mean scores before and after intervention with results of t-tests.

Measures	Mean Before	S.D.	Mean After	S.D.	t (df=9)	p
BDI	16	4.9	8	4.1	8.00	0.000 **
HAD Anxiety	10.6	3.8	8.2	3.5	3.42	0.008 *
HAD Depression	7.6	2.9	5.5	2.7	2.47	0.035 *

* Significant at $p > .05$

** Significant at $p > .005$

Positive changes were observed in the scores on the BDI and the HAD scales (Table-2, 3.) before and after therapy that were found to be statistically significant. To measure the significance of this finding, the effect size measure was calculated which is the difference in means between the pre and post therapy scores divided by the standard deviation of the pre therapy measure (Barker, Pistrang & Elliott, 1994). The calculated effect size for the BDI and the HAD anxiety and depression were 1.63, 0.63 and 0.72 respectively. Cohen (1977) suggests that for the behavioural sciences, a value of 0.80 represent a large, 0.50 a medium, and 0.20 a small effect. Using the effect size measures, it can be said that the participants showed, on average, a substantial improvement in BDI scores but less so on the HAD anxiety and depression scores.

Table-4. Clinical range on the BDI and HAD measures.

Participan ts	BDI		HAD			
	PRE	POST	PRE ANXIETY	POST	PRE DEPRESSION	POST
Anne	Mild 14	Normal 8	Clinical 11	Borderline 9	Normal 6	Normal 6
Brigitte	Severe 26	Mild ** 15	Clinical 18	Clinical 16	Borderline 10	Normal 7
Claudia	Moderate 16	Mild 10	Clinical 11	Borderline 9	Borderline 9	Normal 7
Dolly	Mild 12	Normal 0	Clinical 12	Normal** 6	Borderline 10	Normal 3
Ernie	Mild 15	Normal 6	Clinical 12	Borderline 10	Normal 5	Normal 7
Farley	Moderate 20	Normal** 8	Borderline 10	Borderline 8	Normal 7	Normal 6
Gill	Moderate 16	Mild 12	Normal 7	Borderline 8	Clinical 11	Borderline 10
Heather	Mild 11	Normal 5	Clinical 11	Normal** 5	Normal 6	Normal 1
Ivy	Moderate 20	Mild 10	Clinical 11	Borderline 8	Borderline 10	Normal 6
Jack	Mild 10	Normal 6	Normal 3	Normal 3	Normal 2	Normal 2

** Indicates movement across two clinically significant domains

The clinical significance of outcome is defined as an attempt to encapsulate quantitatively what is meant when it is said that an intervention with an individual client was successful (Barker, Pistrang & Elliott, 1994). There are three different ways in which clinical significance may be generally conceptualised (Jacobson & Truax, 1991):

1. That the client's post intervention score has moved outside the range (i.e. more than two standard deviations away from the mean) of the dysfunctional population on the measure in question.
2. That the client's post intervention score represents a return to normal functioning, that is, it has moved inside the range (within two standard deviations of the mean) of the functional population.
3. That the client's post intervention score is more likely to be in the functional than the dysfunctional population. This is usually defined as being closer to the mean of the functional population than the dysfunctional population.

The decision of which of the three alternative criteria to adopt in any given study depends on which of the three ways best fit the conceptualisation of a significant outcome of the intervention that is being researched (Barker, Pistrang & Elliott, 1994).

Another way of looking at clinical significance, which was used here, is to make use of the various domains identified for the scales, namely normal, mild, moderate, severe, and to define it as movement across two of these domains (e.g. severe to mild, moderate to normal). Although this might be seen as unconventional, it has the advantage of excluding cases that merely jump between adjacent domains because of a change of only one scale point.

Taking this conservative definition of clinical significance as movement across two clinically defined domains (e.g. severe to mild, moderate to normal), the outcome on the BDI can be said to be clinically significant in two cases (Table-4). The overall post-intervention scores on the BDI for the participants were more in the functional range than the dysfunctional range (four in the mild and six in the normal range). In the pre-intervention scores, there was one participant who scored in the severely depressed range, four who scored in the moderately depressed range, and five who scored in the mildly depressed range. No participant scored worse on post test than on pre-test.

On the HAD anxiety scale, again taking the stringent criteria for clinically significant change, two clients made such a change. There were seven participants who scored in the clinical range, one in the borderline range and two in the normal range, in the pre-intervention scores, while the post intervention scores showed one in the clinical range, six in the borderline range and three in the normal range.

On the HAD depression scale in the pre-intervention scores, one was in the clinical range, four were in the borderline range and five were in the normal range while the post-intervention scores showed one in the borderline range and nine in the functional range. On this scale, none made changes that could confidently be defined as clinically significant.

Section three: Evidence showing awareness of and/or use of CBT strategies introduced in the group sessions

The data presented below (Table-5) illustrated the participants' ability for incorporating new information and learning into their existing coping strategies. The

evidence for the use of cognitive behavioural strategies was based on the interviews rather than group therapy session notes.

Table-5. Evidence for use of CBT coping strategies.

CBT elements/strategies mentioned	Number of people who mentioned this
1. Catching negative thoughts and dealing with it using pleasant thoughts, positive self statement, looking for alternative explanations, pros and cons.	<p style="text-align: center;">7/10</p> <p>Heather: If I get panicky I know I can control meself. By controlling meself, I think about what I'm thinking about and doing the right thing. I remind meself of helpful things. I look at my expectations and see what I can do.</p> <p>Jack: Whenever I have negative thoughts I try and think about something else and try to do things that make me feel good. I think of my parents, my brother who learn me so much. He learn me everything like dancing, horse riding, lots of happy memories.</p>
2. Monitoring self	<p style="text-align: center;">6/10</p> <p>Dolly: Right now I would rate my level of confidence as 6. The numbers rating is useful. I use the rating scale as a check on myself.</p>
3. Explanations given, the talks, chart, sketch, handouts.	<p style="text-align: center;">4/10</p> <p>Ernie: The sketch on the first day (the cbt model), that had a lot of things, it was good. ...I felt more uncomfortable before I went into the session than during the session. As I just said to you, explaining this from the beginning, it was the explanation which, it took a while but then I just settled down.</p>
4. Group discussion	<p style="text-align: center;">4/10</p> <p>Dolly:... Well I think what we all discussed and what we all talked about, made a lot of difference.....to how we see things and find a way out, look at what was harder, what was easier.</p>
5. Planning ahead, pleasant activities.	<p style="text-align: center;">3/10 e.g.</p> <p>Dolly: I must confess, I don't like staying indoors, so I go out, sometimes to the park, or concerts, holidays. We are making plans for going out regularly, to concerts.</p> <p>Heather: ...but I am better now and it make me plan, to do things in the future, I like company now.</p>
6. Relaxation	<p style="text-align: center;">1/10 e.g.</p> <p>Jack: I do relaxation regularly.</p>
7. Practice	<p style="text-align: center;">1/10 e.g.</p> <p>Dolly: What I'd really like is for Pat and I to go there a bit more often.I am going to the supermarket for practice.</p>

Section four: Interview analysis.

Overview: Overall, participants often gave answers that reflected the changes they saw or their experience in group therapy and frequently did not precisely answer the question on the specific aspects of therapy that helped, even with audio assisted recall. As the main research interest was broadly in the participants' experience of CBGT, categories were developed that encompassed all the types of answers given. From these 14 main categories emerged. These are outlined in Table-6 given below, in a descending order of the number of participants who had made comments that fitted the categories.

Table-6. Categories to emerge from the interviews

Theme	Brief definition	Number who mentioned theme
1. Listening & sharing	Being able to talk, share, learn from each other.	10
2. Specific aspects of therapy/tools mentioned + Coping strategies	Rating, the talks/chart/sketch/model/, relaxation, thought catching, positive self statements, Use of taught coping strategies such as pleasant activities, dealing with negative thought, etc.	9
3. Feelings about the group	Client describes their positive feelings /thoughts about the group and sadness at ending.	8
4. Belonging / togetherness	Being part of it, ownership (our group), like a family.	8
5. Personal Insight	Client sees something new about self, new learning.	7
6. Understanding	Client can understand self/others better.	7
7. Personal contact	Client relates to others in the group as a person.	6
8. Problem clarification	Client is clearer about what needs to change/ be worked on in therapy, explained.	5
9. Task involvement	Client feels more involved in the tasks of therapy, is made to think more /differently.	5
10. Reassurance	Client feels understood, supported.	5
11. Comparing	Self favourably with others, with self in the past.	5
12. Facilitator helpfulness	Therapist contribution	4
13. Being listened to /heard	Positive self worth that they can make a difference.	3
14. Distracted	Mind goes wandering due to poor memory, concentration problems, can't follow discussion due to poor hearing.	2

Analysis of the participants' general experience

The main categories generated from the interviews are presented below. To reduce the possibility of any participant being identified, all names of people and places have been changed. Any text included within brackets [] within the quotes from the participants denotes comments from the researcher for clarification purposes to make it easier for the readers of the script. A row of dots within the quotes indicates where some text has been omitted. Examples are given for each theme, but a full set of quotes for each category is given in Appendix-12.

1. Listening / sharing: Taking/showing interest in others, being able to talk, share, learning from each other.

Anne I'd say it was very enjoyable, and by listening to other people, it helps us in so many ways.

.... Well, really, all the way, though I wasn't saying much meself but I was listening to them. I thought it was interesting how the other half were carrying on.

..... By listening to others, I find it helpful. It makes me think different, lots of ideas are shared and that's helpful too.

Brigitte I liked it very well. I like to listen to Gill and that other gentleman,

Ernie.I like it because you hear other peoples' feelings and troubles.

.....it helps to listen to other people.

..... I was listening to everybody and then I thought to meself, well, I'm afraid Brigitte everybody got their problems, and everybody seem to fight.

.....I listen to everybody especially Gill and Jack and the sadness and I thought to myself at least they try, they try, they don't moan, they give their heart out. I think it's good to bring it all out than hide it.

Jack listen to each one, conversation of what they got and how they tried to come through with it.

2. Feelings about the group: Describing their positive feelings / thoughts about the group and sadness about ending.

Anne I think we was all sad it was the last session.

..... Though we were sad, we also had a laugh and that was helpful.....
 Things are very hard on me now. I have very high blood pressure which makes me feel ill. And the group made me feel so much better. I can hear myself talking more now

Dolly The only specific thing that I can think of is when I come back from the group and meet up with my Pat. I don't know how to put it, but it gives me an inner strength. I feel the group does wonders for me. I feel a lot better in myself. I feel I have done something, a positive feeling.

Ivy ... I found it very nice, and it relaxed me a bit, you know as well.

..... I was a bit down but I felt relaxed and that was very helpful.

..... I feel less shy now and I feel a lot better now.

.....When I first went there I thought that the other people might be you know, a bit iffy. The first session I did feel a little bit uncomfortable, then after that, it was really lovely.

..... Well, everything was helpful to me you know, but I did feel a bit down at the time. The chance of more group therapy was helpful. I just latched onto that.

3. Belonging / togetherness: Being part of it, ownership (our group), like a family.

Brigitte.... I feel we are like a little family in our group....and I must be honest, our group is good to fight against it [problems].

Claudia I like how people pull together.

..... We pull together as a group.

Dolly I feel I am one of the group.

3. Specific aspects of therapy/tools mentioned as expanded on in section three:

Rating mood, the talks, chart, sketch, model, relaxation, positive self statement. It also includes use of taught coping strategies mentioned such as pleasant activities, dealing with negative thoughts, etc.

Brigitte ... Like when I do my cleaning , it's not easy, but I tell myself you've done it and it's lovely. Before I start, I sit there trembling but once I start, it's funny but I get on with it.

DollyCatching your thoughts. Claudia talked about times when she didn't want to dress herself and how she talked herself into being positive and doing positive things even though it is hard.

JackWith me now, anything that happen to you, badly... with me, that's my position, it will come back to you sometime, but just try... and think about something ...that make you feel better. Ideas...even from the ...you gave the seminars...something bad and something good ... you try to think about

the good things and forget about the bad things. If it come at some time, but there's no future. I using all of those ideas, that's what get me out, that's what get me going, yeah. Do little bit at a time!

5. Personal insight: Client sees something new about self, sees links, new learning.

Claudia ...It made me feel more positive despite all my troubles.

Dolly Now I go to St. Mary's [Day Centre] by myself. I'm not frightened

anymore. I'm doing more than I was before and I am taking an interest in things like television, crochet, going out more with Pat [her fiancée]. I was feeling insecure at one time, there's no doubt about it.

Gill Well, now I know how hard I can make things for meself like telling meself off if something isn't perfect. I don't get so angry with meself now like the time I dropped the mince pie and it went all over the kitchen. I can laugh now. Oh my God, I was in tears and I had worked so hard to make it.

6. Understanding: Client can understand self/others better. This was regarded as different from category 5, (personal insight which refers to new learning through self monitoring), as it refers to learning from feedback /validation from others [??] or other sources.

Brigitte But poor Gill, she can't do much in the home and starts scolding herself and Jack, bless him, he's wonderful. Gill helped me to understand the pain in my leg, some form of sciatica that comes and goes. Heather reminded me of how much I had coped with, so many deaths since Christmas. The warden came up to me the other day and said well done. I said I did not do enough [referring to the neighbour who knocked on her door asking for help and died

of a heart attack in front of her while the warden was on leave]. She told me I couldn't have helped more as you have to be trained for that. Oh it was horrible, all that stuff coming out of his mouth, my sofa and carpet was full of it. Yes I have coped with a lot.

Ernie Actually, when you started speaking it caught me, brought home to me, understanding myself. I can make more sense of how I feel.

..... I got interested in other people and what they were saying. It helped me to understand myself better. It helped to bring me out, I was talking more easy to others, about services, about canals, especially when I used to go for a smoke outside. The main thing is it brought me around, the sketch, the chart was especially helpful in understanding myself.

7. Personal contact with others in the group: Client relates to others in the group as a person.

Anne ... It was very good of you that you got Claudia a wheelchair. I mean for all those months she hadn't had anything at all and she couldn't walk and it was only when you suggested it and you went all out to get it for her and then she got it. She goes out now and she's not stuck at home. She's a lovely lady. And Farley, he's lovely, always giving advice. He always has a smile. He's always joking with me, he's a nice man. We've got so much in common and we've got more or less the same thing.

..... It felt like a party. We exchanged telephone numbers so we can keep in touch.

Gill ... Yes it was very good. I thought the, you know like. sometimes you can't think of anything and then all of a sudden something ticks and it, you

know, reminds you of something else. And other people... their reactions are not quite the same but you feel how can I say, mix with them like. I thought it was quite good.

8. Problem clarification: Client is more clear about what needs to change or be worked on in therapy, explained.

ClaudiaWe feel very good because of the explanations.

..... The model is very helpful to make sense of problems.

Ernie Well yes, everything as I said to you, everything that was explained to me, it was good.

..... As I said to you, the explanation given for understanding depression/anxiety, for a little while I was mesmerised and when you study it, you can see what it is. It really caught me, I could really see what everything meant. I understood what you were speaking about, you see, because it was all up there on the wall, you know what I mean. From the first time, very very helpful.

9. Task involvement: Client is made to think more or differently, feels more involved in the tasks of therapy.

DollyI come away with what I heard I was discussing, I come away and think about it.

..... Well, when we go there, we have one outlook and then by the end of the session, it changes our outlook and helps to focus on what can be done.

Heather I know the day centre they was going, that was it, made me think I

could go too, twice a week. I'd like to do the same thing. [This was a goal she chose to reduce her social isolation, an idea that she had disregarded before group therapy].

10. Reassurance: Client feels understood, supported, relieved at not being different or alone.

Claudia I felt supported when I got to unload myself, about my troubles.

Ivy ... People understand me there you know and all that kind of thing. ... It relieves me a bit as well, when I hear that I'm not the only one, you know that kind of thing.

Jack All the time you listen to each one view, and thing like that, what they feel, what they experience and thing like that, and you say whoa, I've got something like that, just in my head.

11. Comparing self favourably with others /self in the past: Attempts to buttress self esteem by comparison with those more unfortunate, with self in the past.

Brigitte Yes I'm very interested because it's very nice to hear other people's problems and think to yourself sometimes that oh well I'm not so bad after all.

..... There's so many people like us.

..... That's what interests me, when I hear other people then I think well I'm not that bad after all.

DollyUmm.. I think it was the lady who said she had a fear of, that she comes to the hospital on her own but she had a fear, and I think that's when I might have said well at least I can cross the traffic lights on that.

12. Facilitator helpfulness: Therapist contribution.

Although no specific questions were asked about the group facilitator, the participants made some comments nevertheless.

Anne ... Well, you try and help us, you tell us what you think may be right or what might be wrong and what you say is to our advantage. So it was good to talk.

Brigitte.... and you like to explain everything nice, which is good, you know, sometimes like some of them are quite and they listen to us, and I like that you ask things, then you know what to answer.

..... And I like to listen to you. You explain everything so good, honestly, make you understand, being foreign, you know, some things that you don't understand, but I must say, I do understand.

Claudiaand you explain things to us, it makes you feel better. We feel very good you care and that's very nice.

Ernie ... and very well explained.

.....I remember that and you made sure that we all had our chance to voice our opinion.

..... What you've been speaking about don't overdo it, do what you can do. I have my own way of doing bit by bit.

13. Being heard/listened to: Positive self worth that they can make a difference to others and to themselves.

Brigitte ... We can listen to somebody and they listen to us and I like that.

..... No. I can't say that I've ever felt uncomfortable 'cause everybody is so nice. Everybody listens and I think that is so important.

..... That's what I like about it. Because when you think on your own all the time, you like to know what other people have to say, like in here. When I see those two old people, I do a bit of shopping for them and they are so grateful, oh it's so wonderful. The fact that I can make a difference to their life and feel good about it myself too.

Farley Ah, I can hear myself bring out laughs in the others. I can't tell you how good that makes me feel. We've all got our troubles but to think that just by talking about it, that it makes a difference. That I can make a difference to others, is a boost for me.

14. Distraction

Two participants identified problems in the group sessions in the first set of interviews when they could not follow the group discussion due to hearing problems and when the mind wandered off interfering with concentration. For example,

Anne ...all the time [interested in the group discussion] but I can't hear all of it. I can hear people sitting next to me.

Farley ... When someone is talking to you and my thoughts are being a bit lazy, I started to go back in meself, I wasn't concentrating, bit distracted with my mind wandering off. I get distracted by my thoughts.

These problems were minimised in the group sessions by providing more frequent summaries of the group discussion so that participants were able to stay focussed and by checking with the participants if they were able to follow the discussions and encouraging them to ask questions if anything was not clear.

DISCUSSION

The discussion section will include a brief overview of the findings of the present study, followed by a discussion of these findings in the light of previous research, then a critique of the methodology adopted, clinical implications of the findings and finally suggestions for future research and conclusion.

Brief Overview of Findings

Positive changes were observed on the clinical outcome measures (BDI and HAD) that were found to be statistically significant. Using the effect size measure, it can be said that the participants showed on average a substantial improvement in BDI scores (greater than one standard deviation) but a lesser one on the HAD scores. The outcome on the BDI could be said to be clinically significant in two individual cases (Brigitte, Farley). On the HAD anxiety scale, two participants (Dolly, Heather) made such a change while on the HAD depression scale, none made changes that could be defined as clinically significant using the fairly strict criterion adopted. There was evidence showing that generally, participants were aware of specific aspects of therapy and in some cases mentioned the use of some of the coping strategies that were introduced in the sessions.

Fourteen main categories were generated from the analysis of the older adults' interviews, which were described as listening and sharing, specific aspects of therapy/tools mentioned, positive feelings about the group, belonging/togetherness, personal insight, understanding, relating to others as a person, problem clarification, task involvement, reassurance, comparing self favourably with others/with self in the past, facilitator helpfulness, being heard/listened to and distraction due to poor memory, concentration difficulties or hearing problems. Use of interpretative

phenomenological analysis (IPA) (Smith, 1995, 1996a, 1996b) to analyse the helpful aspects of therapy mentioned by the participants allowed a more detailed analysis of process.

Exploration of these categories illustrated how engagement in therapy was closely related to interpersonal factors within the group. For example, the notion of listening/sharing, being part of it, personal contact, reassurance, comparison and being heard illustrated the positive impact of interpersonal factors within the group.

Discussion of Results

The substantial reduction in negative thinking as measured on the BDI in this study is consistent with the findings of Steuer et al. (1984) who found statistically and clinically significant reductions in BDI scores and depression in older adults that occurred over the nine months of group therapy (cognitive and psychodynamic). Taking the groups together, these authors reported 30 per cent showed some improvement and 40 per cent clear remission on the clinician rated HRSD. On the self report measures, these rates were lower (20-25 per cent remission) and although both cognitive and psychodynamic group psychotherapy were found to be equally effective, the cognitive group therapy showed a greater reduction in BDI scores. The authors suggest that the BDI may have measured shifts in cognition which were not accompanied by corresponding shifts in depression symptomatology. This may suggest an explanation of the smaller change found on the HAD depression scale than the BDI in the present study. The HAD measures general depression symptoms and is less sensitive to cognition.

A strong theme that emerged from the IPA was that of interpersonal relations. It can be speculated that the concept of 'consensual validation', a term first

used in psychoanalysis by Sullivan (1953), might be a relevant underlying concept. Consensual validation is a process whereby promoting an environment that will allow the client to have an experience (interpersonal exchange), can act as a catalyst to transform perception. For Sullivan, the immediacy of the interpersonal communication (exchange between analyst and client) serves as a vehicle for generating an emotionally relevant experience for the client because the analyst consensually validates the client's narrative, thereby challenging the client to reflect upon, evaluate and redefine perceptions of experience. The analyst works as a participant observer who embodies an objective vision of reality that is used to validate the client's subjective experience, thereby encouraging the client to both devise new forms of adaptations as well as to continually revise these patterns in order to attain a more optimal interpersonal experience.

This concept seems relevant because the participants in this study appeared to feel a strong sense of validation from the members of the group. According to Yalom (1985), consensual validation is a major approach in group psychotherapy that is used to facilitate reality testing by encouraging group members to check out their perceptions with one another, and to compare their interpersonal evaluations with those of others. The group members, through consensual validation and self observation, become aware of significant aspects of their interpersonal behaviour.

The process of CBT can also be seen to be consistent with the concept of consensual validation. CBT utilises the relationship between client and therapist in collaboration to work together as equal partners in exploring the client's thoughts and beliefs and their relationship to mood and behaviour to bring about more adaptive changes. Various techniques including reframing, generating alternatives, examining the evidence, guided discovery and Socratic questioning, are used to

identify negative automatic thoughts and cognitive distortions. Clients are encouraged to view their beliefs as hypotheses to be tested against logic and available evidence.

According to Yost et al. (1986), the high level of structure in cognitive behaviour group therapy makes it particularly appropriate for use with older adults as it can accommodate their mental and psychological struggles while allowing for individual differences and needs. Collaboration is an integral part of the CBGT process in which eliciting and responding to feedback from group participants is crucial to developing a sense of acceptance among group members and therapist, to help participants in identifying the nature of their problems within a CBT framework and to initiate changes in thinking and behaviour in the participants. It is possible that the spirit of co-operation inherent in CBT may have influenced the group interaction so that people became very supportive of each other's struggles (Yost et al., 1986).

Similarly, Hunter (1989) observed that groups of older adults cohered particularly quickly. Studies undertaken on small groups have shown that it is 'cohesion', which is the most influential variable in bringing about change (Bloch & Crouch, 1985; Yalom, 1985). Yalom (1985) defined group cohesion as "the resultant of all the forces acting on all the members to remain in the group" or more simply, "the attractiveness of a group for its members". Groups with members who show high mutual understanding and acceptance are, by definition, cohesive. We rely on others not only for approval and acceptance but also for continual validation of our important value systems.

The current findings are similar to previous research studies highlighting both common (nonspecific interpersonal factors) and specific aspects of therapy that clients have found helpful. Stiles, Reynolds, Hardy, Rees, Barkham & Shapiro

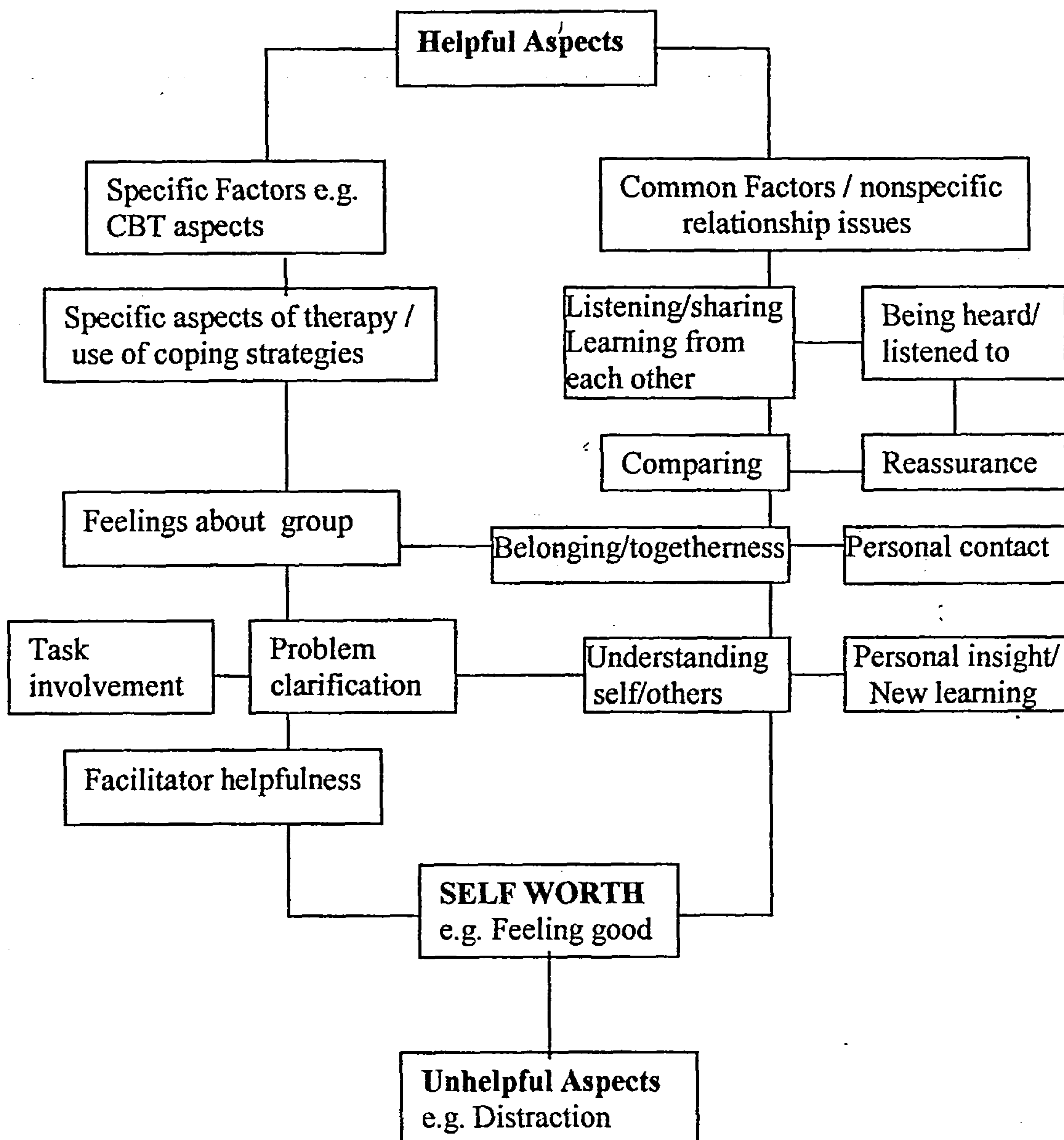
(1994) found that client-reported task impacts of sessions (gaining understanding and problem solving) were highly correlated with relationship impacts. This seems to be consistent with the close association between relational factors and personal well-being found in the present study.

Many researchers have noted the contribution of non-specific common factors to helpful factors reported by clients (Lambert & Bergin, 1994). Therapist techniques occur as part of a complex interaction with the client, and their effect is likely to be mediated by this context. In other words, specific interventions do not have fixed meanings independent of context and cannot be assumed to contribute discretely and uniquely to outcome. It is difficult to separate specific interventions from the context of the therapeutic relationship and it is likely that common and specific factors are reciprocally interactive. This may be as true of the group situation as it is of individual therapy, or perhaps more so, given the greater number of individuals contributing to the overall social context.

A tentative schematic representation based on the emergent themes

Following Smith, Jarman and Osborn (in press), a tentative schematic representation of how group CBT is experienced by this sample of older adults is presented below (Figure-1) on the basis of the interview data. However, these hypothesized links are not meant to imply causality. The hypothesised relationships between different themes the participants produced, making links between feeling good and the interpersonal themes and using CBT strategies, are examined in the light of existing literature. Then the theorised benefits for people of any age, on older adults' special problems, on CBT and how it is thought to work as it did in at least some measure for all, though with considerable variability, are considered.

Figure-1. Example of a tentative schematic representation (where no causality is implied by the links shown) based on the emergent themes of how CBGT is experienced by this sample of older adults.



The above figure describes the hypothesized relationships between different themes that emerged from the interviews, making links between feeling good and the specific and common (nonspecific relationship issues) factors.

transcripts where participants make frequent references to what others in the group have said and show their concern and regard for each other and 'being part of it'.

Another more speculative way of interpreting may be to use Teasdale and Barnard's Interacting Cognitive Subsystems (ICS) model that attempts to encompass both the acquisition of coping skills and the individual's subsequent interpretation of these within an integrated schema (Teasdale & Barnard, 1993). The ICS model distinguishes between nine cognitive subsystems, two of which are of primary relevance to this discussion. These are the Propositional ('objective' or factual knowledge which can be articulated) and the Implicational (that which is 'felt' or 'known'). Both subsystems encode different but reciprocally interacting levels of meaning. According to the ICS model, acquisition of new skills modifies the knowledge coded at the Propositional level of meaning, leading to modification of the higher levels of abstraction coded at the Implicational level. These in turn modify the individual's Implicational Schematic model, and hence the interpretation of, and response to, subsequent events that could lead to acquisition or rejection of further new skills.

Dysfunctional or unhelpful models are those in which an existing coding of unsuccessful passive helplessness forms a vicious circle such as 'there is nothing I can do to help myself, so why try'. Adaptive functional or helpful models are those in which a coding of successful active problem solving forms a virtuous circle such as 'here is a mood state to be dealt with, what has been done in the past to cope' (Palmer, Williams & Adams, 1995).

According to this theoretical stance, effective therapies are those that replace dysfunctional models with adaptive functional models. Such therapies help participants by introducing active problem solving techniques and coping strategies

which, through repeated experiences within therapy and homework practice, can become encoded within and help build up adaptive models of coping. The present study found some evidence about participants using new coping strategies introduced in the group therapy that was presented earlier in the Results section. However, the present study does not provide direct evidence for the Teasedale and Barnard model.

Speculating on what might be special or unique about this sample, or whether they may reflect older adults more generally in some respects, it was notable how strong the interpersonal factors were in this group of older adults. It is an open question whether this was an idiosyncrasy of the particular people sampled or whether it might be found in other older adult groups, or groups from a similar disadvantaged background to the present sample. It may be something to do with the characteristics of a deprived, inner city locality and catchment area, or a history of adversity and having had to 'pull together' in the past, for example, through experiences of war. This issue will be returned to in the section on Contribution to Knowledge and Suggestions for Further Research.

Discussion and Critique of Methodology

The manner in which the participants responded to the interviews would appear to be one of the strengths of the adopted methodology. They seemed to respect the notion of research, and seemed pleased that their opinion was being sought. They were able to reflect upon their experience in a meaningful way. It is hoped that this is apparent to the reader as a result of the inclusion of as much of their words as possible.

A potentially problematic area was being both the researcher and the therapist and respondent bias (e.g. overly positive responding) was an important consideration. Being the therapist/researcher fits well with the scientist-practitioner

model however, where the therapist/researcher allows participants to give feedback as part of the ongoing process, which it has been argued should be an integral part of clinical work (Barker, Pistrang & Elliott, 1994; Elliott, 1985; Llewelyn, 1985).

It was possible that participants might have felt reluctant to give critical feedback to the therapist/researcher. An attempt was made to minimise this possibility by reassuring clients that the feedback was not a personal reflection on the therapist/researcher but focussed on their experience of the therapy, where the therapist/researcher was also a participant. They were further reassured that they could choose to stop the interview at any time as well as drop out of the study and still continue with the group therapy programme. As far as the author could tell, the participants were not distressed by the interview and generally seemed interested and pleased to be asked for their opinion. In the early stages, some problems were mentioned, suggesting people were able to do so.

The use of the recorded replay of specific group therapy sessions was helpful as a memory aid, but the participants did not specify significant moments or events from the recorded session. Gershefski et al., (1996) reported a similar observation in their study of 162 outpatients (men and women) aged between 21 and 60 years, with an average age of 35 years. They used the Evaluation of Therapy form (with an open ended question on description of any helpful aspects they found of their treatment), that was administered at post-treatment. Most other studies have used the HAT questionnaire or interviews immediately after individual therapy session (Llewelyn et al., 1988; Shapiro, 1995) or within 48 hours which was not practical in the present context due to time pressures and the number of participants that were interviewed by this lone researcher. The interviews in this study took place within two weeks from the specific group session but it is possible that the time gap

may have obscured the therapeutic impact because of the participants' experience in a subsequent intervening group session.

It is also important to bear in mind memory effects as a possible alternative explanation of these results. It is known from general psychology that cueing of recall of interpersonal events will be more likely than recall of new information, which is what the CBT elements of the group comprise.

The small sample size makes generalisation from this study difficult. However, the aim of qualitative methodology is not to generalise but to generate hypotheses about possible causal relationships. Considering the tentative model suggested earlier, interpersonal relations appeared to play an important part in the clients' positive experience of therapy. It may be that people in this sample were particularly open to finding support from each other, or it could have been the way the group was set up. Hence there is a need for further research on group therapy for older adults from a similar background to the present sample as well as from other backgrounds, and with therapies having different levels of implicit or explicit emphasis on intra-group relations. Yost et al. (1986) and Hunter (1989) had observed that group therapy had an advantage over individual therapy for older adults because of the opportunities that group therapy offers for socialisation, altruism and universality of problems and feeling valued deciding for themselves what is important to talk about. More research is needed to establish this.

The respondent validation carried out was only able to feed back a short summary of the researcher's interpretation of each participant's general reaction to the group rather than a derived model of their experience as would be suggested by some adherents of qualitative methods (Pidgeon, 1996). The findings of the respondent validation exercise suggested the researcher's assessment of the

participants' positive reactions to the therapy was largely accurate (Appendix-10). However, as to the hypothesised associations between different components of the therapy and participants' responses, these were not put before participants.

The improvement shown on the standardised measures could have happened without the intervention as there was no control group used in this study. However, in this present study, the standardised clinical measures were not used as an outcome measure as such but used more to provide the context for participants' experience of the CBGT. The improvements in this study on the BDI, were comparable to those found in other studies. A possible reason for the finding of less change on the HAD may be a reflection of ongoing stressors such as ill health affecting participants' quality of life.

It was also not possible to be certain that all of clients' use of cognitive strategies were always as a result of the group therapy as some strategies may have been gained from earlier therapy or other sources, or may have been used for many years. However, CBT aims to enhance people's existing strategies by clearly identifying helpful ones so they can be used more consistently. It would ideally have been useful to examine participants' usual coping strategies before the CBGT but this was beyond the scope of the present study.

A single case study design was used for each participant. For current purposes, attempting to achieve the optimum amount of internal validity was more important than establishing external validity, as the main aim was to explore the perception of a specific intervention in a specific setting with a specific population. A major threat to internal validity is that factors other than the group therapy may have led to a change in symptoms of anxiety, depression and coping. These confounding variables limit the possibility of causal attribution of any potential

change in symptoms to the group therapy itself.

One way of attempting to account for extraneous factors is the use of a pre and post measure design. Although by no means ruling out threats to internal validity (Rossi & Freeman, 1993; Cook and Campbell, 1979), such a design seemed optimal within the constraints of the setting. However, it is also important to bear in mind these potential threats to validity when interpreting the results.

The rhetorical power of the study appears to be fair. The present research has aimed to allow older adults to articulate for themselves their attitudes and opinions about their therapy. However, the interpretations and implications of their words can only be presented as the subjective view of the researcher. Analysis of the data links the findings with self worth and interpersonal issues, and the use of specific coping strategies. However, further investigation based on a combination of deductive and inductive methodology would be required to corroborate this.

The issue of researcher bias, addressed earlier, is clearly a potential weakness when considering the reliability and validity of the present findings. The aim of the approach here was to generate a phenomenological account taking into account the wider context of the participants' circumstances and the group situation. It may be that the wider context (i.e. the group situation, the participants' personal background, and assumptions gathered from reading case notes) has not been sufficiently represented to allow an accurate judgement as to the validity of the findings. In terms of the reliability of the theme categories, the inter-rater reliability test appeared satisfactory.

The issue of reflexivity

The researcher was aware of her own biases including predisposition to expect good results based on previous therapeutic work with older adults, and doubts about the capacity for new learning in older adults while wishing to portray older adults in a positive light, especially as they are members of an under represented group. The researcher was pleasantly surprised that all ten participants approached were agreeable to be interviewed for the research. The process of drawing out main themes was difficult, as it necessarily involves at some level imposing one's own meanings on the data. Keeping a research diary would have been useful as it would have highlighted the interplay between the emotional and rational.

For example, it appeared to emerge that the present researcher may have accepted the positive feed back from participants as a significant finding more readily than another researcher may have done. There could be some residual doubt perhaps as to whether the author's reassurances to participants really did address sufficiently any positive response bias due to a need to maintain good relations with a key service provider. The researcher was humbled by the participants' willingness to co-operate with the interviews and their giving so much of their time for it. However, in retrospect this too may reflect more about the relatively isolated and difficult circumstances of the participants than their willingness to contribute to research.

In terms of development as researcher and clinician, the researcher was aware of getting lost in the potential for abstraction and interpretation in inductive methodology. The researcher is aware that the information presented is only a selection of possibilities emerging from the interviews that were carried out. Smith

Effectiveness of CBGT with older clients in this study reflected one clinician's performance with a small group of clients in a specific psychological intervention under ordinary conditions. However, the feedback from the clients had a direct impact on service delivery for this client group as unhelpful aspects interfering in the sessions were dealt with in the early phase of therapy such as by incorporating the use of more frequent summaries of the group discussion within the subsequent sessions and ensuring that all participants were able to follow the pace of the group discussion. This current experience will also be incorporated in future service planning of therapy service delivery to ensure that CBT and CBGT can be made more available to older adults in this locality and that detailed records are kept of the adaptations made as required.

Contribution to Knowledge and Suggestions for Further Research

Further careful studies of the psychotherapy process and outcomes in naturalistic settings will provide a greater pool of more realistic information for the valuation of psychotherapy services. More research is required to determine if the strong role of interpersonal relations may be unique to this small sample and locality, or if it is a feature of older adults with a relatively disadvantaged background, or if it is something about the collaborative ethos that CBT sets up in a group setting. It is possible that older adults from a disadvantaged background and/or living in a small catchment area relatively close to each other can particularly benefit from a group approach because of the possibility for continued contact outside the group. Furthermore, there is a need to carry out studies with longer follow-up to see whether gains are maintained over time, in the context of perhaps deteriorating health in old age. More experimental designs with control groups incorporating

the process element in future studies would be fruitful.

The positive and thoughtful manner with which the older adults responded to the research interview lends support to the suggestion that older adults could become more active in thinking about their own therapeutic process. It also indicates that they could provide meaningful contributions to research and clinical audit on service user experience. Further studies on process of therapy will need to address more efficient use of IPA or something like it in the clinic setting so that rich qualitative information can be generated contributing to eliciting the effective ingredients in therapy.

On a more provocative note, the notion of 'insight' and the theory about the role of insight needs to be tested more carefully as against the very strong evidence from not only the present research but others as well, that what people value more is support, feeling reassured they are not alone or different, and understanding of problems.

Conclusion

This qualitative study of participants' perception of being in cognitive behaviour therapy makes some important contributions to current clinical and research literature. It highlighted the importance of explaining a CBT framework in general, and in enabling participants to understand their distress and acquire particular coping skills and strategies. This study made an attempt to explore the participants' perception of helpful aspects of CBGT with a flexible methodology that has thrown up an important link between interpersonal issues and self regard.

It is recommended that more emphasis on eliciting user views on the process of therapy be incorporated as part of routine clinical work. The present findings are

encouraging in suggesting ways in which psychological therapy practice could accommodate the needs of older adults such as the use of the CBT framework incorporating changes in role due to loss and bereavement and physical health issues, and the use of collaborative empiricism to highlight that any treatment success must be due to the efforts of the participants.

The present study, although it included a small and possibly idiosyncratic sample, demonstrated that effective and constructive group cohesion was possible within a short space of time. The richness of the information generated by this method reinforces the importance of process research and the need to address older adults about their experiences in therapy and where possible, link this with outcome research.

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LIST OF APPENDICES

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- 5 HAT-CBGT (adapted version)
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- 8 Individual case histories.
- 9 Covering letter to participants about feedback from the interviews.
- 10 Individual feedback to participants from the interviews.
- 11 Ratings of mood in the sessions before and after the group discussion.
- 12 Categories and quotes from the participants.
- 13 Transcripts in a separate booklet form that will be removed later in order to preserve the anonymity of the participants.

Dr A H Huq
Consultant Clinical Psychologist

Our ref: DO/SB/n99031

11th June 1999

Dear Dr Huq

Re: N/99/031 – Exploring the perception of cognitive behaviour group therapy for older adults with depression and/or anxiety

I am happy to tell you that the above study was approved at the recent meeting of the Research Ethics Sub-Committee.

Please note the following conditions to the approval:

1. The Committee's approval is for the length of time specified in your application. If you expect your project to take longer to complete (i.e. collection of data), a letter from the principal investigator to the Chairman will be required to further extend the research. This will help the Committee to maintain comprehensive records.
2. Any changes to the protocol must be notified to the Committee. Such changes may not be implemented without the Committee or Chairman's approval.
3. The Committee should be notified immediately of any serious adverse events or if the study is terminated prematurely.
4. You are responsible for consulting with colleagues and/or other groups who may be involved or affected by the research, such as extra work for laboratories.
5. You must ensure that, where appropriate, nursing and other staff are made aware that research in progress on patients with whom they are concerned has been approved by the Committee.

6. The Committee should be sent one copy of any publication arising from your study, or a summary if there is to be no publication.

I should be grateful if you would inform all concerned with the study of the above decision.

Your application has been approved on the understanding that you comply with Good Clinical Practice and that all raw data is retained and available for inspection for 15 years.

Please quote the above study number in any future related correspondence.

Yours sincerely



P.p. Asst. Administrator

Ms Dora Opoku

Chair

Research Ethics Sub-Committee

Dr A H Huq
Consultant Clinical Psychologist

Our ref: DO/SB/n99031

20th April 1999

Dear Dr Huq

Re: N/99/031 – Exploring the perception of cognitive behaviour group therapy for older adults with depression and/or anxiety

I can confirm that the ELCHA Research Ethics Sub-Committee considered the above study at its recent meeting. The Sub-Committee regrets that it is unable to approve the above study in its present form, for the following reasons:

- a) The Sub-Committee is not familiar with the HAT questionnaire and therefore further information on the modified version to be used i.e. has it been validated, when and how has it been modified is required. If validated the appropriate reference should be included.
- b) Given that you are both the therapist and researcher what measures have you taken to ensure that participants feel able to give critical and honest comments, or indeed to freely opt out of the research?
- c) It was felt that section 3 of the application form should be used to reflect the emotional anxiety/distress as the normal routine was been changed from a therapeutic forum to semi structured interviews.
- d) Would the participant normally have expected a home visit outside of their participation in your research? How would this be negotiated?
- e) In the event that a participant chose to drop out of the study but still wanted to continue with that form of therapy how would this be dealt with?

- f) A letter from both the clinician responsible for patient care and the manager giving consent to the subject being approached and to the site being used are required.
- g) Paragraph 3, line 2 of the information sheet please delete "a number of".

The Sub-Committee would, of course, be happy to consider another full application (12 copies are required) for this study in a revised form. I enclose a list of dates of forthcoming Sub-Committee meetings.

Yours sincerely



P.p. Asst. Administrator

Ms Dora Opoku

Chair

Appendix-2. Research invitation / Participant information sheet.

Exploring the perception of cognitive behaviour group therapy for older people with depression and/or anxiety.

Invitation to Participate in a Research Project

I invite you to take part in a research study which I think may be important. The information which follows tells you about it. It is important that you understand what is in this leaflet. It says what will happen if you take part and what the risks might be. Try to make sure you know what will happen to you if you decide to take part. Whether or not you do take part is entirely your choice. Please ask any questions you want to about the research and I will try my best to answer them.

I am trying to find out what you find helpful and unhelpful in the group therapy that you are attending now. This will help me to plan the sessions in a way that would be more helpful for you and others attending. This would also make me more aware of unhelpful aspects of therapy which will guide me in delivering therapy in the most appropriate way for you.

You have been identified as suitable to take part in the research as you are attending the group therapy for depression/anxiety. Participation in the research will involve three interviews following group sessions over a period of three months that you are in the group therapy. The interviews can take place either in your home or in the hospital, as you prefer.

The interviews will be recorded on tape so that I can work on it later. The tapes will be erased after the study is completed. There are no potential hazards for you in taking part in this research. The information you give me will remain confidential and no one else will have access to it.

You don't have to join the study. You are free to decide not to participate in the interviews on the helpful aspects of therapy or you can drop out any time. If you decide not to participate in the study, or drop out, this will not put at risk your ordinary mental health care.

If you are worried or if you have any questions about this study, you will always be able to contact me to discuss your concerns.

Afreen Husain Huq
Consultant Clinical Psychologist (.....)

Appendix-3. WRITTEN CONSENT FORM

Title of research proposal: Exploring the perception of cognitive behaviour group therapy for older adults with depression/anxiety. REC Number: N/99/031

Name of Patient/Volunteer (Block Capitals):

Address:

(Delete if unnecessary to the research project)

- The study organiser has invited me to take part in this research.
- I understand what is in the leaflet about the research. I have a copy of the leaflet to keep.
- I have had the chance to talk and ask questions about the study.
- I know what my part will be in the study and I know how long it will take.
- I know how the study may affect me. I have been told if there are possible risks.
- I understand that I should not actively take part in more than 1 research study at a time.
- I know that the local Research Ethics Committee has seen and agreed to this study.
- I understand that personal information is strictly confidential: I know the only person who will see information about my part in the study is the researcher.
- I freely consent to be a subject in the study. No one has put pressure on me.
- I know that I can stop taking part in the study at any time.
- I know if I do not take part I will still be able to have my normal treatment.
- I know that if there are any problems, I can contact:

Mrs. Afreen H.Huq.
Tel. No. .0181 510 8640

Patient's : Signature

Witness's Name

Witness's Signature:

Date

The following should be signed by the Clinician/Investigator responsible for obtaining consent

As the Clinician/Investigator responsible for this research or a designated deputy, I confirm that I have explained to the patient/volunteer named above the nature and purpose of the research to be undertaken.

Clinician's Name: Afreen Husain Huq

Clinician's Signature: Date:.....

Appendix- 4. HELPFUL ASPECTS OF THERAPY QUESTIONNAIRE (HAT) (Llewelyn, 1985)

Session no:

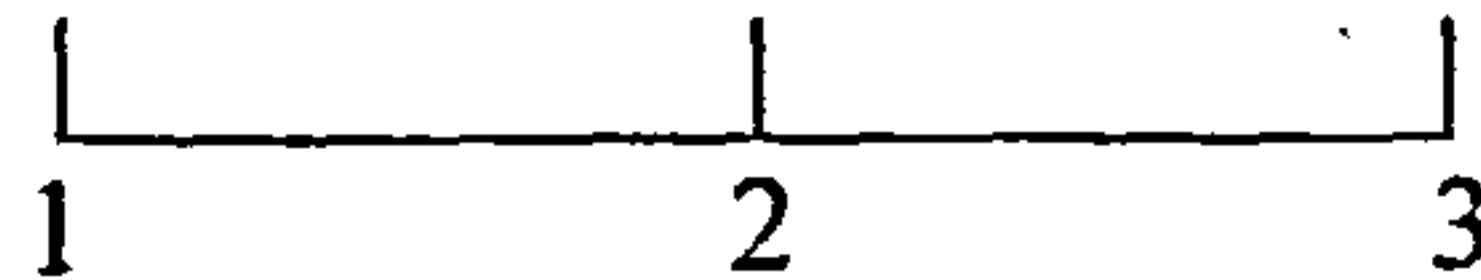
Name:

Date of session:

Today's date:

1. Of the events which occurred in this session, which one do you feel was the most helpful for you personally? It might be something you said or did, or something the therapist said or did. Can you say why it was helpful?

2. How helpful was this particular event? Mark this on the scale, where '1' is very helpful, and '3' is neither helpful or unhelpful.



3. Can you rate how helpful this session was overall:

- Very helpful
- Fairly helpful
- Neither helpful or unhelpful
- Fairly unhelpful
- Very unhelpful

4. Did anything else of particular importance happen during this session? Include anything else which may have been helpful, or anything which might have been unhelpful.

5. Has anything particularly important happened in your life since your last session?

Appendix – 5. HELPFUL ASPECTS OF THERAPY QUESTIONNAIRE
(HAT- CBGT).

Session no:

Participant no:

Date of session:

Today's date:

- 1. What was the session like for you?**
- 2. Did anything important happen during this session? I'd like to hear about anything that stood out to you.**
- 3. How much of the time did you feel interested/involved in what people were talking about?**
- 4. Did you feel you could talk about the things that were important to you?**
- 5. Were there any times during this session when you felt uncomfortable? Can you tell me about those times?**
- 6. Can you think about all the things that happened in this session and tell me whether you think any were helpful for you? Can you describe what happened? (audio replay at this point).**
- 7. Can you say why it was helpful?**
- 8. How helpful was this? Was it very helpful? Medium helpful? Or neither helpful or unhelpful?**
- 9. What do you think about the session overall? Very helpful, Fairly helpful, Neither helpful or unhelpful – normal, Fairly unhelpful, Very unhelpful.**
- 10. Has anything important happened to you or anyone in your family since the last group session?**

Appendix-6. The group therapy programme

“KEEPING WELL” A COGNITIVE BEHAVIOUR GROUP THERAPY FOR DEPRESSION / ANXIETY

Coping with depression and anxiety is not easy. When things go wrong, we can find ourselves feeling lonely and isolated or angry and upset at those around us. You are being invited to join a group of people who want to learn about coping with depression and anxiety.

Over a number of group sessions, we will explore different aspects of depression and anxiety and use a number of ways / techniques aimed at developing and improving skills that will help you to cope with depression and anxiety.

Sessions

Agenda for the group therapy sessions

- 1 Introduction to coping with depression and anxiety: understanding the links between thinking, feeling and behaviour.
- 2 More about coping with depression and anxiety.
- 3 Recognising positive / negative thoughts, helpful / unhelpful beliefs or rules and depression / anxiety.
- 4 Activity and depression / anxiety – goal setting.
- 5 Anxiety management - what needs to be done to make it easier.
- 6 Preparing for the future – planning ahead.
- 7 Participant's set the agenda for the remaining group therapy sessions—
how are you coping ?
- 8 What else needs to be done to make things easier.
- 9 Identifying stress.
- 10 What is working well.
- 11 Lessons learned so far.
- 12 Closing session.

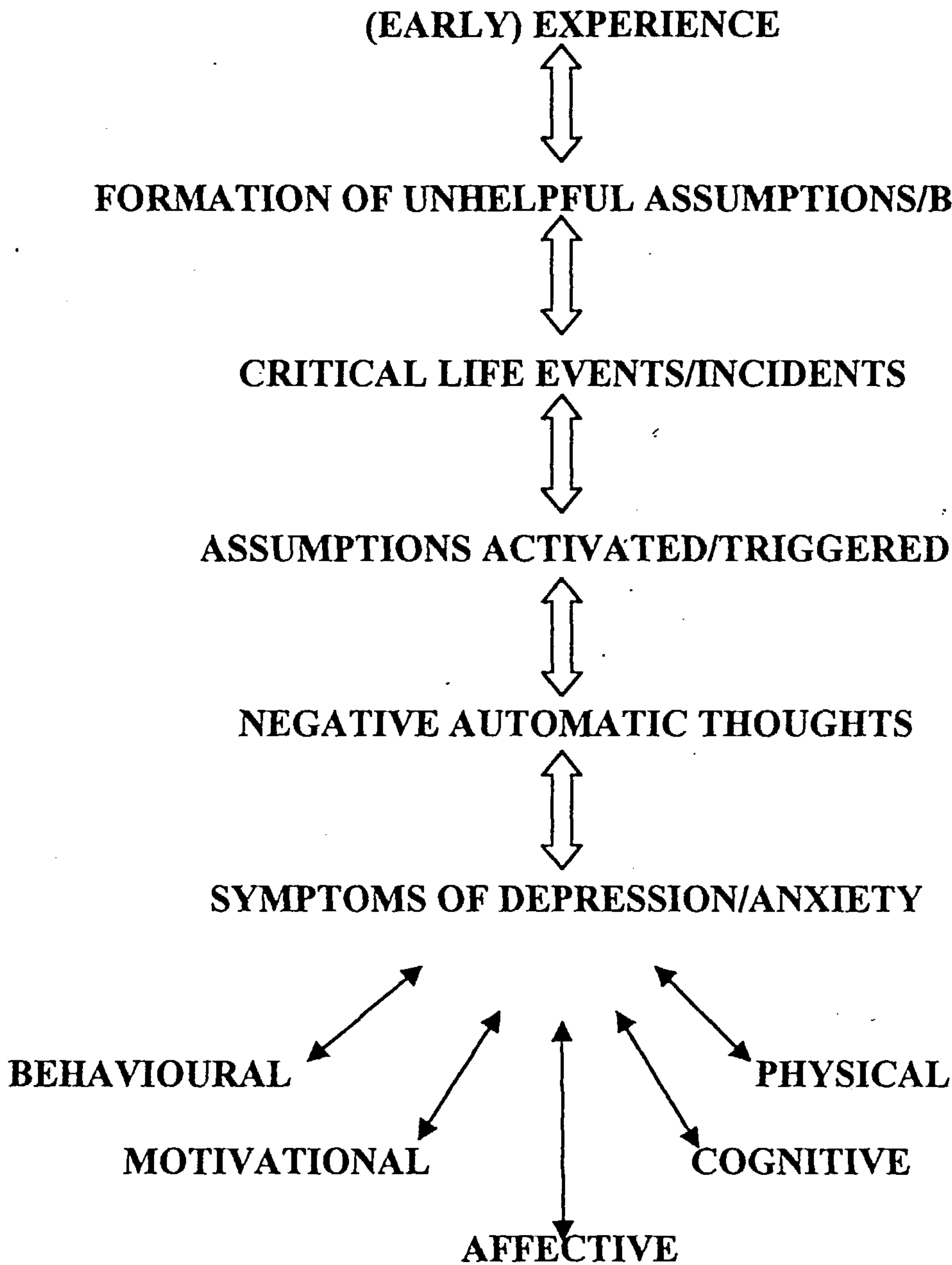
We hope you enjoy coming to the group and find it beneficial. To make the best use of it, it is very important that you attend all the sessions. If you think you will not be able to attend any of the session, please remember to let us know.

Afreen H. Huq
0181 510 8640

A sample of a group therapy session content.

The participants were informed of the aims of the group. The group focused on the "here and now", with emphasis on how thinking affected feeling which in turn affected behaviour. The ground rules for sessions were generated such as confidentiality, and taking turns to speak. Then patients were asked to rate how they felt at that moment on a scale of 0 to 10 where 0 represents the worst that they can feel and 10 represents the best they can feel. Rating their subjective feelings is one way of demonstrating that feelings are variable, that they can understand their feelings by learning to recognise the helpful and unhelpful thoughts behind those feelings and learn to monitor themselves more effectively. The group leader led the agenda for the first six group sessions with a mini lecture (listed below) while participants determined the agenda from the seventh session onward. They were invited in turn to share their frustrations and difficulties with coping with feeling depressed and or anxious. These experiences were related to the cognitive-behavioural approach. Goals and plans were generated for individuals in a realistic way. The facilitator encouraged participants to generate alternative coping strategies as a group. Finally, after summarising the session, there was another rating of feelings and patients were asked to give verbal feedback on the usefulness of the session.

Appendix-7. The cognitive behavioural model for understanding depression/anxiety.



From Fennell, M.J.V. (1989). Depression. In K. Hawton, P. M., J. Kirk & D. M. Clark (Eds.), Cognitive Behaviour Therapy for Psychiatric Problems - A Practical Guide. New York: Oxford University Press.

The CBT model for understanding depression and anxiety

Beck's cognitive model suggests that experience leads people to form assumptions or beliefs (helpful as well as unhelpful) about themselves and the world, which are subsequently used to organize perception and to govern and judge behaviour. The ability to predict and to make sense of one's experiences is helpful and indeed necessary, to normal functioning. The common goal of all helpful (functional) beliefs is the achievement of a sense of worth that is crucial in maintaining a sense well-being. A person's early history, temperament and upbringing might determine the sorts of beliefs and attitudes utilized to maintain a sense of worth. However, some assumptions/beliefs, are rigid, extreme, resistant to change, and therefore unhelpful or counterproductive. A person's relative degree of positivity and negativity changes continuously. It is important to identify helpful as well as unhelpful beliefs that has helped the person to cope well in the past.

Problems arise when critical incidents occur which mesh with the person's own belief system. For example, the belief that personal worth depends entirely on success could lead to depression/anxiety in the face of failure. Once the unhelpful beliefs are activated, it can lead to negative automatic thoughts which may be interpretations of current experiences, predictions about future events, or recollections of things that have happened in the past. These thoughts, in turn, lead on to other symptoms of depression/anxiety., and so a vicious circle is formed. The more depressed/anxious a person becomes, the more depressive/anxiety provoking thoughts they think, and the

more they believe them, the more depressed and/or anxious they become. Participants are encouraged to check if they can relate to this way of making sense of distress.

It is emphasized that depression/anxiety exaggerates and intensifies thinking processes present in all of us and that the fact that thoughts influence mood does not imply that negative thinking causes depression/anxiety, it is part of it. Thoughts (cognitions) can act to trigger, enhance and maintain many symptoms. For this reason, they form an ideal point for intervention.

Appendix-8. Individual case histories.

P01, Anne, was a 75 year old woman, born and brought up in the East End of London. Her father drowned accidentally at the age of 49 and her mother died of a stroke at the age of 78. She had seven siblings, three of whom died some years ago. She had two siblings still alive with whom she had some contact. She missed a lot of school when she was in Hospital with meningitis at 14. She worked as a machinist. She married at the age of 19, had her first child about seven years later, and her second child six years later. She continued to work whilst bringing up her family with help from her mother who lived with her until she died. She had a good marriage and looked after her ill husband in the final years of his life. He died in 1989.

She suffered from depression at the age of 32 following the birth of her second child, again in 1989 following the death of her husband, three hospital admissions for depression in 1996/97 which coincided with one of her daughter suffering from post natal depression at the time, and the onset of a disturbance of posture and gait in herself resulting in a series of falls. She had a past history of hypothyroidism, had E.N.T. surgery (a left mastoid operation at 14), a recent history of Parkinson's disease, ischaemia and high blood pressure. She also had significant hearing impairment. She took pride in her appearance and maintaining her self image was important for her, even at a cost for example, wearing smart heeled shoes despite her unsteady gait or her flat refusal to consider the use of a walking stick for balance.

P02, Brigitte, was a 78 year old woman of Belgian origin, who married an Englishman (military police) at the end of the war and moved to U.K. after the war. Her husband had a number of illnesses and they did not have any children. He died of a heart attack in 1971. As a catholic, she attended church regularly, participated in church activities and had a number of friends. She lived in a convent with her sister between age 7 – 16 where the nuns were very strict but she liked it. Her sister lives in Belgium and they maintain regular contact with phone calls and visits. She had a recent history of severe anxiety attacks with depression since 1996/97, which reminded her of the wartime experience of the German occupation (Germans would lock the family in the cellar, subjected them to verbal abuse and verbal sexual advances). She had worked as a tailoress. Her main fears were about being a burden and going into a nursing home, 'of being a foreigner in this country' despite having worked and lived here for so many years, and more recently, the Belgian ambassadors' advice that she would be better off here than in Belgium financially, when she consulted him about the feasibility of returning to Belgium. She suffers from pain as a result of arthritis and sciatica. She lived in sheltered accommodation.

P03, Claudia, was a 74 year old woman of German origin, with a longstanding history of depression and barbiturate dependence (20+ years). She was born and brought up in a German village, had a happy childhood until her father started affairs with other women. When she was 18/19, she supported her mother through the traumas until the mother committed suicide when Claudia was 20. She was also involved in looking after her only sister, 16 years junior to her. She married a British man in Germany at age 19.

They had a close but rather turbulent relationship and had four children, the first of whom died at the age of six months in Germany. They moved to the U.K. soon after this where she worked as a home help for over 20 years. She had two daughters and a son, all living far away from home. She had heart disease, kidney problems, rheumatoid arthritis and a history of recurrent depression and marital problems since retirement. This also coincided with the necessity to withdraw her from barbiturates as it was affecting her physical health. Her husband had a diagnosis of bone cancer and more recently she had become wheelchair bound due to severe rheumatoid arthritis affecting her knees. Sometimes she became preoccupied with her mother's suicide and felt guilty for leaving Germany to be with her husband in the U.K. She had intermittent thoughts about being better off dead but no suicidal thoughts or plans.

P04, Dolly, was a 67 year old woman, born in British Guyana and schooled in a convent until she was 12. She then moved to Trinidad before settling in Canada. Both parents have died and she has no surviving siblings although she had two brothers who died when she was very young. Her husband had a drink problem and they had a stormy marriage for over thirty years. She worked as a typist/secretary for the Evening Standard and for Zetters, the Pools' people. She had paranoid delusions in 1990 after her divorce when the husband continued to harass her, even after they parted. She had a son and a daughter who were both happily married. She was contented about her children but regretted that she did not have any grandchildren. She remained well on medication until 1995 when she had another episode of depression with paranoid ideas and hearing voices when she had set fire to her neighbours garden furniture. It was also noted that

she had a road traffic accident while crossing the road in 1994/95 and developed a fear of crossing the road. She had retired from work in 1993/94. She was referred to this service in 1998 for management of depression and anxiety. CT brain scan did not detect any organic changes. Her self esteem was very low and she felt insecure especially about losing her boyfriend.

P05, Ernie, was a 75 year old man, was born in Northern Ireland and brought up in a strict roman catholic family. He was in the army for four and a half years and moved to England on his return and worked as a painter and decorator. He had to give up his work 21 years ago due to ill health. He has been married for 50 years despite longstanding marital difficulties and heavy alcohol use in the past. He has seven children. He lost his father in 1991 and a younger brother in 1992 and had become very depressed. He moved house last year and also had a testicular lump removed and thought he had cancer. He had ischaemic heart disease and had a heart attack in the past. He took an overdose of aspirin and alcohol in August 1998, soon after moving to the new house and was admitted to hospital briefly. He said he had been under pressure with redecorating the house and became distressed that he could not do as much as he used to be able to do and tired very quickly. He admitted to not coping with stresses in life (e.g. the deaths in his family, his poor health status, the move).

P06, Farley, was a 74 year old man, born and brought up in London. He was the only child. He truanted a lot while in school and left at 14 to work in a hardware shop and then went into engineering. He married his wife when she was 16 and he was 22. She died in 1983 after a long illness. He had two sons from the marriage. His older son

died after an asthma attack in a swimming pool about 32 years ago. His second son was separated from his wife and had alcohol problems. He had a history of periods of heavy drinking himself. He had six grandchildren and eight great grandchildren. His son used to live in a flat below him until 1994 when he moved home five miles away. He retired at 65 and then worked in a sewing machine shop until he was made redundant in January 1995 after the shop was sold. He became depressed after this as he lost his confidence and self esteem. He had vascular dementia, prostate problems and high blood pressure. He had a steady relationship with his girlfriend for a few years now. He was particularly sensitive to loss (son, wife, father, his poor memory functioning) and prone to depression and severe anxiety. He has had four admissions to hospital since 1995 for depression and inability to cope with self medication.

P07, Gill, was a 81 year old woman, who recently celebrated her 60th wedding anniversary. She had a history of depression since 1992 and also had high blood pressure, diabetes and heart disease. Her father died in the WWI and her mother became paralysed after a stroke when she was seven years old. She was the youngest of twelve siblings and there were only two of them left since many of her other siblings died many years ago. She looked after the mother and worked in a shirt factory during the day until she married at the age of 21. Her sisters took over the care of her mother but she died in Hospital soon after. She still felt guilty about this. She remembered her childhood as 'not much fun' and she did not feel loved. She described herself as always being highly strung. She had two daughters who were very supportive. Her main

complaints were dizziness and loss of balance when standing which made her depressed and anxious about going out of the house.

P08, Heather, was a 69 year old woman of West Indian origin, who had come to the U.K. in 1955 and married here. Her husband is a taxi driver. She worked as a dressmaker and in making dolls. She had three sons who have left home. Her home life had been fraught with domestic violence and she divorced in 1982. However, she had a reconciliation with her husband some years ago and they had been together since. However, the relationship between father and sons remained fraught which was stressful on her. She had a past history of psychosis (paranoid delusions) in 1988 following a domestic violence incident when her husband had come to her for money. She had remained well on medication since although she appeared slowed down and blunted in her affect. She owned her own home and did all her housework and stayed at home mainly and the husband helped her when she needed some help. She went out of the house only when she had to, like the post office for her pension. She had relatives in London and the West Indies and had some contact with them but remained socially isolated. She would not consider the suggestion of attending a day centre, to reduce her social isolation. She had been struggling to cope with depression, anxiety, and pain from arthritis.

P09, Ivy, was a 68 year old religious woman, born in Dublin, raised in Southern Ireland in a strict roman catholic family. She is the fourth of 11 children of whom four girls are still alive. She did not like school, left at 13, worked as a domestic until the age of 17 when she got married, had two boys by age 18 and moved to England. She had a

third son about ten years later. She mainly had short term jobs, in factories, as a waitress or domestic. Her mother lived with her and helped to look after her three boys until she died in 1972 and her husband died in 1989. She lived alone and had regular contact with her children. She had a longstanding history of depression and anxiety since the birth of her youngest son. Guilt feelings about taking birth control pills, unhappy marriage and an extra marital relationship many years ago, sterilisation in 1966, doubts about whether she was a good Christian and more recently, worried about a Rastafarian neighbour who she believed persecuted her by making noise (tapping on the wall, playing drums) that may be related to the practice of black magic. She had recurrent thoughts that she was evil and that she should kill herself by throwing herself under the traffic.

P10, Jack, was a 69 year old divorced man of Jamaican origin, with a longstanding history of persecutory ideas and hearing voices of unknown aetiology and a recent history of depression since retirement in 1994. He was an only child and both his parents have died. He had six children in Jamaica where he was born and brought up. He came to the U.K. in 1960 where he mainly worked in the factories. He lived alone and had no contact with family and friends. He became socially isolated since he retired. It was possible that his mental health problems influenced his life to the extent that either he had become increasingly withdrawn from family and friends, or as a result of social isolation, he had become increasingly paranoid and depressed. A CT brain scan result did not suggest any organic impairment. He had a two month hospital admission in 1997/98 for depression and paranoid delusions when he was very withdrawn and

retarded in his movement. Following discharge from the hospital, he had moved into sheltered accommodation and was persuaded to attend the day hospital but had remained somewhat isolated.

Appendix-9. Covering letter to participants about feedback from the interviews.

Dear

I am writing to you to let you know what you said in the interviews we had on the helpful aspects of the 'Keeping Well' group therapy sessions. Please read carefully and indicate on the rating scale given below, how much you agree or disagree with my understanding of what you have said about the group therapy sessions. I would much appreciate if you would reply, as soon as possible, using the stamped / self addressed envelop that is enclosed.

If there is anything you don't agree with, would you please underline the words or sentence to indicate this.

You can expect a telephone call in about a weeks time so I can answer any questions you may have.

Thank you for your cooperation.

Yours sincerely,

Afreen H. Huq
Consultant Clinical Psychologist
0181 510 8640

Appendix-10. Individual feedback to participant no.4

Dolly

You said you enjoyed the sessions, it made you feel more positive as reflected on the rating scale of mood before and after the group discussion and that you had your say and came away feeling much better. What stood out for you from the sessions were the discussions in general, being understood and that the atmosphere was friendly. You were interested and involved in what others were saying from the time you came in for the sessions and felt able to talk and did not feel uncomfortable at any time. Helpful aspects for you from the sessions were talking together, the numbers rating as a check on yourself, coming away with the discussion in mind, practising behaviour for example, going out for pleasure despite the fear of crossing roads, catching unhelpful thoughts, when Joseph pointed out not to undermine yourself, and listening to Cathy how she talked herself into being positive and doing more positive things even though it was hard. This was helpful for you as you are doing more now than before, taking more interest in doing things and feeling less insecure. You feel you are going forward, you have accepted how things are for you, you are not worrying about Patrick leaving you like before and you feel more confident. You acknowledged sadness about ending the group and also felt positive and looking ahead to the future.

If there is anything you don't agree with, would you please underline the words or sentences above.

Please tick in the box to indicate how much you agree or disagree with my version of what you have said. For example, if you agree with about half of it, you can tick the box at 50.

											X
--	--	--	--	--	--	--	--	--	--	--	---

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**Don't
Agree
With any
Of it.**

**Agree
with all
of it.**

Appendix-10. Individual feedback to participant no.5

Ernie

You said the sessions were very good. What stood out for you from the sessions were knowing there were others like you, how they try to cope, the sketch was good and explained very well, 'listening to others pulled you up a bit', and that I made sure everyone had their chance to talk. You were interested and involved in what people were saying all of the time and also felt able to talk freely. You felt 'a bit uncomfortable in the first session only' but not anymore as you felt part of the group. You felt more uncomfortable before you came into the first session than during the session.

Helpful aspects of the therapy sessions for you were the explanations given for understanding distress, listening to others, looking for common issues and differences, the rating of mood was good as it highlighted that mood can vary according to what's going on in the mind and behaviour, you were able to understand yourself better, you felt encouraged to see positive changes in yourself and in others, you found it easier to be more friendly with others and sharing information, you became more interested in what others were saying, it helped to bring you out and that the sketch was especially helpful in understanding yourself better.

If there is anything you don't agree with, would you please underline the words or sentences above.

Please tick in the box to indicate how much you agree or disagree with my version of what you have said. For example, if you agree with about half of it, you can tick the box at 50.

										X
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Don't										Agree
Agree										with
all										
With any										of it.
Of it.										

Appendix-10. Individual feedback to participant no.6

Farley

You said that there was a time initially when you were not 'feeling up to normal', and hiding your thoughts and later on you were much more open about it and enjoyed the sessions and felt 'morbid'(though you said morbid isn't the exact word you would use) in the last session because it was the last session. What stood out for you from the sessions were things you had mentioned in the group and that you could not remember other details. You were interested and involved in what people were saying all of the time and you were able to talk openly. There were only one or two occasions when you felt uncomfortable in the sessions initially when you said your 'mind was being lazy' and you felt distracted with your mind wandering off. Since we have been summarising the group discussions more frequently in the sessions, you were able to stay focussed on the discussions. In the last session you felt 'morbid that the meetings were closing'.

Helpful aspects of the therapy sessions for you were you observed more people were joining in the conversation, it makes you 'feel part of the group' and that you are 'not left out of any thing', you felt 'elated' when you can bring a smile or a laugh from the others, and how good it made you feel to know you can make a difference to others and you liked the 'atmosphere in the sessions, it was cheerful despite talking about problems and you were glad you were part of it, the explanations and the rating scale of mood was useful as 'it got you going'. The reason it was helpful for you was that the atmosphere was cheerful and it made you feel elated that you were helping others as well.

If there is anything you don't agree with, would you please underline the words or sentences above.

Please tick in the box to indicate how much you agree or disagree with my version of what you have said. For example, if you agree with about half of it, you can tick the box at 50.

									X		
--	--	--	--	--	--	--	--	--	---	--	--

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Don't Agree With any of it. Agree with all of it.

Appendix-10. Individual feedback to participant no.7

Gill

You said the sessions were very good and pleasant, and you were happy everyone had their say. What stood out for you from the sessions was that you felt good in yourself and you were interested and involved in what people were saying all of the time. You were more confident to talk in the sessions and felt uncomfortable in the first session only but not after that. Helpful aspects of the therapy sessions for you were learning to recognize that when you 'feel awful', you have been telling yourself off, listening to others made you realise you were not alone, learning to recognize some rules you have for yourself such as I must do this or that and learning to relax some of those rules and making it easier on yourself and you felt you were able to understand how others felt.

This was very helpful for you as you don't tell yourself off so much now, sharing with the others helped you to unload, you don't get so angry with yourself now, it helped you to understand yourself better, you felt supported and you learned to recognize and catch your negative thoughts.

If there is anything you don't agree with, would you please underline the words or sentences above.

Please tick in the box to indicate how much you agree or disagree with my version of what you have said. For example, if you agree with about half of it, you can tick the box at 50.

											X
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
Don't agree with any of it.											Agree with all of it.

Appendix-10. Individual feedback to participant no.8

Heather

You said the sessions were good and you enjoyed it. What stood out for you from the sessions were that you remembered what everyone had said about themselves and you were interested and involved in the sessions all of the time. You could talk about things you wanted to talk about, and felt free to talk with no interruptions and did not feel uncomfortable at any time. Helpful aspects of the group therapy sessions for you were listening to others problems, comparing others with yourself and feeling reassured, discussion on feeling depressed and how to cope with it and what can make it worse, using the chart to understand yourself better, sharing practical ideas such as attending day centres, and doing things bit by bit, learning to recognize negative thinking and learn to control it by reminding yourself of more helpful things. This was very helpful for you because you felt part of the group and you enjoyed that.

If there is anything you don't agree with, would you please underline the words or sentences above.

Please tick in the box to indicate how much you agree or disagree with my version of what you have said. For example, if you agree with about half of it, you can tick the box at 50.

								X		
--	--	--	--	--	--	--	--	---	--	--

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**Don't
Agree
With any
Of it.**

**Agree
with all
of it.**

Appendix-10. Individual feedback to participant no.9

Ivy

You said you found the sessions were very nice, it relaxed you, and you were sad at the last session but otherwise it was excellent. What stood out for you from the sessions were knowing there were others like you, the sessions pulled you up when you were feeling down and that you were getting the help you needed. You were interested and involved in what people were talking about all of the time and that you were able to say more and more over time. You felt uncomfortable in the first session only and after that you were less shy and more able to share your thoughts and feelings. Helpful aspects of the therapy sessions for you were sharing ideas on catching your unhelpful thoughts, rating of how you feel, the chart explaining understanding depression and anxiety, saying things to yourself to counter 'horrible thoughts', listening to others and learning from them, feeling encouraged to see others doing more and looking better, more confident, which made you feel more confident in yourself and you felt part of the group. This was very helpful for you as you were encouraged to go out and face your fears and feel a sense of achievement, it gave you confidence that you are not controlled by horrible thoughts and made you look forward to things to come.

If there is anything you don't agree with, would you please underline the words or sentences above.

Please tick in the box to indicate how much you agree or disagree with my version of what you have said. For example, if you agree with about half of it, you can tick the box at 50.

									X	
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Don't agree with any of it									Agree with all of it	

Appendix-10. Individual feedback to participant no.10

Jack

You said that you found the sessions enjoyable and what stood out for you from the sessions were the discussions. You were interested and involved in what people were saying all of the time and were able to talk about things you had to say. You did not feel uncomfortable in the sessions at any time. Helpful aspects from the sessions for you were the chart, as an explanation for understanding depression/anxiety, recognizing 'good and bad thoughts' that affect your feelings and behaviour, so that you can try to stop yourself from thinking negatively and 'replace it with more happier thoughts', 'doing bit by bit' over time to make things easier on you, remembering to be pleased with yourself when you have made the effort, the rating with numbers on how you feel was helpful to look at ups and downs in mood. You found all of this very helpful because you were reassured you were not the only one, that there were others like you and that sometimes they were people worse off than you. You felt encouraged when others were working hard on their problems and were getting better, that you were also helping others with your own suggestions as well as trying out others suggestions at home such as doing relaxation on a regular basis, understanding yourself better, and being able to do more things gradually and remembering to feel pleased with yourself.

If there is anything you don't agree with, would you please underline the words or sentences above.

Please tick in the box to indicate how much you agree or disagree with my version of what you have said. For example, if you agree with about half of it, you can tick the box at 50.

										X
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Don't agree										Agree
with any										with all
of it										of it

Appendix-11. The subjective mood rating scale

The ratings given below is a reflection of how the participants were feeling at the time in the group therapy sessions. Overall there was marginal variation in their ratings of mood in the sessions. Three of the participants did not show any variation in their ratings. The mood rating scale was used mainly as a therapeutic tool to help participants learn to make the links between thinking, feeling and behaviour so that they were better able to catch their negative automatic thoughts and take positive action.

Subjective mood rating scale where 0 is the worst and 10 the best that they can feel, taken before and after the group discussions in the group therapy sessions.

P	01		02		03		04		05		06		07		08		09		10	
	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A
I	6	6	5	6	5	5	5	9	-	-	7	7	6	6	7	7	5	6	10	10
2	6	6	6	6	-	-	-	-	-	-	8	7	6	6	7	7	5	7	10	10
3	7	7	6	7	5	6	5	7	7	8	5	7	6	6	7	7	5	7	10	10
4	6	6	6	6	5	5	7	8	8	8	5	7	6	6	7	7	8	8	10	10
5	5	5	6	6	-	-	5	7	7	7	4	7	6	6	7	7	6	7	10	10
6	-	-	7	7	5	6	7	8	-	-	9	10	-	-	7	7	9	9	10	10
7	5	6	6	6	-	-	6	8	3	6	6	8	6	6	7	7	6	8	10	10
8	6	7	7	8	5	6	7	9	8	8	6	8	6	6	9	9	6	7	10	10
9	5	5	6	6	5	5	6	9	7	7	4	8	6	6	7	7	5	5	10	10
10	4	4	-	-	-	-	6	9	8	7	-	-	6	6	7	7	4	5	10	10
11	4	5	6	7	5	5	5	7	7	7	3	5	6	6	7	7	5	5	10	10
12	4	4	7	7	4	5	5	6	8	8	3	5	7	7	7	7	6	7	10	10

*P= participants; S= sessions; B= before group discussion; A= after group discussion,
 '-=' dna (most often due to hospital transport difficulties, a few due to ill health such as flu / infection).

Appendix-12. Categories and quotes from the participants.

Analysis of the participants' general experience

The main categories generated from the interviews are presented below. To reduce the possibility of any participant being identified, all names of people and places have been changed. Any text included within brackets [] within the quotes from the participants denotes comments from the researcher for clarification purposes to make it easier for the readers of the script.

1. Listening /sharing: Taking/showing interest in others, learning from each other.

Anne I'd say it was very enjoyable, and by listening to other people, it helps us in so many ways.

.... Well, really, all the way, though I wasn't saying much meself but I was listening to them. I thought it was interesting how the other half were carrying on.

..... Millie [her daughter] says he's [her neighbour] unloading himself and I listen to him. Him, I feel sorry for. In a way that's what we do in group therapy, we listen to each others troubles.

..... By listening to others, I find it helpful. It makes me think different, lots of ideas are shared and that's helpful too.

..... We share what's helpful or what's not helpful which is for our own good.

Brigitte I liked it very well. I like to listen to Gill and that other gentleman, Ernie. I like it because you hear other peoples' feelings and troubles.

..... it helps to listen to other people.

..... I was listening to everybody and then I thought to meself, well, I'm afraid Brigitte everybody got their problems, and everybody seem to fight.

..... The first session, maybe, I thought to meself, well, I can't see that's going to help us, you know, but it does because you hear other people.

..... I thought when you listen everything is helpful, it helps you to listen to other people, that's what I like, I listen to other people and I think to myself.

..... I listen to everybody especially Gill and Jack and the sadness and I thought to myself at least they try, they try, they don't moan, they give their heart out. I think it's good to bring it all out than hide it.

..... To me it was helpful. I used to like coming on Mondays because we could talk you know, and I think that is important.

Claudia and say what's on their mind and their problems, it is very good because you can learn from them.

..... If you've got something on your mind, and you are really heavy loaded may be, you come here, talk to people, we talk to you.

..... and we learn from each other's experience.

..... I suppose when we come from your place, we cone home, and we've talked things over, we feel a lot better, easier.

DollyI was interested in this session listening to other people.

..... Listening to each other and just talking and chatting with others...

..... When I used to come to the sessions I was able to say how things were between Pat and myself which is so important to me..... When Joseph said don't undermine yourself. There's a lot of truth in that.

.... I enjoyed the session. We all had our say and I came away feeling much better.

....Well it was nice because we were able to talk between ourselves.

Ernie ... All the time I was there once I got started (interested/involved in the group discussion). See, you listen to everyone, you really listen, you want to know. I am very bad in crowds you know. I don't like crowds. I m not a mixer(referring to how unusual this is for him).

..... I was very interested all the time in what people were talking about.

..... And yes, listening to other people was helpful, because most of those people have, you know what I mean, well they are different medical wise, you know, some have lost people, like me as well and things like that you know, well you listen to everybody but its different for a lot of people, you know. Some common things come into it. You get to know them, you get used to them.

..... I remember Jack said he was getting more out of him, he spoke alright but he seemed a bit shy. He summed up a lot of how I feel. That helped me. I feel encouraged to see the positive changes in him. That other lady who does a lot of work for the church, Brigitte, how she fights back And that other coloured lady, Heather, I could see she's looking better, she speaks more freely now, it's very encouraging. I've noticed the changes in others as a whole, especially in Jack over the last couple of sessions.

..... Sharing information is very helpful. Like the lady who went to Age Concern for advice on tax. That was good because then I went there and it was good advice.

Farley Oh, all of the time (interested/involved in the group discussion), I like to hear people.

Gill I thought it was very nice. We all said different things and we all talked about what helped us and I was very happy with that.

.... all I know is it was quite a good session. We all had a little bit of something to say.

.... I mean, at the end, I don't talk to anyone. But when I go there, at least I can talk and let myself unload.

..... And I thought you're feeling sorry for yourself and there's other people that you know, they seem more cheerful and I think that kind of helped to pull me through. I thought so anyway.

Heather I was interested in all the talking that was going on all the time. ...

Brigitte said she feel like she could kill herself. I feel sorry for her.

... People were talking about falling ill. Anne said she fell ill and Brigitte said about all the deaths in her flat. Ernie said he had started gardening again.

..... I like to listen to others. Now my life is all sorted out and that was it.

..... Like Brigitte said about her neighbour, she was being kind and the neighbour slammed the door shut on her face, that was bad. She was talking about all the people dying in her flat, she was close to them and how she miss them and she feel

sad. She said she go to church and she have a good time. How even though it's hard for her, she make herself go out and feel better for it.

..... I'm comfortable all the time 'cause there was nobody there to interrupt me, so I feel alright. I was free to talk.

IvyI think I came out and spoke a little bit about it and that kind of thing and it did make it a little bit easier.

.... I just tend to look forward to going there [group therapy], to listen to like you know and there's always something interesting every week. Listening and sharing is helpful absolutely.

Jack listen to each one, conversation of what they got and how they tried to come through with it.

2. Specific strategies mentioned + Use of Coping strategies: Use of taught coping strategies such as pleasant activities, dealing with negative thoughts, etc.

Brigitte ... Like when I do my cleaning , it's not easy, but I tell myself you've done it and it's lovely. Before I start, I sit there trembling but once I start, it's funny but I get on with it.

..... The rating of mood before and after is useful. It's funny how one day you feel up and then you feel different. The talks you give on symptoms...

..... The rating of feelings is good. It tells you sometimes you're better and sometimes worse.

.... The talks you give on symptoms, my sleep is affected, like last night I thought I wouldn't go to church, then in the morning I thought I'll ring taxi and go and honestly for £3 to stand in the cold for the bus, then I went and I felt better but it was an effort, I tell you. I felt pleased when I came back. The sister when she saw me said Oh thank god you're here Brigitte and that made me feel good.

..... Now I'm making plans to go to St. Ann's [Day Centre] on a Friday too. Gill goes there and Jack too. I know two other ladies who goes on a Friday. After the group finishes, I need to go away, I need to go home, to my sister in Belgium.

.... When I feel bad I go out, to the church and pray and it calms me down.

.... We talked about looking forward to things, like the next lot of group sessions. And some of the others said they were looking forward to day centres.

....Because it helps me to make decisions and choices, even when it is hard, I can remind myself of the benefits.

..... I worked hard all my life, I haven't got much money, but I manage. I try to plan for nice things. I spoke to my sister last night and she's coming after Easter. I'll plan to go later in the summer.

Claudia It reminded me to look forward to things.

Dolly ...I think on the numbers rating, I could be wrong, I think I said 7 and I think I finished with 9 at the end (indicating improvement in mood).

..... I really feel as I'm sitting here with you that I'm going to get my confidence back and I'm going to do it with Pat. Right now I would rate my level of confidence as 6..... The numbers rating is useful.

..... The rating scale was useful. and I used the rating scale as a check on myself.

.....Catching your thoughts. Claudia talked about times when she didn't want to dress herself and how she talked herself into being positive and doing positive things even though it is hard....

....What I'd really like is for Pat and I to go there a bit more often.

....I am going to the supermarket for practice.

....I must confess, I don't like staying indoors, so I go out, sometimes to the park, or concerts, holidays. We are making plans for going out regularly, to concerts.

... Well I think what we all discussed and what we all talked about, made a lot of difference.....to how we see things and find a way out, look at what was harder, what was easier.

... I use the rating scale as a check on myself.

ErnieThe sketch on the first day (the cbt model), that had a lot of things, it was good.

..... I felt more uncomfortable before I went into the session than during the session. As I just said to you, explaining this from the beginning, it was the explanation which, it took a while but then I just settled down.

..... The rating of mood is good as I know it keeps changing.

.....

Farley ... The rating scale of mood was helpful, I say that as it gets you going.

Gill ... I've been quite happy all along and I've said that before too. Rochelle was feeling very sad. At one time, I couldn't even get out of this chair. The discussion was very helpful.

.... I don't tell meself off so much now.

Heather ...It was the conversation [the group discussion], ainit ? Whether how you feel from how you don't feel, I was interested in the conversation cos' I apply it to work for myself.

..... Well, all the talking about feeling depressed, and how bad that can be, and how others can make it worse...about grieving and coping with it....The chart was alright 'cause you feel within yourself whether positive or negative.

.... I look at my expectations and see what I can do.

.....It make me feel sad that others were sad but I am better now and it make me plan, to do things in the future, I like company now.

.... If I get panicky I know I can control meself. By controlling meself, I think about what I'm thinking about and doing the right thing. I remind meself of helpful things.

IvyWell, I found it all very useful really you know. I use some of the ideas, like what you say in that, you know, about catching your thoughts and that kind of thing. The talks like you know, as well. It leaves me relaxed you know, at the time. To say

how you feel is really useful (rating of mood in the session).. Through reading this [hand outs from group therapy], you know like.

.... I'm fighting it now more or less you know and that kind of thing and the thoughts I'm fighting as well. It's a constant battle more or less and that kind of thing. I use praying too help me with my thoughts, which does help. When I'm walking along like, I just try to knock the fear out, it's hard to explain you know. Like I say to myself I'll be alright.

..... Well I find that every time I go out, you know, and I think I could throw myself under, it's a big job you know, and I still go, so there must be some powerful confidence that goes there. Yes as I said some days I can go out and stand and look at the traffic coming towards me and it doesn't bother me but otherwise, on bad days, I still go out and live through it, I walk through it now you know. I used to be very frightened, terrified with these thoughts you know and then only when I came in, I'd feel alright. Now when I come in, I feel I've achieved something by going out now, I feel more confident.

..... It encourages me to go out, you know and face my fears and when I get back, I feel I've achieved something. It was horrendous before, terrified, people used to go by and I'd think they don't know what I'm suffering, what I'm going through you know. That gives me confidence that I'm not controlled by the horrible thoughts.

Jack the chart is helpful, and I do relaxation regularly.

..... The rating with numbers was helpful. The discussion was alright.

..... What really helped me was relaxation, I tell other people, in the street, when they say this pain here, that pain there. Some say it's stupid and some who tried my idea have said thank you very much, it works. Some of them now point to me for advise, they say talk to him (laughs).

... Well... this remind me of ...them loved one... that lost... and if this will always be this time... holiday time ...like the Christmas... that bring back memories...that you cannot snap out of... like most other time. The discussion was helpful.

.....With me now, anything that happen to you, badly... with me, that's my position, it will come back to you sometime, but just try... and think about something ...that make you feel better. Ideas...even from the ...you gave the seminars...something bad and something good ... you try to think about the good things and forget about the bad things. If it come at some time, but there's no future. I using all of those ideas, that's what get me out, that's what get me going, yeah. Do little bit at a time.

....so...all I have to do is think back and try and... pick something that... used to make you feel good...and try and go at it...little by little... and sometime that, you might just... like going out getting the papers.. or ...whatever it is, you come back in when you come through the door, you just...with a cuppa and sit and say thank you very much, I've done it. Yeah, to be pleased with yourself...I always do that.

.....Whenever I have negative thoughts I try and think about something else and try to do things that make me feel good. I think of my parents, my brother who learn me so much. He learn me everything like dancing, horse riding, lots of happy memories. Well, the session was helpful in every way.

3. Feelings about the group: Describing their positive feelings / thoughts about the group and sadness about ending.

AnneI think we was all sad it was the last session.

..... Though we were sad, we also had a laugh and that was helpful..... Things are very hard on me now. I have very high blood pressure which makes me feel ill. And the group made me feel so much better. I can hear myself talking more now.

Brigitte I think it is very useful to come here myself. It makes you feel very different you know.

.....I feel satisfied with coming here. I like when the Monday comes and that's the truth.

.....You know, I was a bit sad when you said it was finished for a little while because you get used to people you know.

..... To be honest, I was very sad, you know, then you said you will start again. I do hope so.

Claudia It was as always a great help. I don't know how but I miss it all and it did help me to feel better.

..... We talked about feeling sad, it was ending but the session itself felt so positive.

..... Sometimes I feel so alone and when I come to the group I talk about things that I can't say to anyone else.

Dolly ...The only specific thing that I can think of is when I come back from the group and meet up with my Pat. I don't know how to put it, but it gives me an inner strength. I feel the group does wonders for me. I feel a lot better in myself. I feel I have done something, a positive feeling.

..... Although there was sadness about ending the group, everybody was positive and looking ahead to the future. I'm taking more interest in things.

Ernie I liked coming to the group more than I did at first. We were all strangers then and I never knew what to say, and then I got used to it and I look forward to it.

..... Usually we go outside for a smoke before we go home, we can talk easy now. I used to be like if someone came in, I'd go out, I always walked out and left my wife to the talking. Meeting people was always hard for me.

Farley I wasn't feeling up to normal to be quite honest, perhaps I was hiding me thoughts and I felt depressed and I didn't say nothing. That was last Friday, the mood I was in.

..... I just felt a bit morbid that the meetings were closing.

..... What was helpful was more people were joining in the conversation. Correct me if I'm wrong I think I'm the one who starts it. I don't mind, it feels good once it gets going.

..... All of the time I was going home, I was thinking about the group, about more things I would have liked to have said that I couldn't remember to say at the time.

Sometimes I would plan what to say in the next session but I'm not so sure I remembered at times. I can't think of anything not helpful.

Gill I felt more like confident to talk.

.....I may have [felt uncomfortable] when we first started perhaps, as though I shouldn't be there but I kind of look forward to it now, to try. Because I don't go out a lot, and I only sit here, and I haven't got the confidence to go out. I might pass out there, it happens so quick.

Ivy ... I found it very nice, and it relaxed me a bit, you know as well.

..... I was a bit down but I felt relaxed and that was very helpful.

..... I feel less shy now and I feel a lot better now.

.....When I first went there I thought that the other people might be you know, a bit iffy. The first session I did feel a little bit uncomfortable, then after that, it was really lovely.

..... Well, everything was helpful to me you know, but I did feel a bit down at the time. The chance of more group therapy was helpful. I just latched onto that.

4. Belonging: Togetherness, being part of it, ownership (our group), like a family.

Brigitte.... I feel we are like a little family in our group....and I must be honest, our group is good to fight against it (problems).

....Like when we come to the group, it feels like our group. When we come home I don't feel so down.

Claudia I like how people pull together.

..... We pull together as a group.

Dolly I feel I am one of the group.

Ernie Now I feel part of the conversation.

Farley as I said once the ice was broken, people started talking, I've probably said this before, it makes you, it makes me feel a bit more, like I'm not being left out of anything, being part of it.

..... I am glad I was part of it.

..... It makes me feel part of it, that I am not left out. It makes me feel a bit more contented.

..... Like I said before, knowing that I help others is a wonderful feeling. It makes me feel elated.

..... The atmosphere was cheerful and it made me feel elated that I was helping others as well.

Heather I enjoy the group when I was there. I felt part of it and I enjoy it. It made me think of myself and the others.

..... And we all cope together ain't it.

Ivy ... Of course, I like the people as well, very much, they're very nice and I feel part of the group. I go because I want to go.

Jack Everybody was just pulling together.

5. Personal insight: Client sees something new about self, sees links, new learning.

Claudia ... It made me feel more positive despite all my troubles.

..... We have talked about it in the group. You know what I mean, years ago I would have expected to be given tablets for this and now we are coming to you where we don't get the tablets and still conquer it in the end and that's the important thing about it.

Dolly Most of all, I want my confidence back and I 'm not worried about Pat leaving me any more, I believe him now.

..... Now I go to St. Mary's [Day Centre] by myself. I'm not frightened anymore. I'm doing more than I was before and I am taking an interest in things like television, crochet, going out more with Pat [her fiancée]. I was feeling insecure at one time, there's no doubt about it.

..... I feel at the present time I'm going forward. I have accepted how things are.

..... The rating with numbers is specially useful to look at how we go up and down on a daily basis.

Ernie When I used to get a cup of tea, I used to take my tea away and sit on my own. I wouldn't sit with them. I would keep away. It's not that I 'm against crowds, it's just because I am a bad mixer in crowds. And now I've got to know them and I join them. I am more relaxed.

.... Usually I don't like being with a group of people as my wife says I run to my gardening when we have people coming in. I was surprised how I looked forward to the group.

..... I feel more encouraged to do things. It seems that the more I am going now, the more encouraged I am getting.

Gill Well, now I know how hard I can make things for meself like telling meself off if something isn't perfect. I don't get so angry with meself now like the time I dropped the mince pie and it went all over the kitchen. I can laugh now. Oh my God, I was in tears and I had worked so hard to make it.

..... 'cos I can see thinking the way I do I feel awful, sometimes it's so bad. I've got to stop thinking that I musn't do this and I musn't do that, the rules for myself that can make it easier on me.

Heather I can stop myself thinking negative because I can control meself. It's been a long time I have not felt stressed and I'm not worrying.

Ivy ... just that it was helpful when I was feeling down, it pulled me up.

... Well, I don't know but how can I put it, each time I felt I was getting the help I want, really, I didn't understand at first about psychology.

Jack With me now, I never plan anything. I just go out like routine and make sure I make it easy to go out. Nothing and no one stops my going out. Some people don't. I remember I didn't go out at one time. Jessi had been talking about day centres and then I thought I would give it a try. Now I'm glad that I did. Every time I go out and come back in, I feel I have achieved something. I used to think I can't go out, then I thought how would I know if I didn't try. And then I started

going out everyday. It's good to discuss things in the group and then we go away and practice step by step.

6. Understanding: Client can understand self/others better.

Brigitte But poor Gill, she can't do much in the home and starts scolding herself and Herbert, bless him, he's wonderful. Gill helped me to understand the pain in my leg, some form of sciatica that comes and goes. Heather reminded me of how much I had coped with, so many deaths since Christmas. The warden came up to me the other day and said well done. I said I did not do enough [referring to the neighbour who knocked on her door asking for help and died of a heart attack in front of her while the warden was on leave]. She told me I couldn't have helped more as you have to be trained for that. Oh it was horrible, all that stuff coming out of his mouth, my sofa and carpet was full of it. Yes I have coped with a lot.

Dolly ...I think doing the session as we had, we understood one another and it was on a friendly basis.

Ernie Now with the cold, I don't feel so good but I can understand more.
..... Actually, when you started speaking it caught me, brought home to me, understanding myself. I can make more sense of how I feel.
..... I got interested in other people and what they were saying. It helped me to understand myself better. It helped to bring me out, I was talking more easy to others, about services, about canals, especially when I used to go for a smoke outside. The main thing is it brought me around, the sketch, the chart was especially helpful in understanding myself.
....I know Brigitte was sad, when we got picked up that day we were the only two in the bus, and she started chatting to me about another death in her block and I used to know him as well. She was very upset as he died in her flat. I suppose the numbers rating showed that. I find that helpful as it shows how others are feeling too, it made me feel I wasn't the only one. Remember the sketch you have on the wall? That is me. Mostly everything was helpful. I can see myself in the sketch.
..... Because it's what I understood meself, you know everything was there to understand myself, the explanation was good. I feel easier and more friendly. The rating of mood is useful. I can understand myself more.

Farley It's the atmosphere and we feel encouraged to say more.
..... Ah, once I got going, it was nice to see more people joining in the discussion, I felt elated that I was able to make people laugh. I liked the atmosphere, it was cheerful.

Gill ... Yes that I don't tell meself off so much now.
..... I just like to feel better in myself, as I say, don't tell meself off so much and try.
..... Sharing is a big help. It helps me to unload and understand other people's problems.
..... It helped me to understand meself better.

Ivy ... When Claudia talked about her difficulties with her husband, it reminded me of my husband when I was younger, he wasn't that kind either, you know, I

understood her, he had good points but then again, he could be very cruel at times, which wasn't good. I found he used to get in on me a lot, you know, and make me very nervous and make me feel a bit down, you know. But I was more or less sheltered because of the children and of course, my mother, she was with me, so I had a lot of support. And it was helpful when Dolly talked about how she was trying to get her confidence back, you know. She looks wonderful now.

Jack.... Well, um...I um myself from the top to the bottom, I am experienced all those things and it just kind of looked right. You got those two sessions to understand, and remind you.

..... When I used to say 10, everyone would laugh. But that was how I felt, positive. Everything in the whole session is helpful. I understand myself better.

..... Most of the things that people talk about in the group, I have gone through all of them, sometimes worse than them, I've learned to cope with it now.

7. Personal contact with others in the group: Client experiences contact with others in the group as a person.

Anne ... It was very good of you that you got Claudia a wheelchair. I mean for all those months she hadn't had anything at all and she couldn't walk and it was only when you suggested it and you went all out to get it for her and then she got it. She goes out now and she's not stuck at home. She's a lovely lady. And Farley, he's lovely, always giving advice. He always has a smile. He's always joking with me, he's a nice man. We've got so much in common and we've got more or less the same thing.

..... It felt like a party. We exchanged telephone numbers so we can keep in touch.

Brigitte ... I like to listen to Gill, and Jack, bless him, he's wonderful (laughs). He's been a good friend when I came there to St. Ann's [Day centre].

..... Oh all the time [interested/involved in the group discussion], especially with Gill and what's his name, Jack.

..... I was very sad going back home. I was speaking to Anne, we were both sad but we keep in touch. She calls one evening and I call her the next. She's not keeping well with her high blood pressure.

Ernie ... Yeh, that lady [Anne] who has similar effects like me, the heart trouble, common issues, the same symptoms and how hard it is. And also about how they live, how they are getting on, you know what I mean. ... Listening to that other old woman, she keeps speaking all the time, Gill. She pulls you up a little bit because she goes on about her cooking.

.... When Gill spoke about her heart ailment, I knew exactly what she was saying. I have the same ailment.

Farley some of them I don't know if they are too shy, but don't talk much, like Ivy, she don't say a lot, unless she's drawn out of herself. She seems to be in a shell,

but she's saying more now in my opinion, she's speaking to me more now than when she first come, she'd only smile at first.

Gill ... Yes it was very good. I thought the, you know like. sometimes you can't think of anything and then all of a sudden something ticks and it, you know, reminds you of something else. And other people... their reactions are not quite the same but you feel as at can I say, mix with them like. I thought it was quite good.

..... I felt very supported and I was thinking more positive, not negative.

Heather..... I was interested in what they were all saying about how they feel. I know how they feel.

8. Problem clarification

Claudia We feel very good because of the explanations.

..... The model is very helpful to make sense of problems.

Ernie Well yes, everything as I said to you, everything that was explained to me, it was good.

..... As I said to you, the explanation given for understanding depression/anxiety, for a little while I was mesmerised and when you study it, you can see what it is. It really caught me, I could really see what everything meant. I understood what you were speaking about, you see, because it was all up there on the wall, you know what I mean. From the first time, very very helpful.

Farley I would say the explanations were useful, I don't want to say no, because that's the way I felt. I'll look forward to another group like this somewhere. But that's only my opinion.

Gill When you like say why I can't do this and I can't do that, the only thing is as I say, I keep saying I can't do this and I won't do this and I am lazy, I've got to try and make myself think that well you've done it, and you can't do it now, that's the only way that I can get through it. I mean it's hard to see, not to be able to do things.

Ivy ... The explanation is very good you know.

9. Task involvement : Client is made to think more/differently, feels more involved in the tasks of therapy.

Anne Why it is helpful is 'cause it makes me think, gives me new ideas and we share what's helpful or not.

Dolly I come away with what I heard I was discussing, I come away and think about it .

..... Well, when we go there, we have one outlook and then by the end of the session, it changes our outlook and helps to focus on what can be done.

Heather I know the day centre they was going, that was it, made me think I could go too, twice a week. I'd like to do the same thing.

..... Jack was talking about the day centre that I want to go to.

... The idea of attending day centre was helpful.

Ivy It makes me think differently you know,

Jack..... Things we talk about, I try it at home myself. Now I don't even worry what I'm going to do. I just know what's right for me and I do it.

10. Reassurance: Client feels understood, supported, relieved at not being different or alone.

Claudia I felt supported when I got to unload myself, about my troubles.

..... The support I get from the group, my problems, it's really great, it helps.

..... I feel understood and I don't have to pretend.

FarleyI'll say to myself I'm not the only one.

GillListening to other people's problems as well, makes me realise that I am not on my own, and other people have got problems even most probably worse than mine. You know, they've all got their worries and although you think to yourself you're the only one, but you're not because there's others are really worse.

..... It's always interesting to hear other people talking. When I listen to others, I think to myself well, I've been through that and I know exactly what it is 'cause I feel the same as them.

.....When I share things with other people, it made me feel that I'm not the only one in this position.

..... It helped me to think that I was not the only one feeling this way. There were other people in the same boat.

Ivy ...People understand me there you know and all that kind of thing. ...It relieves me a bit as well, when I hear that I'm not the only one, you know that kind of thing.

... I think it was just listening to other people and you know, suffering something similar to me, which also helps a great lot, you know as well.

.....It relieves me a bit as well, when I hear that I'm not the only one, you know that kind of thing.

Jack All the time you listen to each one view, and thing like that, what they feel, what they experience and thing like that, and you say whoa, I've got something like that, just in my head.

11. Comparing self favourably with others /self in the past : Attempts to buttress self esteem by comparison with those more unfortunate, with self in the past, by identifying with others.

BrigitteI like to think, bless them, there's people worse off than me.

..... I like the other dark, black lady, she lives not far from me. When she talks you know, you can see she also had a hard life. You know and believe me, I had a hard life too. I'm a widow 28 years now, and my husband died very young and I've never asked for anything from anybody. When I talk to that lady and then I thought to myself well, she's had a hard life too. You know I mean, unfortunately I've got no children and she got children and she's ever so nice.

.....Gill, you know is not so well, it's sad believe me. I'm lucky thank God that I can still do my housework, my shopping, and all that. I'm lucky there.

.....You know, you listen to everybody and everybody has got problems. One worse than the others.

..... I like to listen to other people, because then you know your own problems you know, whether you're worse or better. It's like when Gill feels down with her poor health, like she could do so much at one time.

..... Yes I'm very interested because it's very nice to hear other people's problems and think to yourself sometimes that oh well I'm not so bad after all.

..... There's so many people like us.

..... That's what interests me, when I hear other people then I think well I'm not that bad after all.

..... What I found helpful was listening to other people, it helps me to compare my own worries to others.

..... I think to myself I'm not that bad. And when I listen to the news on Kosovo and what they're going through, and we moan here sometimes, oh god, that's terrible how they suffer.

DollyUmm.. I think it was the lady who said she had a fear of, that she comes to the hospital on her own but she had a fear, and I think that's when I might have said well at least I can cross the traffic lights on my own now, not the ones further down but the that.

..... When I go to St.Mary's [feel less confident]. But at least I don't get the butterflies any more now. But I did used to have that.

.....that we have more or less the same thing in common, some may be worse than others.

..... Well I think the talking together was helpful for me because I could see other people having similar problems to me.

GillI used to curl up in a chair at one time and not move. That was terrible.

.... I can't see myself improving any more than I am now, and I am better. I used to sit in this chair all curled up with my knees up. I have to sort out my photos to show you. It was horrible. I never knew Jean took a photo, I hope I never feel like that again.

..... I was terrible when I first came and Teri [her CPN] will tell you that, I didn't talk to anyone at all when I first came there and then I had the sessions and it helped me to get through it all. And I feel fine now.

HeatherIt was helpful with all the patient talking, I could see with them...what they were talking about...about their feelings ain't it? They couldn't go out on their own, I can do it myself, I can go out on my own. I go out shopping by myself and they couldn't.... Gill couldn't do the hoovering. She fainted. I felt sorry for her, but she couldn't do a lot of thing... I've been doing mine.....

Jack ... Well...it's ...some people...you know what they go through and thing like that and you think, oh there's someone out there same like me or worse than me.I mostly listen to others... why... you might think you get the worst end of it but when you hear the other person, you say... oh, I am not too bad.

..... I remember I used to be on a lot of pills, and now I've cut it down myself slowly, slowly. When I was taking injections, it made me worse, I couldn't talk. Now I don't take any. Plenty of people ask me how I did it. And I say that I try and try, bit by bit. If you was taking one pill, cut it in half and then gradually none at all. I understand better now. Like I used to drink a lot and after I come out of hospital I said I have to stop the drink, no more drinking, so I would take something light. Sometimes when I go to shops I see the whisky but not buy it. One time I buy it then I didn't like it so threw it in the bin. It was my choosing. And upto now I don't want anything strong, ordinary beer, nothing stronger than that. I am quite alright now I would say.

..... Many times I listen to what someone has said and I think, oh, I thought I was bad, and now there's someone worse than me and that person is trying to push himself forward and that gives me more strength.

12. Facilitator helpfulness

Although no specific questions were asked about the group facilitator, the participants made some comments nevertheless.

Anne ... Well, you try and help us, you tell us what you think may be right or what might be wrong and what you say is to our advantage. So it was good to talk.

Brigitte.... and you like to explain everything nice, which is good, you know, sometimes like some of them are quite and they listen to us, and I like that you ask things, then you know what to answer. It's good because you don't always know what to say or you feel a bit shy you know. You explain everything and make us understand what it is all about, some of them wouldn't, they tell you , yes, but you make us understand and that's when you can follow what's wrong with you. That's how I feel, I don't know about the others. Because last Monday I was really depressed, and I think you saw it. I think it's a lot to do with the weather too, dull and miserable and you can't be bothered to do anything.

..... And I like to listen to you. You explain everything so good, honestly, make you understand, being foreign, you know, some things that you don't understand, but I must say, I do understand.

Claudiaand you explain things to us, it makes you feel better. We feel very good you care and that's very nice.

Ernie ... and very well explained [the cbt model].

.....I remember that and you made sure that we all had our chance to voice our opinion.

..... What you've been speaking about don't overdo it, do what you can do. I have my own way of doing bit by bit.

..... I said that to you before, you are a great help for a start and getting to know others, otherwise I'm a little backward [socially].

13. **Being heard/listened to:** Positive self worth that they can make a difference to others and to themselves.

Brigitte ... We can listen to somebody and they listen to us and I like that.

..... No. I can't say that I've ever felt uncomfortable 'cause everybody is so nice. Everybody listens and I think that is so important.

..... That's what I like about it. Because when you think on your own all the time, you like to know what other people have to say, like in here. When I see those two old people, I do a bit of shopping for them and they are so grateful, oh it's so wonderful. The fact that I can make a difference to their life and feel good about it myself too.

..... and it makes me feel better when others listen to me and sometimes even try out some of the suggestions.

Claudia It feels like when people listen to my troubles and offer suggestions, that's very helpful. I feel like a person. The others are so kind to me.

Farley Ah, I can hear myself bring out laughs in the others. I can't tell you how good that makes me feel. We've all got our troubles but to think that just by talking about it, that it makes a difference. That I can make a difference to others, is a boost for me.

14. **Distraction**

Two participants identified problems in the group sessions in the first set of interviews when they could not follow the group discussion due to hearing problems and when the mind wandered off interfering with concentration. For example,

Anne ...all the time (interested in the group discussion) but I can't hear all of it. I can hear people sitting next to me.

Farley ...When someone is talking to you and my thoughts are being a bit lazy, I started to go back in meself, I wasn't concentrating, bit distracted with my mind wandering off. I get distracted by my thoughts.

These problems were minimised in the group sessions by providing more frequent summaries of the group discussion so that participants were able to stay focussed and by checking with the participants if they were able to follow the discussions and encouraging them to ask questions if anything was not clear.