

**Telephone-Delivered Group CBT for Anxiety:
Experiences of Group Members**

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

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Overview

Cognitive behavioural therapy (CBT) for common mental health problems is increasingly being delivered by telephone, over the internet and via guided self-help. This thesis examines telephone-delivered interventions for anxiety and depression and is presented in three parts.

Part I is a literature review of the effectiveness of telephone interventions for anxiety and depression. Sixteen studies met criteria for the review. Overall, study quality was good and there was reasonable evidence that telephone interventions show promise in reducing symptoms of anxiety and depression. Further research is required to determine the characteristics of people who find telephone-delivered interventions beneficial.

Part II presents the findings from a qualitative study of recipients' experiences of a 14-week telephone-delivered CBT group for anxiety disorders. Seventeen people completed a telephone interview. Interview transcripts were analysed using the 'framework' approach and yielded 10 themes organised into three domains. There were therapeutic benefits from taking part in the groups, even in the absence of symptom change. However, a number of barriers and challenges (e.g. difficulties in connecting with others over the telephone) sometimes prevented people from making full use of the groups. Further research is needed to understand the impact of delivering group CBT by telephone, in order to guide the delivery of similar low-intensity interventions for anxiety.

Part III is a reflection on the research process and focuses on the impact of using the telephone for semi-structured interviews, the advantages and challenges of conducting research with external organisations, and the implications for the delivery of low-intensity interventions.

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Part I: Literature Review

The Effectiveness of Telephone Interventions for Anxiety and Depression

Abstract

Aims: The telephone is increasingly used to deliver psychological therapies to people experiencing common mental health problems. This review aimed to explore the effectiveness of telephone-delivered psychological interventions in reducing symptoms of anxiety and depression and to assess the quality of the evidence base.

Method: A systematic search of the literature for relevant articles was conducted via a combination of electronic database searches, citation searching, manual searches of bibliographies of relevant papers and hand searching of key journals. The methodological quality of the studies included for review was assessed using the Effective Public Health Practice Project Quality Assessment Tool.

Results: Sixteen papers met inclusion criteria for the review. Ten papers reported findings from telephone treatment of depression, five papers reported treatment of anxiety and one paper reported telephone treatment for both depression and anxiety. Ten studies used randomised controlled designs, five were uncontrolled studies and one was a benchmarking study. Overall, study quality was good although some papers lacked adequate detail to fully appraise the methodology. All studies but one reported significant reductions in symptoms of depression or anxiety following a telephone-delivered psychological therapy. Cohen's d ranged from .38 to 4.31, with a median of 1.08. Only three studies reported clinically significant change.

Conclusions: The findings of this review indicate that telephone interventions show promise in reducing symptoms of depression and anxiety. However, further research is required to establish the types of interventions that are most effective and the characteristics of people who find them beneficial.

Introduction

Depression and anxiety are common and debilitating mental health conditions. Epidemiological research indicates that in the UK, between 8% and 12% of adults experience depression in any year and approximately one in six adults suffer from a clinically significant anxiety disorder (Singleton, Bumpstead, O'Brien, Lee & Meltzer, 2001). Depression and anxiety often co-occur and research indicates that only 2% of people experience a depressive episode without comorbid anxiety (Singleton et al., 2001). Furthermore, mixed anxiety and depression is the most common mental disorder in Britain, with almost 9% of adults meeting criteria for diagnosis (McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009).

Psychological therapies such as cognitive behavioural therapy (CBT) are effective in treating anxiety and depression and produce comparable outcomes to pharmacological interventions (DeRubeis et al., 2005). However, there are a number of barriers to accessing and engaging with psychological therapies (Hollon et al., 2002; Wells et al., 2002). These include practical barriers such as lack of provision of local mental health services, lack of transportation, time constraints and caregiver demands, as well as emotional barriers including stigma and concerns about talking about problems (Hollon et al., 2002; Mohr et al., 2006; Mohr et al., 2010; Wells et al., 2002; Yuen, Gerdes & Gonzales, 1996). Research indicates that these barriers prevent people from accessing effective treatment and many adults with depression or anxiety do not receive psychological therapy (Brody, Khaliq & Thompson, 1997; Young, Klapp, Sherbourne & Wells, 2001). In the UK, before the introduction of Improving Access to Psychological Therapy (IAPT) services in 2007, as many as 90% of people with anxiety or depression did not receive a psychological intervention for their problems and only 5% of people had access to an evidence-

based psychological treatment (McManus et al., 2009). Therefore, there has been a drive to improve access to psychological therapies, including developing alternative methods of therapy support and delivery via remote communication technologies (Maheu, Whitten & Allen, 2001; Mohr et al., 2010; Nickleson, 1998).

Psychological therapies have traditionally been delivered face-to-face, but in recent years there have been considerable advances in the provision of talking therapies by the telephone, over the internet and via guided self-help (Mohr, 2009). Telephone-delivered psychological therapy can be cost-effective and has the potential to offer clients immediacy of help, anonymity and ease of access (Leach & Christensen, 2006; Mohr, Vella, Hart, Heckman & Simon, 2008). Research has shown that telephone interventions are convenient for patients and therapists, remove barriers to treatment, and can reduce treatment time by up to 40% (Lovell et al., 2006; Mohr et al., 2006; Robinson, Berman & Neimeyer, 1990). In the United States, as many as two thirds of psychologists use the telephone to provide at least one session of psychological therapy (e.g. providing psychoeducation and reviewing homework; VandenBos & Williams, 2000) and in the UK, low-intensity therapy is offered to clients by telephone in IAPT services (Gyani, Shafran, Layard & Clark, 2011). However, it has been argued that telephone-delivered psychological therapy may be less effective as the absence of direct interpersonal contact may disrupt the development of a strong therapeutic alliance (Kraut et al., 1998; Stamm, 1998).

Research has thus begun to explore the effectiveness of non face-to-face therapy. Systematic reviews indicate that computer-delivered CBT programmes, internet based therapy, self-help treatment and therapy mediated by remote communication technologies (e.g. videoconference) are effective (Bee et al., 2008; Hailey, Roine & Ohinmaa, 2008; Kaltenthaler et al., 2006; Marrs, 1995; Spek et al.,

2007). With regard to telephone-delivered therapy, the majority of research has focused on people with physical health conditions (e.g. Muller & Yardley, 2011). For example, CBT delivered via the telephone has been shown to reduce mortality and improve quality of life in patients with chronic heart failure (Clark, Inglis, McAlister, Cleland & Stewart, 2007), aid smoking cessation (Lichtenstein, Glasgow, Lando, Ossip-Klein & Boles, 1996), and provide support for patients with cancer and HIV/AIDS (Mermelstein & Holland, 1991; Wiener, Spencer, Davidson & Fair, 1993).

More recently, an emerging body of literature has evaluated the effectiveness of telephone-delivered therapy for psychological disorders. For example, initial observational data from two IAPT demonstration sites indicated that brief telephone-delivered CBT based interventions were effective in reducing symptoms of anxiety and depression (Richards & Suckling, 2009). Similarly, a large-scale study of 39,227 adults referred to IAPT services in the East of England found that low-intensity CBT delivered by telephone significantly reduced symptoms of anxiety and depression and was not inferior to face-to-face therapy, except for people with more severe symptomatology (Hammond et al., 2012). Furthermore, the cost for a session of telephone therapy was 36.2% lower than a similar face-to-face session (Hammond et al., 2012).

Previous Reviews

A number of reviews have begun to explore the effectiveness of telephone-delivered psychological therapies (Bee et al., 2008; Leach & Christensen, 2006; Mohr et al., 2008; Muller & Yardley, 2011).

Muller and Yardley (2011) reviewed eight randomised controlled trials (RCTs) of CBT for people with chronic health conditions and concluded that

telephone-delivered CBT can improve health, particularly for people with chronic illnesses that are not immediately life-threatening. Although treatment components included stress and anger management, managing negative emotions and coping skills, the primary focus was on physical health outcomes (e.g. the functional impact of arthritic symptoms). Therefore, while this review is relevant to understanding the effectiveness of delivering CBT via the telephone, it did not specifically address mental health outcomes.

Leach and Christensen (2006) reviewed 14 studies evaluating telephone-based interventions in the areas of depression, anxiety, eating disorders, substance use and schizophrenia. They found that telephone interventions can be effective in reducing symptoms in mental health disorders, particularly if the intervention included structured therapy sessions and homework tasks. However, as the authors noted, small study numbers and sample sizes prevented them from drawing firm conclusions. Furthermore, although this review provided some preliminary evidence for the effectiveness of telephone-administered psychological therapy, it did not report effect sizes, clinical significance or directly consider the quality of the included studies. An additional limitation of this review is that it focused on a wide range of mental health disorders with differing treatment guidelines and outcomes.

A meta-analytic review found preliminary support for the use of therapy mediated by remote communication technologies (Bee et al., 2008). Although this review included studies of telephone-delivered treatment, it focused more widely on the use of remote communication technologies and also included studies where the telephone was not the sole mode of therapy delivery.

Mohr et al. (2008) reviewed 12 RCTs of telephone-administered psychotherapy for depression. They found significant reductions in depressive

symptoms from pre- to post-therapy compared to controls and a significantly lower attrition rate than in traditional face-to-face therapy. This was a comprehensive review that took into account a number of important aspects of telephone-administered therapy. However, a limitation of the review is that it included some studies where participants had additional severe physical illness which may have confounded the results. Furthermore, it prioritised RCT designs, which may have potentially led to the exclusion of noteworthy non-controlled studies. Additionally, as in all the previous reviews, study quality was not considered explicitly.

Aims of the Current Review

The findings of the reviews outlined above contribute to a developing body of research that indicates that the telephone may be an effective way of delivering psychological therapy to traditionally hard-to-reach populations. However, this is a relatively new field of research and it remains unclear whether telephone interventions specifically targeting common mental health conditions are effective in reducing mental health symptoms. In order to address this gap in knowledge, the current review aimed to explore the effectiveness of telephone-administered psychological interventions for depression and anxiety. Both studies of depression and anxiety were considered as these disorders are highly prevalent and often co-occur. Furthermore, depression and anxiety may be particularly amenable to telephone interventions as the recommended therapies (e.g. CBT) can be adapted for non-face-to-face conditions and treatment guidelines recommend a stepped-care approach to depression and many anxiety disorders (NICE, 2005, 2009, 2011). An additional aim of this review was to formally assess the quality of the studies included for review, in order to highlight areas for future research.

Method

Inclusion and Exclusion Criteria

The inclusion criteria were that studies must:

1. Evaluate a one-to-one telephone based intervention designed to specifically target symptoms of depression and/or anxiety;
2. Use the telephone as the main mode of delivering the intervention;
3. Include a psychometrically sound measure of either anxiety or depression as a main outcome measure; and
4. Obtain quantitative outcome data at a minimum of two time points e.g. pre- and post-intervention.

Telephone-delivered therapy is a relatively new and developing field.

Therefore in order to fully capture all the relevant research, no restrictions were placed on the type of study design and studies which utilised a variety of methodologies were considered for review. These included case studies, uncontrolled studies and controlled trials (randomised and non-randomised) which compared telephone interventions with a control group.

Studies were excluded from the review if:

1. The telephone intervention was delivered in adjunct to another therapeutic intervention e.g. face-to-face therapy or computer based therapeutic programmes;
2. The main component of the intervention was peer-support;
3. The intervention involved the use of videoconference software or other electronic visual-aid;
4. The intervention was based on a one-off call to a telephone hotline or crisis intervention service; or

5. The reported results were taken from a previous publication.

Search Strategy

Studies were identified via a combination of computerised database searches, citation searching, manual searches of bibliographies of relevant papers and hand searching of key journals (e.g. *Journal of Telemedicine and Telecare*).

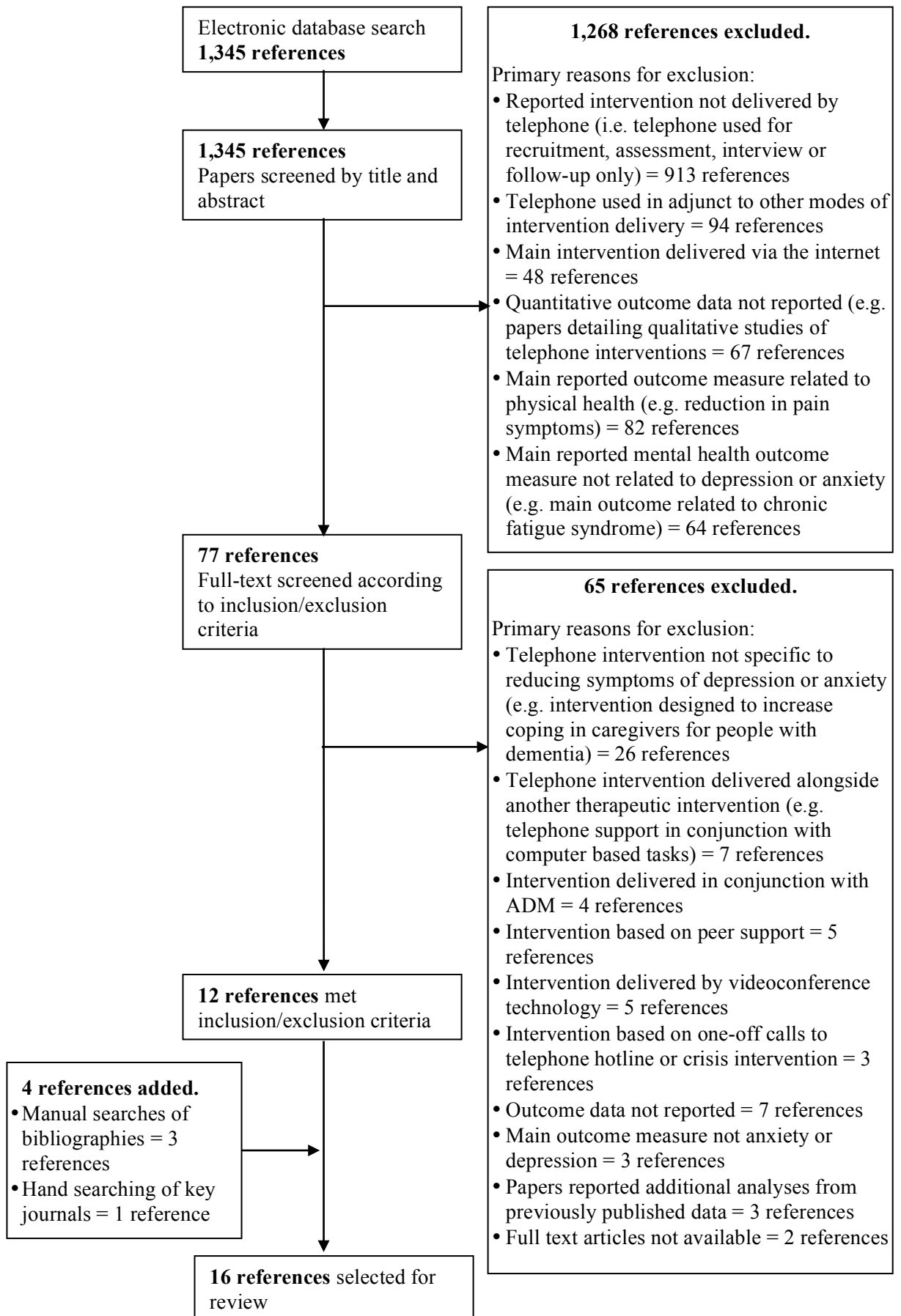
A systematic search of the literature for relevant articles published prior to August 2012 was performed using the databases PsycINFO and PubMed. Results were limited to English language, peer-reviewed journal articles. Preliminary scoping searches established that including specific anxiety disorder terms (e.g. 'panic') was necessary in order to fully capture all relevant papers. Truncated terms were used in order to allow for variations in keywords (e.g. depression/depressive) and to identify both British and American-English publications. The following keyword search strategy was used:

(Anx* OR depr* OR panic OR obsess* OR phobia OR fear)
AND (telep*) AND (therapy OR treat* OR intervention OR
counsel*)

Study Selection

The study selection process is outlined in Figure 1. The electronic search resulted in a total of 1,345 hits. Initially, the results were screened by scanning titles and reading abstracts to identify relevant papers. This resulted in the exclusion of 1,268 papers. The full-text articles of the remaining 77 results were then read and considered in detail against the inclusion and exclusion criteria and a further 65 papers were excluded from further review. The reason for exclusion was usually

Figure 1. *The Process of Study Selection and Primary Reasons for Reference Exclusion*



based on multiple reasons. The primary reasons for exclusion are shown in Figure 1. Judgements about eligibility were made by the author and then by her supervisor in case of doubt. An additional four studies were identified from manual searches of bibliographies and hand searching of key journals, see Figure 1.

Data Extraction

For each of the studies included in the review, key data were extracted, including author, date, journal, title of study, design, sample size, participant characteristics, details of intervention (including theoretical orientation, number of sessions and duration), details of any control group, primary outcome measures, follow-up, statistical techniques used for analysis, and summary of outcome. Data were organised by target problem (i.e. depression, anxiety or mixed depression and anxiety).

Assessment of Methodological Quality

The quality of the studies included for review was assessed using the Effective Public Health Practice Project Quality Assessment Tool (EPHPP; Jackson & Waters, 2005; Thomas, Ciliska, Dobbins & Micucci, 2004). This tool assesses the overall quality of quantitative studies by taking into account subscale scores in six domains: selection bias, study design, the presence of confounding variables, blinding, data collection methods, and participant withdrawals and drop-outs. The tool also provides a framework for evaluating intervention integrity and data analyses. The EPHPP tool was selected as it was designed for use in public health research. Additionally, the EPHPP tool can be used to evaluate a range of study designs, includes consideration of intervention integrity, has reported content and construct validity (Jackson & Waters, 2005; Thomas et al., 2004) and has been

judged suitable for systematic reviews of intervention effectiveness (Deeks et al., 2003).

Table 1 describes the criteria for strong, moderate and weak quality ratings for each of the six domains. Following the tool guidelines, each domain was rated as *strong* (3 points), *moderate* (2 points) or *weak* (1 point) based on information contained in the paper. Judgements about quality were made by the author and then by her supervisor in case of doubt. A global rating for each paper was then calculated by averaging the total score and taking into account the total number of weak ratings. Papers with no weak ratings were rated as *strong*, papers with one weak rating were rated as *medium*, and papers with two or more weak ratings were rated as *weak* (see Appendix A for further information).

Synthesis

Following the quality assessment, a synthesis of the studies was carried out, focusing on study design, participant characteristics, nature of the intervention, outcome measures and the outcomes reported. Studies exploring interventions for depression, anxiety and mixed depression-anxiety were compared. Outcomes were considered in terms of statistical significance, effect sizes and clinical significance. Cohen's *d* was used as a measure of effect size (Cohen, 1969). Effect sizes were either extracted from the papers or computed from study data and figures where possible. Effect sizes were calculated by dividing the difference in mean values pre- and post-intervention by the pre-treatment standard deviation (Cohen, 1969). Where studies used multiple outcome measures, effect sizes were based on the primary outcome measure identified in the paper, or calculated based on the most widely used and validated measure. Clinical significance (Jacobson & Truax, 1991) was extracted from papers where appropriate.

Table 1. *Quality Assessment Ratings for the Six Domains of the EPHP Quality Assessment Tool*

Domain	Strong Rating	Moderate Rating	Weak Rating
Selection bias	Very likely to be representative of the target population and greater than 80% participation rate	Somewhat likely to be representative of the target population and 60-79% participation rate	All other responses or not stated
Study design	RCTs and CTTs	Cohort analytic, case control, cohort or an interrupted time series	All other designs or design not stated
Confounders	Controlled for at least 80% of confounders	Controlled for 60-79% of confounders	Confounders not controlled for, or not stated
Blinding	Blinding of outcome assessor and study participants to intervention status and/or research question	Blinding of either outcome assessor or study participants	Outcome assessor and study participants are aware of intervention status and/or research question
Data collection methods	Tools are valid and reliable	Tools are valid but reliability not described	No evidence of validity or reliability
Withdrawals and dropouts	Follow-up rate of >80% of participants	Follow-up rate of 60-79% of participants	Follow-up rate of <60% of participants or withdrawals and dropouts not described

Note. RCTs = randomised controlled trials; CCTs = controlled clinical trials.

Results

The characteristics of the 16 studies that met the inclusion criteria for review are outlined in Table 2. Ten studies examined the role of telephone interventions in depression, five focused on anxiety disorders and one study explored the effectiveness of telephone therapy in depression and anxiety. Of the five studies focusing on anxiety disorders, four specifically targeted symptoms of obsessive-compulsive disorder (OCD) and one targeted panic disorder with agoraphobia. The majority (89%) of the studies were conducted since 2000. Three studies were conducted in the United Kingdom, two studies were conducted in Canada and the remaining 11 were conducted in the USA. Ten studies used randomised controlled designs, five were uncontrolled studies and one was a benchmarking study. Fifteen out of 16 studies reported statistically significant reductions in symptoms of depression or anxiety.

Quality Assessment of Included Studies

The quality ratings of the included studies (as rated by the EPHPP) are shown in Table 3. Overall, the quality of studies was good, with the majority (13 studies) receiving an overall rating of moderate (seven studies) or strong (six studies).

Overall, the quality ratings for selection bias was mixed; this was in part due to variability in the detail in which studies reported the recruitment methods and the response rates at different stages of recruitment. Study design was generally of high quality, although only two studies reported details regarding the method of randomisation (Dwight-Johnson et al., 2011; Lovell et al., 2006). The majority of studies reported a consideration of the presence of confounding variables and controlled for these in either the design or analyses e.g. by controlling for baseline differences in level of depression between treatment groups. The ratings for blinding

Table 2. *Characteristics of Reviewed Studies*

Author	Target Problem	Study Design	Sample Characteristics	Telephone Intervention	Outcome Measures	Follow-up	Drop Out	Study Findings
<i>Depression studies</i>								
Dobkin et al. (2011)	Depression in Parkinson's disease	Uncontrolled	<i>N</i> = 21 Mean age = 66 38% male	10 sessions (60-90 min) CBT	HAM-D BDI-II	4 wks	5%	Significant reductions in depression pre-post; gains maintained at follow-up, $p < .001$
Dwight-Johnson et al. (2011)	Depression in rural Latino primary care patients	RCT – Enhanced usual care control	<i>N</i> = 101 Mean age = 40 22% male	8 sessions (45-50 min) CBT	PHQ-9 SCL	6m	12%	Significant reductions in depression compared to controls, $p = .013$ (PHQ-9); $p = .018$ (SCL); gains maintained at follow-up
Himelhoch et al. (2011)	Depression in HIV	Uncontrolled	<i>N</i> = 6 Mean age = 44 17% male	11 sessions (27-70 min) CBT	HAM-D QIDSSR	None	0%	Significant reductions in depression pre-post, $p < .006$ (HAM-D); $p < .002$ (QIDS)
Miller & Weissman (2002)	Recurrent Depression	RCT – no treatment control	<i>N</i> = 30 Mean age = 32 0% male	12 sessions (60 min) IPT	HAM-D	None		Significant reductions in depression compared to controls, $p < .02$
Mohr et al. (2000)	Depression in MS	RCT – usual care control	<i>N</i> = 32 Mean age = 43 38% male	8 sessions (50 min) CBT	POMS-DD	None	28%	Significant reductions in depression compared to controls, $p = .003$
Mohr et al. (2005)	Depression in MS	RCT – T-SEFT control	<i>N</i> = 127 Mean age = 49 24% male	16 sessions (50 min) CBT	HAM-D BDI-II	12m	6%	Significant reduction in depression, p 's $< .01$. Greater reduction in HAM-D score in CBT group compared to control, $p = .02$; differences between groups on BDI-II ns. Gains maintained at 12m follow-up, but differences between groups ns

Author	Target Problem	Study Design	Sample Characteristics	Telephone Intervention	Outcome Measures	Follow-up	Drop Out	Study Findings
<i>Depression studies (continued)</i>								
Mohr et al. (2006)	Depression in veterans	Uncontrolled	<i>N</i> = 8 Mean age = 57 100% male	8 sessions (50 min) CBT	BDI-II HAM-D	None	Not reported	Significant reductions in depression, pre-post, <i>p</i> = .007 (BDI-II), <i>p</i> = .02 (HAM-D)
Mohr et al. (2011)	Depression in veterans	RCT-TAU control	<i>N</i> = 85 Mean age = 56 91% male	16 sessions (45-50 min) CBT	HAM-D PHQ-9	6m	2%	No significant time x treatment effects, <i>p</i> 's > .20
Ransom et al. (2008)	Depression in HIV	RCT- usual care	<i>N</i> = 79 Mean age = 44 84% male	6 sessions (50 min) IPT	BDI-II	None	16%	Significant reduction in depression compared with controls, <i>p</i> < .05
Tutty et al. (2010)	Depression	Benchmarking study	<i>N</i> = 30 Mean age = 33 34% male	10 sessions (30 min) CBT	SCL	6m	10%	Significant reduction in depression at 6m, <i>p</i> < .001
<i>Anxiety studies</i>								
Lovell et al. (2000)	OCD	Uncontrolled	<i>N</i> = 4 Mean age = 35 25% male	8 sessions (15 min) ERP	Y-BOCS BDI-II	1m	0%	3 out of 4 participants improved
Lovell et al. (2006)	OCD	RCT – ERP delivered face-to-face control	<i>N</i> = 72 Mean age = 33 44% male	10 sessions ERP	YBOCS BDI-II	6m	6%	Outcome of telephone ERP equivalent to face-to-face therapy
Swinson et al. (1995)	Panic disorder	RCT – waitlist control	<i>N</i> = 46 Mean age = 41 11% male	8 sessions (60 min) BT	FQ STAI-T BDI-II	3m	8.69%	Significant reductions in anxiety pre-post compared to controls, <i>p</i> < .001. Gains maintained at follow-up

Author	Target Problem	Study Design	Sample Characteristics	Telephone Intervention	Outcome Measures	Follow-up	Drop Out	Study Findings
<i>Anxiety studies (continued)</i>								
Taylor et al. (2003)	OCD	RCT – delayed treatment control	N = 33 Mean age = 38 24% male	12 sessions (45 min) CBT and ERP	YBOCS BDI-II	12 wks	21.21%	Significant reductions in OCD compared to controls. Gains maintained at follow-up
Turner et al. (2009)	OCD in young people	Uncontrolled	N = 10 Age 13-17 80% male	16 sessions CBT	YBOCS	None	20%	All participants reported improvements in OCD symptoms
<i>Depression and anxiety studies</i>								
Veazey et al. (2009)	Anxiety and Depression in Parkinson's disease	RCT – telephone support control	N = 10 Mean age = 66 100% male	8 sessions CBT	PHQ-9 BAI	1m	20%	All participants in CBT condition reported reductions in depression and anxiety

Note. ADM = Anti-Depressant Medication; BAI = Beck Anxiety Inventory; BDI-II = Beck Depression Inventory-II; BT = Behaviour Therapy; CBT = Cognitive Behavioural Therapy; ERP = Exposure and Response Prevention; FQ = Fear Questionnaire; HAM-D = Hamilton Depression Rating Scale; IPT = Interpersonal Psychotherapy; MDD = Major Depressive Disorder; MS = Multiple Sclerosis; POMS-DD = Profile of Mood States Depression-Dejection Scale; PHQ-9 = Patient Health Questionnaire-9; QIDS-SR = Quick Inventory of Depressive Symptomatology; SCL = Hopkins Symptom Checklist; STAI-T = State-Trait Anxiety Inventory – Trait Version; TAU = Treatment as Usual; T-SEFT = Telephone Administered Supportive Emotion Focused Therapy; Y-BOCS = Yale Brown Obsessive Compulsive Scale – Self Report Version.

Table 3. *Quality Assessment of Reviewed Studies*

Study	Selection Bias	Study Design	Confounders	Blinding	Data Collection Methods	Withdrawals and Drop-Outs	Total Score	Global Rating
<i>Depression studies</i>								
Dobkin et al. (2011)	Weak	Moderate	Strong	Moderate	Strong	Strong	2.33	Moderate
Dwight-Johnson et al. (2011)	Moderate	Strong	Strong	Moderate	Strong	Weak	2.33	Moderate
Himelhoch et al. (2011)	Moderate	Moderate	Strong	Moderate	Strong	Strong	2.50	Strong
Miller & Weissman (2002)	Weak	Strong	Strong	Moderate	Strong	Moderate	2.33	Moderate
Mohr et al. (2000)	Strong	Strong	Strong	Moderate	Strong	Moderate	2.67	Strong
Mohr et al. (2005)	Strong	Strong	Strong	Moderate	Strong	Strong	2.83	Strong
Mohr et al. (2006)	Moderate	Moderate	Moderate	Moderate	Strong	Strong	2.33	Strong
Mohr et al. (2011)	Moderate	Strong	Strong	Moderate	Strong	Strong	2.67	Strong
Ransom et al. (2008)	Moderate	Strong	Strong	Weak	Strong	Moderate	2.33	Moderate
Tutty et al. (2010)	Moderate	Moderate	Strong	Weak	Strong	Strong	2.33	Moderate
<i>Anxiety studies</i>								
Lovell et al. (2000)	Moderate	Weak	Moderate	Weak	Strong	Strong	2.00	Weak
Lovell et al. (2006)	Strong	Strong	Strong	Moderate	Strong	Strong	2.83	Strong
Swinson et al. (1995)	Moderate	Strong	Weak	Weak	Strong	Strong	2.17	Weak
Taylor et al. (2003)	Moderate	Moderate	Strong	Weak	Strong	Moderate	2.17	Moderate
Turner et al. (2009)	Strong	Moderate	Strong	Weak	Strong	Strong	2.50	Moderate
<i>Depression and anxiety studies</i>								
Veazey et al. (2009)	Weak	Moderate	Strong	Weak	Strong	Moderate	2.00	Weak

Note. Total score average of six domain scores, maximum total score = 3.

were generally moderate or weak; however, this was due to the fact that it is usually not feasible to blind participants to a treatment intervention. In general, studies of depression used outcome assessors who were blinded to participant treatment intervention (thus gaining a moderate score for this domain), whereas the assessment data in the studies of anxiety were not blind to participant condition. All studies included a psychometrically sound outcome measure and therefore all studies received a strong score for the data collection methods domain. The majority of studies retained a reasonable number of participants to follow-up and ten studies reported a follow-up rate of >80% of participants. However, it is noteworthy that overall the number of eligible participants at each stage of the research (e.g. numbers of participants who consented, attended, withdrew, dropped-out or did not return questionnaires) was not always transparent.

The EPHPP also provides a framework for evaluating intervention integrity and quality of data analyses. With regard to intervention integrity, six of the 10 studies on depression reported that the consistency of the intervention was measured throughout the study, compared to one of the five studies on anxiety. It was unclear whether intervention consistency was measured in the study of mixed depression and anxiety. All studies generally reported whether participants had received an unintended intervention (either via contamination or a co-intervention) that may have influenced the results. One study (Ransom et al., 2008) reported that 81% of participants were receiving some form of mental health treatment outside of the study's protocol, which may have influenced the findings.

All studies reported quantitative analyses appropriate to the research question. An intent-to-treat (ITT) analytic procedure was used in seven of the 10 studies on depression and in two of the five anxiety studies. ITT analysis was not

used in the study of participants with both anxiety and depression. ITT analyses are preferable in studies of intervention effectiveness as they mirror the non-compliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

Study Design

Of the 10 depression studies, six used randomised controlled designs, three used uncontrolled designs and one was a benchmarking study. Three compared a telephone intervention targeting depression with treatment as usual; one compared a CBT based telephone intervention with enhanced usual care (which included use of antidepressant medication and referral to outside services); one compared a CBT intervention with a telephone-administered supportive emotion focused therapy; and one compared telephone-administered interpersonal psychotherapy with a no-treatment control.

Of the five anxiety studies, three used randomised control designs and two used uncontrolled designs. One compared telephone-delivered exposure and response prevention with treatment delivered in-person; one compared behaviour therapy with a wait-list control; and one used a delayed treatment control design.

The study that examined the effectiveness of a telephone intervention for mixed anxiety and depression used a randomised controlled design and compared telephone-delivered CBT with weekly telephone support calls.

All studies compared participants' symptoms pre- and post-intervention. Additionally, five of the depression studies included a follow-up period (ranging from four weeks to 12 months). Participants were followed up in four anxiety

studies (period ranging from one to six months) and a one month follow-up was used in the study of participants with anxiety and depression.

Sample Characteristics

The sample size of the included studies ranged from four to 127 and, in general, the sample sizes were smaller in the studies focusing on anxiety. Women tended to outnumber men, with the exception of studies that focused on veterans (Mohr, Hart & Marmar, 2006; Mohr, Carmody, Erickson, Jin & Leader, 2011), anxiety and depression in Parkinson's disease (Veazey, Cook, Stanley, Lai & Kunik, 2009) and a study of OCD in young people (Turner, Heyman, Futh & Lovell, 2009). Age was reported in all studies. The majority of participants were adults (mean age range 32 – 66 years), with the exception of one study which examined OCD in young people aged 13-17 years. Fourteen studies reported exclusion criteria. Common reasons for exclusion in both studies of depression and anxiety were suicidal ideation/intent, diagnosis of bipolar disorder and/or psychosis, and substance or alcohol abuse.

The majority of the studies looking at depression tended to study participants with physical health problems e.g. HIV, multiple sclerosis or Parkinson's disease. In contrast, participants in the studies of anxiety disorders did not report any additional physical health concerns. The majority of anxiety disorder studies (80%) reported telephone interventions for OCD.

One aim of telephone-delivered interventions is to improve access to psychological therapy; however, it was not always clear whether participating in the research had enabled participants to receive treatment that they would not have otherwise been able to access. Of the 10 depression studies, three explicitly stated that they recruited participants who would have been unable to receive psychological

therapy elsewhere. Five depression studies recruited participants in contact with health care services where mental health was not the primary focus (e.g. HIV or Parkinson's disease clinics). Two studies recruited participants who were already in contact with mental health services. Of the five anxiety studies, three recruited participants from mental health services, one targeted participants living in rural areas and it was unclear in one study whether participants were recruited because of a potential barrier to access psychological therapy. In the study of anxiety and depression, participants were recruited from a Parkinson's disease service.

The percentage of participants who were concurrently taking anti-depressant medication was not always clearly reported.

Nature of Telephone Intervention

The number of telephone intervention sessions targeting depression ranged from six to 16 (mean number of sessions = 9.7) lasting between 27-90 minutes each. All sessions were delivered by telephone, but in the study focusing on depression in rural Latino primary care patients, 22% of participants chose to receive their first session in-person (Dwight-Johnson et al., 2011).

The number of sessions for anxiety tended to be slightly higher, ranging from 10 to 16 (mean number of sessions = 11.2), but each session was shorter in length lasting between 15-60 minutes each. All studies offered telephone sessions on a weekly basis. One of the anxiety studies also included face-to-face sessions in addition to an intervention delivered by telephone (Lovell, Fullalove, Garvey & Brooker, 2000). Participants in this study received an initial face-to-face session followed by eight sessions of telephone guided exposure and response prevention for OCD, followed by a final appointment in person (Lovell et al., 2000). The study

exploring anxiety and depression offered participants an initial face-to-face assessment session followed by eight weekly telephone sessions.

A strength of the studies included in this review is that they delivered an evidence based treatment for the target problem. CBT was the main treatment modality for participants with depression (used in eight of the 10 depression studies). The remaining two studies (Miller & Weissman, 2002; Ransom et al., 2008) offered participants interpersonal psychotherapy, which is also a recommended treatment for depression (NICE, 2009). In general, the treatment protocols for CBT for depression were well described and included common treatment components such as psychoeducation, behavioural activation and challenging negative automatic thoughts. A number of studies specifically tailored the treatment programmes to the participants' physical health needs, for example Mohr et al. (2000, 2005) developed a CBT protocol for treating symptoms of depression whilst coping with Multiple Sclerosis.

All interventions for the five anxiety studies incorporated a behavioural component to treatment. In general, less detail was provided regarding treatment protocols for the anxiety studies than for the depression studies. The studies by Lovell et al. (2000, 2006) exploring the effect of telephone interventions on symptoms of OCD focused solely on exposure and response prevention, whereas the other two studies involving participants with OCD (Taylor et al., 2003; Veazey et al., 2009) also incorporated a cognitive component to treatment. Swinson, Fergus, Cox and Wickwire (1995) delivered a behavioural based therapy to people with panic disorder and agoraphobia which involved graded exposure to feared situations.

Veazey et al. (2009) provided telephone CBT for people with Parkinson's disorder with depression and/or anxiety. Treatment included psychoeducation,

relaxation training, cognitive restructuring, formal problem solving, activity scheduling, exposure and sleep management skills. Compared to the other studies included in this review, the treatment protocol reported in this paper was less detailed. However, a strength of this paper was the inclusion of a detailed case example to illustrate the clinical considerations associated with delivering telephone therapy to people with depression and Parkinson's disorder.

The number of participants completing therapy was not always reported clearly and treatment adherence was defined in a number of ways. For the studies on depression, drop-out rates ranged from 0-28%; in anxiety studies, the drop-out rate varied from 0-21%; and the drop-out rate for the study on anxiety and depression was 20%.

Therapist characteristics. A strength of the studies included in this review is that the large majority (13 out of 16 studies) reported details of the therapists delivering the telephone interventions. In all of the 13 papers where information regarding therapists was available, all interventions were delivered by qualified professionals. In the five anxiety disorder studies, all interventions were delivered by qualified clinical psychologists or trained CBT therapists. The characteristics of the therapists in the 10 depression studies were more varied; in three studies, the therapists were qualified psychologists and in the remaining five studies where therapist information was reported, students or health professionals with specific training in the treatment protocol delivered the interventions.

Outcome Measures

All studies reported outcomes based on reliable and valid measures. The majority of studies reported outcome in terms of multiple self-report questionnaire measures. In the depression studies, the most used outcome measures were the

Hamilton Rating Scale for Depression (Hamilton, 1960; used in six studies) and the Beck Depression Inventory – Second Edition (Beck, Steer & Brown, 1996; used in four studies), both of which can be considered as ‘gold standard’ measures of symptoms of depression. Other measures included the Patient Health Questionnaire (Kroenke, Spitzer & Williams, 2001; used in two studies), the Hopkins Symptom Checklist (Derogatis, Rickels, Uhlenhuth & Covi, 1974; used in two studies), the Quick Inventory of Depressive Symptomatology (Rush et al., 2003; used in one study) and the Profile of Mood States Depression-Dejection Scale (McNair, Lorr & Droppelman, 1981; used in one study).

In the anxiety studies, all four papers reporting interventions for OCD used the Yale-Brown Obsessive Compulsive Scale (YBOCS; Goodman et al., 1989), considered to be the ‘gold standard’ measure for OCD symptoms. Three of these studies also included the Beck Depression Inventory – Second Edition (Beck et al., 1996) as a primary outcome measure. The paper reporting an intervention for panic disorder with agoraphobia reported outcomes relating to changes in scores on the Fear Questionnaire (Marks & Mathews, 1979) and the State-Trait Anxiety Inventory (Spielberger, Gorsuch & Lushene, 1970).

Three of the 10 depression studies used clinician administered diagnostic interviews as an outcome measure. Two studies used the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer & Gibbon, 1997) and one used the Major Depressive Episode module of the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998). Two of the five anxiety studies used the interview module of the YBOCS (Goodman et al., 1989) in addition to the self-report questionnaire to assess change in OCD symptoms. The study exploring the effect on anxiety and depression relied solely on self-report questionnaires to assess outcome.

Outcomes

Outcome was considered in terms of statistical significance, effect sizes and clinical significance.

Statistically significant change. Fifteen of the 16 studies included in this review reported statistically significant reductions in symptoms of depression or anxiety following a telephone-administered intervention, the one exception being Mohr et al. (2011). Five of the six RCTs on depression reported reductions in symptoms compared to no-treatment controls (Miller & Weissmann, 2002), treatment as usual (Mohr et al., 2000; Ransom et al., 2008), enhanced usual care (Dwight-Johnson et al., 2011) and an alternative active treatment control (Mohr et al., 2005). These studies included people with recurrent depression, multiple sclerosis, HIV/AIDS and people from rural Latino communities. Unfortunately only two of these studies included a follow-up period and were able to demonstrate that the reductions in depressive symptoms were maintained over six months (Dwight-Johnson et al., 2011) and 12 months follow-up (Mohr et al., 2005). Furthermore, it is noteworthy that in one RCT comparing telephone-delivered CBT with telephone-administered supportive emotion-focused therapy, the differential effectiveness of CBT post-intervention was not seen at 12 months follow-up (Mohr et al., 2005).

Three additional uncontrolled studies explored the effectiveness of telephone-administered CBT for depression. Although these studies did not compare the active treatment with a control condition, they provide preliminary evidence that telephone-administered CBT may reduce symptoms of depression in people with Parkinson's disease (Dobkin et al., 2011), HIV (Himelhoch et al., 2011) and for veterans with depression (Mohr et al., 2006). The evidence for veterans with depression, based on a case series design (Mohr et al., 2006) needs to be treated with particular caution as

the sample size was small and participants were not followed-up over time. Furthermore, a later study, using a randomised design, found that telephone CBT did not result in a significant reduction in symptoms of depression in a similar sample of participants (Mohr et al., 2011).

All five studies on anxiety reported significant reductions in anxiety symptoms following a telephone-delivered intervention. Two initial uncontrolled case series demonstrated that exposure and response prevention can successfully be administered via telephone and produce reductions in OCD symptomatology (Lovell et al., 2000; Turner et al., 2009). This was further demonstrated in two high quality studies where participants randomised to telephone treatment reported comparable reductions in OCD symptoms to a delayed treatment control group (Taylor et al., 2003) and to a face-to-face treatment control group (Lovell et al., 2006). In Lovell et al.'s (2006) trial, gains were maintained over a six month follow-up period. Telephone therapy was also shown to be effective for people with panic disorder (Swinson et al., 1995); participants reported reductions in fear pre- to post-treatment compared with a wait-list control and these gains were maintained over a three month follow-up.

In the one study of mixed anxiety and depression, Veazey et al. (2009) reported evidence for the effectiveness of telephone-delivered CBT. All participants in the CBT condition reported reductions in depression and anxiety, but due to the small sample size, only limited conclusions can be drawn.

Effect sizes. Table 4 shows the effect sizes and confidence intervals for the primary outcome measure pre-post intervention for each study included in the review. Effect sizes were reported in only five of the 16 studies included in the review. Effect sizes were calculated by the author for the remaining 12 studies

Table 4. *Pre- to Post-Intervention Effect Sizes for Studies of Telephone-Delivered Interventions of Depression and Anxiety*

Study	Measure	Effect Size
<i>Depression studies</i>		
Dobkin et al. (2011) ^a	HAM-D	1.21
	BDI-II	1.13
Dwight-Johnson et al. (2011) ^b	SCL	3.45
	PHQ-9	4.31
Himelhoch et al. (2011) ^a	HAM-D	1.90
	QIDS-SR	1.30
Miller & Weissman (2002) ^b	HAM-D	.38
Mohr et al. (2000) ^b	POMS-DD	1.09
Mohr et al. (2005) ^b	HAM-D	1.88
	BDI-II	1.27
Mohr et al. (2006) ^c	-	-
Mohr et al. (2011) ^a	HAM-D	.37
	PHQ-9	.25
Ransom et al. (2008) ^b	BDI-II	.44
Tutty et al. (2010) ^c	-	-
<i>Anxiety studies</i>		
Lovell et al. (2000) ^c	-	-
Lovell et al. (2006) ^c	-	-
Swinson et al. (1995) ^b	FQ	.98
	STAI-T	.45
	BDI-II	.42
Taylor et al. (2003) ^a	Y-BOCS	1.07
Turner et al. (2009) ^b	Y-BOCS	1.81
<i>Depression and anxiety studies</i>		
Veazey et al. (2009) ^a	PHQ-9	.63
	BAI	.59

Note. ^a effect sizes reported in paper; ^b effect sizes calculated by author based on reported data; ^c information not available to calculate effect sizes. BAI = Beck Anxiety Inventory; BDI-II = Beck Depression Inventory-II; FQ = Fear Questionnaire; HAM-D = Hamilton Depression Rating Scale; POMS-DD = Profile of Mood States Depression-Dejection Scale; PHQ-9 = Patient Health Questionnaire-9; QIDS-SR = Quick Inventory of Depressive Symptomatology; SCL = Hopkins Symptom Checklist; STAI-T = State-Trait Anxiety Inventory – Trait Version; Y-BOCS = Yale Brown Obsessive Compulsive Scale – Self Report Version.

where the relevant data were available. It was not possible to calculate effect sizes for four studies as means and standard deviations were not reported. For the 12 studies where effect size could be explored, Cohen's d ranged from .38 – 4.31, with a median of 1.08. According to Cohen (1969), this can be interpreted as a 'large' effect size.

Clinically significant change. The majority of papers did not report findings in terms of clinically significant change (Jacobson & Truax, 1991). Two depression studies reported rates of clinical significance. Ransom et al. (2008) found that 23% participants reported post-intervention BDI-II scores below the clinical cut-off compared to 9% of participants in the control condition. Tutty, Spangler, Poppleton, Ludman and Simon (2010) found that 42% of their sample were considered recovered (i.e. scores below the clinical cut-off) post-treatment.

With regard to anxiety studies, Lovell et al. (2006) reported that 77% of participants who received exposure and response prevention delivered by telephone showed clinically relevant change (as measured by a reduction of at least two standard deviations in OCD symptom scores; Jacobson & Truax, 1991) compared to 67% of participants who received the same treatment face-to-face.

Discussion

Of the 16 studies included for review, 15 reported statistically significant reductions in symptoms of depression and anxiety following a telephone intervention. These findings replicate and extend the conclusions of previous reviews in this area (Bee et al., 2008; Leach & Christensen, 2006; Mohr et al., 2008; Muller & Yardley, 2011) and suggest that telephone-administered psychotherapy may be effective in reducing symptoms of depression and anxiety for some client groups. Many of the studies reported using an evidence-based treatment for

depression or anxiety, which is important in this early stage of outcome research into telephone-delivered interventions as it has already been established that these treatments are effective when traditionally delivered face-to-face.

Overall, there was reasonable evidence that telephone interventions can reduce symptoms of depression within specific client populations (e.g. people with Multiple Sclerosis or people from rural Latino communities) compared to no-treatment and treatment-as-usual controls. There were fewer studies of anxiety, and three out of five of these focused on symptoms of OCD. Although the median effect size can be classed as large (Cohen, 1969), the majority of studies did not report effect sizes and therefore the magnitude of these symptom reductions was not always clear. Furthermore, as clinical significance was rarely addressed, it was not possible to establish whether the symptom reductions were clinically meaningful. Despite these caveats, this review does provide preliminary evidence that telephone interventions can impact on symptoms of depression and anxiety.

Study Quality and Methodological Considerations

Overall the studies included in this review were of good quality and thus the results of the review are encouraging. Generally, studies of both depression and anxiety were well designed, utilised appropriate outcome measures and considered the presence of potential confounding variables in either the design or analysis. However, future studies which use a RCT design would benefit from clearly reporting methods of randomisation.

In general, when compared with the studies on anxiety, those focusing on depression were more likely to use assessors blinded to participant treatment intervention, use ITT analyses, and report information regarding intervention

integrity. Future studies focusing on telephone interventions for anxiety would benefit from considering these important areas.

Overall, the way recruitment details were reported was variable and future research would benefit from clearly specifying recruitment methods and response rates at each stage of the recruitment process. Additionally, the numbers of participants at each stage of the research (e.g. drop-out rates) were not always clearly reported. It is important for this data to be transparent in future work to ensure that study quality regarding selection bias and follow-up can be assessed accurately.

RCTs are often considered the ‘gold standard’ of outcome research. However, as the field of telephone-delivered psychological interventions is still relatively new, case series and uncontrolled designs can provide important preliminary findings and shape the direction for future large scale randomised studies. This review used the EPHPP critical appraisal tool, which enabled the quality of a range of study designs to be considered systematically. However, there were a number of limitations to using this tool. It did not include all areas relevant to assessing study quality and there were additional methodological considerations that were not highlighted. For example, a number of studies included in this review had limited follow-up periods or did not follow up participants post-intervention. This means it is difficult to draw conclusions about the long-term effectiveness of telephone interventions, particularly for depression, as it is possible that the interventions effects are transient. Treatment guidelines for face-to-face high intensity treatments for depression recommend that patients are offered three to four follow-up sessions over a three to six month period (NICE, 2009). Future research into telephone interventions should attempt to offer similar levels of follow-up.

The EPHPP quality assessment tool assesses the reliability and validity of outcome measures but it does not distinguish between self-report questionnaires and clinician administered outcome measures. Many studies relied on self-report questionnaire measures to assess reduction of symptoms of depression and anxiety. Only five out of 16 studies included a clinician led interview to establish psychological diagnoses over the course of therapy. Clinician interviews such as the SCID (First et al., 1997) and MINI (Sheehan et al., 1998) are often considered ‘gold standard’ outcome measures and future research should consider including them as part of the assessment package.

It is also important to consider the appropriateness of the control groups used in controlled studies. Overall, there was a noticeable lack of controlled studies that directly compared a telephone intervention with a similar intervention delivered face-to-face. A crucial area for future research will be to compare telephone interventions with comparable traditional therapies, both in terms of statistically significant reductions in symptoms and with regard to clinically significant change. Future work should also determine whether telephone interventions are comparable to traditional psychological therapies in terms of treatment outcome, acceptability and adherence. This would also enable researchers to consider the economical aspects of telephone interventions compared with traditional therapies.

Limitations of the Review

A limitation of this review is the heterogeneous nature of the studies included for analysis, both in terms of study design and patient populations, which made it impossible to draw firm conclusions about the effectiveness of telephone interventions. Furthermore, it was not possible to establish the baseline severity of symptoms due to the variability in outcome measures used in the included studies.

This heterogeneity is in part due to the broad inclusion criteria used in this review; however the review aimed to capture as many relevant studies pertaining to telephone interventions for anxiety and depression as possible. In fact, due to the diverse nature of the field, it is likely that some relevant studies may have been excluded. Future reviews would benefit from considering other avenues where telephone-delivered psychological interventions are used, including in physical health, peer support and in third-sector organisations.

Clinical Implications and Future Research

As highlighted earlier, future studies would benefit from clearly describing all relevant methodological aspects of the research and from ensuring that the treatment protocol (including any supplementary written material or face-to-face contact) is explicitly defined. This is important as additional contact may influence the effectiveness of the treatment. Qualitative analyses of client experiences of telephone interventions would also add an essential aspect to our growing understanding of therapy delivered by remote communication technologies.

The findings of this review indicate that, for some client groups, telephone-delivered psychological therapy may be effective in reducing symptoms of anxiety and depression. More specifically, these preliminary findings suggest that telephone interventions can be effective for decreasing the symptoms of depression for people with some long term health conditions (e.g. MS and Parkinson's disease) and in reducing symptoms of OCD. However, it still remains to be demonstrated which therapies are more effective when delivered by telephone and whether there are certain populations who are more likely to benefit from telephone interventions. This includes psychiatric diagnosis as well as consideration of symptom severity and duration, and nature and content of previous treatment.

Importantly, it also must be established whether there are any populations for whom such telephone interventions are contraindicated, for example veterans with depression. The findings of this review suggest that earlier results from a case series of treatment for depression in veterans (Mohr et al., 2006) should be treated with caution, as a later RCT demonstrated that telephone therapy did not result in statistically significant change for this population (Mohr et al., 2011). Furthermore, the studies of anxiety included in this review focused mainly on OCD symptoms. Further research is needed to establish whether telephone interventions are effective in reducing the symptoms of other anxiety disorders including generalised anxiety disorder and panic disorder.

A key driver for the development of telephone-administered psychological therapies was to reduce barriers to effective care and improve access to treatment (Maheu et al., 2001; Mohr et al., 2010; Nickleson, 1998). However, as highlighted by Mohr (2009), many of the existing studies evaluating the effectiveness of telephone-administered psychotherapy have focused on participants already in contact with services. This bias was highlighted in the current review where only three studies explicitly stated that recruitment targeted participants who were not able to access mental health services. Future research would benefit from exploring the effectiveness of telephone-administered psychotherapy for people with anxiety and depression not already in contact with mental health services.

Previous research has highlighted that the absence of non-verbal communication in telephone-administered treatment may change the nature and quality of the therapeutic relationship (Kraut et al., 1998; Stamm, 1998). This is an important consideration to take into account when deciding on the mode of delivery for therapy. Future research would benefit from exploring the development and

maintenance of the therapeutic alliance over the telephone. This may include consideration of both the client's and the therapist's experience of the therapeutic interactions, which could potentially highlight areas where difficulties in the therapeutic alliance may arise.

Using the telephone to deliver therapy may improve access to evidence based treatments, particularly for people living in rural settings, with physical health conditions or where mental health difficulties prevent them from accessing treatment in traditional settings, e.g. for people with severe agoraphobia. However, therapy delivered in the absence of face-to-face contact (e.g. over the telephone or via the internet) is often considered to be more suitable for so-called 'low-intensity' interventions. Further investigation is needed to establish whether the nature of telephone interventions are less rich than face-to-face contacts. Analysis of the content of telephone sessions and comparison with traditional face-to-face therapies is necessary to determine whether the telephone could be used to work with clients requiring higher intensity or more complex treatments. Furthermore, it would be worthwhile to compare the effectiveness of telephone interventions with other forms of treatment delivery such as internet based treatment programmes and guided self-help. This information is necessary to help guide clinicians in their decision making about how best to deliver effective treatment to different clinical populations.

Conclusions

The findings of this review suggest that telephone interventions show promise in reducing symptoms of depression and anxiety. However, it is important to note that these are preliminary findings and further work is needed before the effectiveness and efficacy of telephone interventions are fully established. In particular, it will be important to identify the types of therapeutic interventions that

are best suited to telephone delivery and the populations for which they are most effective.

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Part II: Empirical Paper

Telephone-Delivered Group CBT for Anxiety:

Experiences of Group Members

Abstract

Aims: Despite a growing interest in the use of transdiagnostic CBT approaches to treating anxiety and a move towards alternative modes of therapy delivery such as groups, internet and telephone-delivered treatment, little is known about recipients' views and experiences of these approaches. This qualitative study aimed to examine people's experiences of a 14-week telephone-delivered CBT group for anxiety disorders, provided by a UK charity.

Method: Seventeen people took part in a semi-structured telephone interview designed to elucidate helpful and unhelpful aspects of the groups. People who completed the full course and those who attended sporadically or dropped out were interviewed. Interview transcripts were analysed using the 'framework' approach.

Results: Experiences of the telephone groups were mixed. The analysis yielded 10 themes organised into three domains: (1) Overcoming anxiety: interpersonal aspects; (2) Overcoming anxiety: making changes; and (3) Barriers and challenges.

Participants emphasised the importance of interpersonal processes over and above strategies for reducing their anxiety. Several barriers and challenges to making full use of the groups were identified.

Conclusions: The findings suggest that telephone-delivered group CBT has potential value as a first step in the treatment of anxiety disorders. Further research is needed to establish the effectiveness of such interventions in symptom reduction; however therapeutic interpersonal benefits, including increased social support, should also be considered. A further understanding of the impact of delivering group CBT by telephone is required, in order to guide the delivery of similar low-intensity interventions for anxiety.

Introduction

It is well established that psychological therapies including cognitive behavioural therapy (CBT) are efficacious in the treatment of a range of anxiety disorders (e.g. NICE, 2011; Norton & Price, 2007). With the exception of post-traumatic stress disorder, a ‘stepped-care’ approach to treatment is recommended (Bower & Gilbody, 2005; Haaga, 2000; Lovell & Richards, 2000; NICE, 2011). In a stepped-care model, interventions of increasing intensity are offered to patients in order to improve access and efficiency (Bower & Gilbody, 2005; Haaga, 2000). Typically, low-intensity interventions use fewer resources than traditional face-to-face therapy and are therefore often more cost- and time-efficient (Bennett-Levy, Richards & Farrand, 2010; Bower & Gilbody, 2005). Low-intensity CBT has been defined as CBT-informed interventions that have one or more of the following features: 1) reduce the time clinicians are in contact with patients; 2) are delivered by non-professionals with some training for the intervention e.g. peer supporters and people in the voluntary sector; 3) have a less intense content e.g. interventions that deliver ‘bite-sized’ information or that are self-paced; 4) increase access or speed of access to treatment (Bennett-Levy et al., 2010). However, it is important to note that low-intensity interventions are often not experienced as less ‘intensive’ by the people receiving them (NICE, 2011).

Low-intensity interventions include brief therapies, group treatments, guided self-help and computerised or telephone-delivered CBT (Bennett-Levy et al., 2010; Bower & Gilbody, 2005) and are now offered in a variety of primary care and Improving Access to Psychological Therapies (IAPT) services as well as through charitable organisations such as Anxiety UK, No Panic and OCD UK. Typically low-intensity interventions for anxiety are based on traditional treatments delivered

in a different or simplified format (Titov, Andrews & McEvoy, 2010). These interventions are growing in popularity and there is a developing body of evidence demonstrating their effectiveness for the treatment of anxiety disorders (Bennett-Levy et al., 2010). This is supported by a recent report indicating the positive outcomes of low-intensity IAPT interventions delivered across the UK (Gyani, Shafran, Layard & Clark, 2011).

As highlighted in Part I, although people with anxiety often find it difficult to leave the house to access support (e.g. due to agoraphobia), very little research has examined the effectiveness of telephone-delivered therapy for people with anxiety disorders. Instead, the majority of research for anxiety disorders delivered in alternative formats has focused on computerised CBT and CBT administered in a group format. There is a large body of evidence demonstrating the effectiveness of CBT delivered in a group format for a range of anxiety disorders, including generalised anxiety disorder (Dugas et al., 2003), social phobia (McEvoy, Nathan, Rapee & Campbell, 2012), obsessive-compulsive disorder (Jonsson & Hougaard, 2009), panic disorder (Marchand, Roberge, Primiano & Germain, 2009) and post-traumatic stress disorder (Barrera, Mott, Hofstein & Teng, 2013). CBT delivered in a group format has grown in popularity as it is both time- and cost-effective, and draws on a number of non-specific curative factors such as group cohesion and the therapeutic alliance (Oei & Browne, 2006; Tucker & Oei, 2007; Vinogradov & Yalom, 1989; Yalom & Leszcz, 2005).

Regardless of the mode of delivery, CBT for anxiety traditionally has focused on disorder specific models of the onset and maintenance of symptoms (Harvey, Watkins, Mansell & Shafran, 2004; Mansell, Harvey, Watkins & Shafran, 2009). However, more recently it has been proposed that there are a number of cognitive

and behavioural processes, such as interpretative biases and experiential avoidance, that are common to a range of anxiety disorders (Harvey et al., 2004; Mansell et al., 2009; Norton & Hope, 2005). In routine clinical practice, patients often present with heterogeneous symptoms and anxiety disorders frequently co-occur (Brown, Campbell, Lehman, Grisham & Mancill, 2001). For example, approximately 90% of individuals meeting criteria for generalised anxiety disorder will also have at least one other Axis I diagnosis (Wittchen, Zhao, Kessler & Eaton, 1994). An emerging literature indicates that transdiagnostic interventions are beneficial in targeting common elements across anxiety disorders such as avoidance and cognitive appraisals of threat, and that this approach may be more time- and cost-effective than delivering multiple disorder specific interventions (Barlow, Allen & Choate, 2004; McEvoy, Nathan & Norton, 2009; Norton, 2006).

In addition to transdiagnostic treatment for anxiety delivered in a traditional format, there is also some evidence that transdiagnostic approaches are effective when they are delivered via the internet or in a group format. A randomised controlled trial of a 10-week internet-based CBT course for people with generalised anxiety disorder, panic disorder and/or social phobia found that relative to wait-list controls, the transdiagnostic treatment group reported significant reductions in anxiety that were sustained at three month follow-up (Titov et al., 2011). Similarly, there is empirical support for transdiagnostic group treatments. Several studies suggest that transdiagnostic group CBT results in equivalent outcomes to diagnosis-specific group CBT (Erickson, 2003; Erickson, Janec & Tallman, 2007; Garcia, 2004; Norton, 2008; Norton & Barrera, 2012; Norton & Hope, 2005). In response to concerns that people may not respond well to group transdiagnostic CBT due to difficulties in establishing rapport with group members with different anxiety

disorder diagnoses (McEvoy et al., 2009), Chamberlain and Norton (2013) found that in a sample of 84 individuals, the diagnostic composition of the group did not significantly influence outcome following a 12-week course of transdiagnostic group CBT. This finding supports the view that the presence of an anxiety disorder represents a sufficient level of diagnostic homogeneity (Erickson, Janec & Tallman, 2009; McEvoy et al., 2009).

Despite the growing evidence for the effectiveness of transdiagnostic therapy delivered in a group format in reducing anxiety symptoms, there has been less emphasis on the experiences and views of the people who receive the intervention. Similarly, as highlighted in Part I, recipients' experiences of telephone interventions have been overlooked and qualitative studies in this area have tended to focus on treatment acceptability (Lovell, 2010). Therefore, in addition to establishing the effectiveness of transdiagnostic and telephone-delivered CBT, it is also necessary to ensure that these interventions are acceptable, worthwhile and meaningful to the people who receive them.

A qualitative study of the acceptability of individual telephone-delivered CBT for depression and anxiety found that people's experiences were mixed and that their views of the therapeutic nature of the intervention changed over time (Bee, Lovell, Lidbetter, Easton & Gask, 2010). Although the majority of participants valued the ease of access to help, some participants discussed barriers in developing a strong therapeutic alliance with their therapist (Bee et al., 2010). This study highlighted a number of relevant issues in individual telephone-delivered therapy; however, there is a need for further qualitative research to explore recipients' experiences of the processes and outcomes of telephone-delivered CBT for anxiety delivered in a group format.

In the UK, one organisation that offers a transdiagnostic therapy delivered in a group format over the telephone is No Panic, a national self-help charity for people with a variety of anxiety disorders. No Panic offer a number of services, including a 14-week CBT telephone recovery group run by trained volunteers. The telephone recovery groups have received widespread acclaim for the innovative support that they provide to anxiety sufferers. A preliminary report commissioned by Rethink in 2006 was the first to systematically evaluate the telephone recovery groups. This report found that scores on a measure of anxiety significantly decreased after completion of the intervention, as compared to a small no-intervention control group (Williams & Pinfold, 2006). Limitations of this unpublished study include that it did not report standard deviations or effect sizes, did not examine clinically significant change and did not use an intent-to-treat analysis. Furthermore, it did not include measures of psychological wellbeing or a more general measure of anxiety symptoms that may be applicable to a range of anxiety disorders. Additionally, the views of group members were not explored.

Aims of the Present Study

The No Panic telephone recovery groups provide a unique opportunity to examine the experiences of people who take part in a transdiagnostic group for anxiety over the telephone. It is increasingly important for all services (including those delivered by charitable organisations) to demonstrate that the support they offer to people with anxiety is efficacious in reducing symptoms and improving psychological wellbeing, as shown by significant reductions on psychometrically sound measures. Qualitative research is also needed to generate rich and detailed information about people's views and experiences of a relatively new form of intervention (Elliott, 2010). Qualitative methodologies are particularly valuable

when the views of a population of interest are not known (Crawford, Ghosh & Keen, 2003; Pope & Mays, 1995) and are a useful way of contributing to knowledge regarding therapeutic processes and outcome (Elliott, 2010).

The aim of this qualitative study was to use semi-structured interviews to examine people's experiences of the No Panic telephone recovery groups.

Specifically it aimed to:

- 1) Examine the subjective experience of the helpful and unhelpful aspects of the telephone groups in order to improve the service delivered to people with anxiety disorders;
- 2) Explore the views of people who drop out or attend the telephone recovery groups sporadically, in order to promote future engagement; and
- 3) Understand the barriers and challenges of holding a transdiagnostic therapeutic group over the telephone.

Method

Ethical Approval

The study received ethical approval from the University College London Research Ethics Committee in September 2011 (see Appendix B). All participants were provided with written information about the study and gave written informed consent prior to participating (see Appendices C and D). Participants were given the opportunity to ask questions about the research as part of the informed consent process.

Setting

The research was conducted in collaboration with the charity No Panic (National Organisation for Phobias, Anxiety, Neurosis, Information and Care), based in Shropshire (www.nopanic.org.uk). No Panic is a national voluntary organisation

that offers support and guided self-help for people with a variety of anxiety disorders including generalised anxiety disorder, panic disorder with and without agoraphobia, specific phobia and obsessive-compulsive disorder. There is a strong user-led focus within the charity, and 95% of the governance and management team is user-led. No Panic specialises in providing support to people who are unable to access face-to-face therapy due to their anxiety difficulties. Their services include a confidential helpline, a crisis line, written self-help materials, one-to-one telephone mentoring and a 14-week telephone recovery group run by trained volunteers. The charity currently has over 3,000 members in the UK and receives approximately 80,000 calls to the helpline annually.

Telephone recovery groups. The 14-week telephone recovery groups are based on CBT principles, take place over the telephone using conference call software and run for one hour weekly. The groups typically comprise six to eight individuals with a variety of anxiety problems, including phobias, panic attacks, obsessive-compulsive disorder and generalised anxiety disorder. The course is designed to help people overcome their fears by providing guided self-help for a number of transdiagnostic topics related to anxiety including goal setting, relaxation, formal problem-solving, reducing safety behaviours, experiential avoidance and tackling unhelpful cognitions. The groups are supplemented with a written manual providing psychoeducation for members to read prior to each session. The groups typically use the following structure but are adapted to fit the individual needs of the group members:

- Week 1: Introductions and goal setting;
- Week 2: Psychoeducation regarding anxiety;
- Week 3: Relaxation, breathing exercises and healthy living;

- Week 4: Monitoring and challenging unhelpful thinking;
- Week 5: Introduction to experiential avoidance;
- Weeks 6-12: Reducing safety behaviours and avoidance;
- Week 13: Relapse prevention;
- Week 14: Endings.

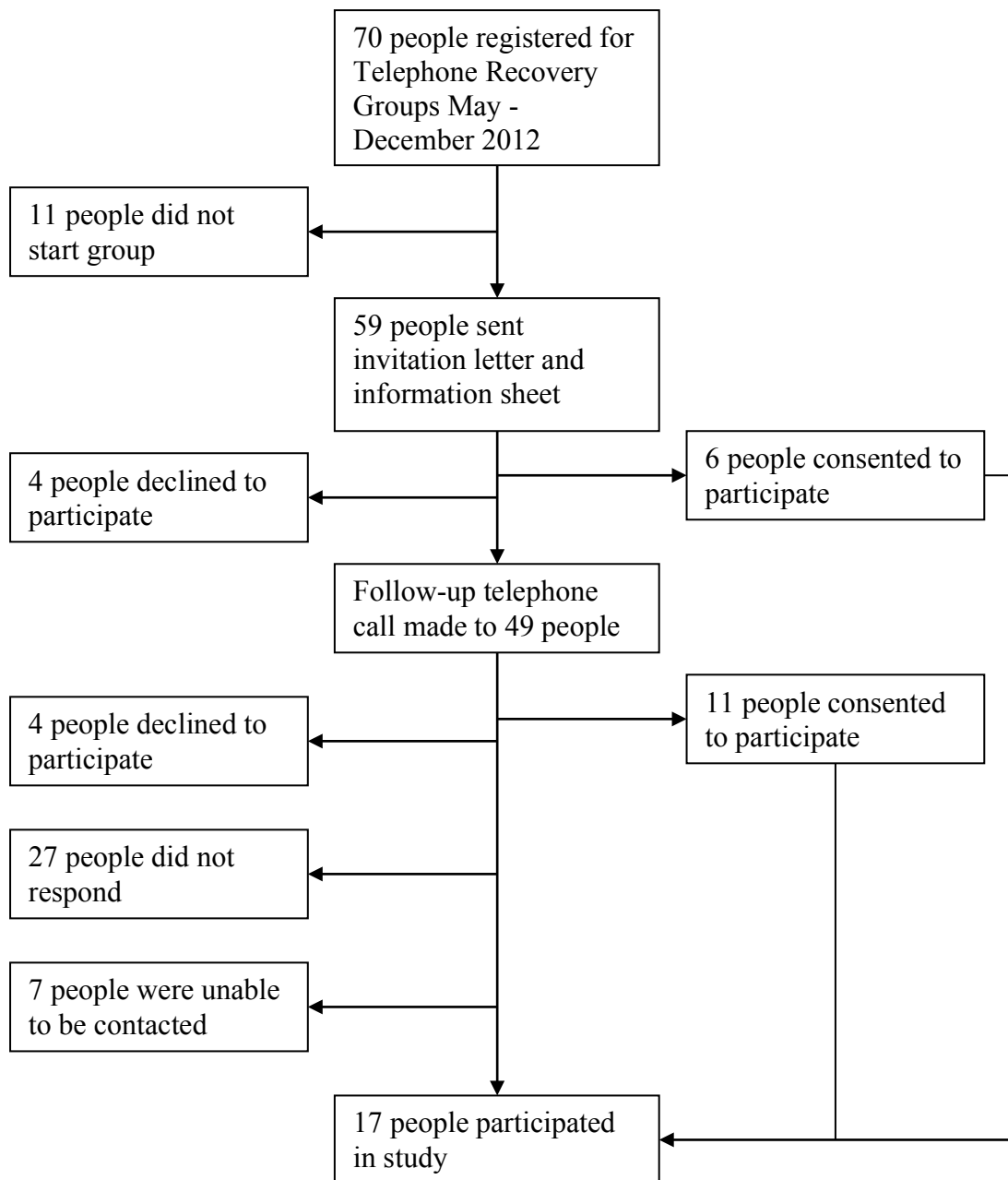
The groups are run by volunteers, who have personal experience of anxiety and may have received support from No Panic in the past. All volunteers complete a 12-week telephone training course prior to becoming a group leader. At the time of the study, there were nine volunteers leading groups.

Participants

Eligibility criteria. In order to be eligible for the study, people were required to: 1) be aged 18 years or over; 2) have attended at least one session of a telephone recovery group; and 3) have attended a group session between one to six months prior to the study. In order to capture a range of experiences, both people who had completed the full 14-week course and people who had dropped out or attended sporadically were invited to participate. The time period of one to six months since attending the last session was selected to allow participants to consolidate and reflect on what they had learnt during the course whilst also ensuring that they would be able to accurately recall key aspects of the group. To ensure that participants could describe their experiences of the groups in depth, people who had completed a recovery group more than six months before the interviews were conducted were excluded from the study.

Recruitment. The recruitment process is outlined in Figure 1. Seventy people aged 18 years and over registered to take part in a No Panic telephone

Figure 1. *Outline of Recruitment Process*



recovery group between May and December 2012. Nine recovery groups were run in this time period. Eleven people did not attend any sessions and were excluded from the study. The 59 people who had completed at least one session of a recovery group were sent an information sheet and a letter inviting them to participate in the study (see Appendix E). People who did not respond to this written invitation were contacted by telephone by the author to ask them whether they wished to participate. A total of eight people declined to participate (common reasons included improved anxiety, a recent decline in functioning, lack of time and physical health problems), 27 did not respond and seven could not be contacted. Of the 59 eligible individuals, 17 agreed to participate, i.e. an overall response rate of 29%.

Based on information provided by No Panic regarding the characteristics of the 59 eligible individuals, there were no significant differences between people who participated, declined to participate or who did not respond/could not be contacted in terms of age [$F(2,56) = .96, p = .39$], gender [$\chi^2(2) = .63, p = .73$], or number of diagnoses [$F(2,56) = 2.59, p = .08$].

Participant characteristics. Seventeen people (three men, 14 women) from nine recovery groups took part in the research. The characteristics of individual participants are shown in Table 1 and were provided by No Panic. Ages ranged from 34 to 82 years ($M = 56.35, SD = 14.08$). The majority of participants were White British (88%), the remaining participants were White Other European (12%). Participants were interviewed between one and six months after their last session of the recovery group ($M = 3.06$ months, $SD = 2.02$).

Participants reported that they had experienced anxiety between nine months to 43 years before they first attended the No Panic Recovery groups, and 10 had experienced anxiety for over 10 years. The number of presenting problems ranged

Table 1. *Participant Characteristics*

ID	Group ID	Gender	Age	Presenting Problem(s)	Duration of anxiety	Previous treatment	No. sessions attended	Time since last session
P1	A	F	60s	GAD	>10 years	Medication	14	6m
P2	A	M	30s	GAD, social phobia, dental phobia, flying phobia	1-5 years	None	14	6m
P3	G	M	50s	Agoraphobia, panic, GAD, social phobia, monophobia	1-5 years	Medication	14	2m
P4	B	F	50s	GAD, agoraphobia, panic	1-5 years	CBT	6	6m
P5	G	F	60s	Panic, OCD, driving phobia	>10 years	CBT, medication	8	2m
P6	D	F	60s	Agoraphobia, panic, GAD, vomit phobia	>10 years	None	14	4m
P7	F	F	70s	Agoraphobia, panic, GAD	<1 year	None	4	2m
P8	E	F	40s	Panic, agoraphobia	>10 years	Medication	12	3m
P9	H	F	80s	Panic, agoraphobia, social phobia	>10 years	None	14	1m
P10	H	F	50s	GAD, panic, depersonalisation	1-5 years	CBT, medication	14	1m
P11	H	F	70s	GAD, panic, monophobia	>10 years	None	14	1m
P12	C	M	40s	OCD	>10 years	Medication	6	5m
P13	H	F	50s	Agoraphobia, panic, GAD	>10 years	CBT	7	1m
P14	E	F	40s	GAD, panic	1-5 years	None	13	3m
P15	F	F	30s	Panic, social phobia	>10 years	Medication	4	2m
P16	I	F	40s	GAD, panic, social phobia	1-5 years	None	14	1m
P17	D	F	60s	Panic, agoraphobia, GAD, flying phobia	>10 years	CBT	14	6m

Note. Presenting problems as defined by No Panic. GAD = generalised anxiety disorder; OCD = obsessive compulsive disorder.

between one and five; the most common presenting problems were generalised anxiety disorder, panic, agoraphobia and specific phobia. Ten participants had previously received treatment for their anxiety; five of these had been prescribed medication, three had completed a short-course of CBT and two had received both medication and CBT. Participants attended between four and 14 sessions of the recovery group ($M = 10.94$ sessions, $SD = 4.02$) and nine completed the full 14-week course.

Semi-Structured Interview

All interviews were conducted over the telephone via Skype (Skype Communications, Luxemburg) as No Panic is a national charity and participants were geographically spread across the UK. Furthermore, this was in keeping with the charity's ethos of providing the majority of their services by telephone in order to improve access.

A semi-structured interview schedule was designed specifically for the study (see Appendix F). Prior to developing the interview, the author observed a complete 14-week recovery programme over the telephone in order to become familiar with some of the common topics and processes involved in the groups. Furthermore, initial drafts of the interview schedule were shared with the CEO of No Panic, a group member and a group leader, to ensure that the questions were relevant and appropriate for participants. Feedback from this process indicated that the interview schedule was comprehensive and covered a wide range of issues relevant to the recovery groups.

The interview was developed after consultation with the literature on psychological interventions and drew on aspects of the Client Change Interview (Elliott, Slatick & Urman, 2001) and the Helpful Aspects of Therapy Questionnaire

(Elliott et al., 2001; Llewelyn, 1988). It was designed to elucidate a number of aspects of participants' experiences including reasons for joining, what it was like to take part in a group over the telephone, their relationship with the leader and other group members, helpful and unhelpful features of the group, and the impact the group had on their anxiety and their lives. Additionally, people who had dropped out of the groups or attended sporadically were asked questions relating to their decision to continue or discontinue with the group.

Participants were initially asked broad questions in these areas, followed by additional follow-up questions as needed (Smith & Eatough, 2009). The interview schedule was designed to be used flexibly to ensure that experiences raised spontaneously by participants were explored fully, and that detailed and meaningful information was obtained (Barker, Pistrang & Elliott, 2002; Patton, 2002). In order to ensure that the interviewer did not focus solely on participants' positive experiences, the interview schedule included questions to elicit any negative or mixed experiences of the recovery groups. Throughout the interview participants were explicitly encouraged to discuss both the positive and negative aspects of the groups.

All interviews were recorded using Ecamm Call Recording software (Ecamm Network, LLC, Massachusetts, USA), with the participants' permission. On average, the interviews lasted approximately 60 minutes. Interviews were transcribed verbatim using Express Scribe software (NCH Software, Canberra, Australia) and any identifying information was removed from the transcripts.

Qualitative Data Analysis

The transcripts were analysed using the 'framework' approach (Pope, Ziebland & Mays, 2000; Ritchie & Lewis, 2003). The transcripts of participants who

had completed and dropped out of the groups were initially considered separately but then analysed together as they shared broadly similar views and no clear distinctions could be made.

The first stage of analysis involved listening to the interviews, transcribing the recordings and then reading transcripts thoroughly to familiarise the author with the data. Preliminary thoughts were recorded in the margins of each transcript and any key phrases were highlighted. In the second stage of analysis, initial codes were then developed inductively from the data by considering each line, phrase or paragraph of each transcript (see Appendix G). Participants' own words were used to summarise key phrases and where possible 'in-vivo' codes were used (Ritchie & Lewis, 2003). In the third stage of analysis, these initial codes were then synthesised to form a coding index (see Appendix H). This index was then applied systematically to all the data in the fourth stage. Following this, the fifth stage of analysis was to develop a series of thematic charts that summarised the relevant data from each interview (see Appendix I). These charts were then used to identify patterns and synthesise the data into an interpretative account to arrive at a final set of themes. Once the final set of themes was identified, the data were gathered into a table indicating the locations in each transcript where the theme occurred with example quotes (see Appendix J).

Credibility checks. Following good practice guidelines for qualitative research, a number of credibility checks were used to ensure the quality and trustworthiness of the analysis (Barker & Pistrang, 2005; Mays & Pope, 2000; Morrow, 2005; Shenton, 2004; Stiles, 1999). A consensus approach was used throughout the analysis. The author's supervisor reviewed a number of transcripts following the initial coding process and different interpretations of the data were

discussed. The author and her supervisor then discussed different possible ways of clustering and synthesising the data before the final coding index was developed. The different ways of synthesising the data into an interpretative account were also discussed. To ensure that this process was transparent, an audit trail was developed. Finally, direct participant quotations were included throughout the descriptive account of the themes to demonstrate that the interpretations were grounded in the data.

Respondent validation. Following each interview, a summary of the main ideas and themes was sent to each participant to allow them to comment on accuracy (see Appendix K). Nine of the 17 participants replied; all reported that the summary accurately reflected their experiences of the telephone recovery group.

Researcher Perspective

I am a 27 year old white British woman and I conducted this research in my second and third years of a doctoral course in clinical psychology. I first became aware of the work of No Panic whilst carrying out research into obsessive-compulsive disorder prior to starting my clinical training and was interested in their model of delivering transdiagnostic therapy for anxiety to people over the telephone. Based on my clinical work I had a number of preconceived ideas about the groups before I began the research. From my experience of group work I thought that the No Panic members would value sharing their experiences of anxiety with other group members. I also thought that a CBT approach was likely to be successful in helping the group members overcome the symptoms of anxiety.

In accordance with good practice guidelines in qualitative research I attempted to 'bracket' my views during data collection and analysis in order to remain open to all of the participants' reported experiences (e.g. Fischer, 2009;

Willig, 2008). I also kept a research journal and used supervision to reflect on how my views and assumptions may have impacted on the research process (Willig, 2008).

Results

Overall Experience of the Groups

Participants described a wide range of experiences of the No Panic telephone recovery group. While some participants reported predominately very positive or negative experiences, other accounts were more mixed and, in general, participants described both helpful and unhelpful aspects of the group. Although many participants still experienced anxiety symptoms at the time of the interview, the majority reported that they had gained something from taking part in a recovery group and had noticed some changes in terms of overcoming anxiety. Many participants emphasised that No Panic had enabled them to access help that they would otherwise not have received due to their anxiety symptoms. The majority spoke highly of the group leaders, describing them, for example, as *“patient, kind and well-trained”* (P1).

Domains, Themes and Subthemes

The analysis yielded 10 themes which were organised into three domains: (1) Overcoming anxiety: interpersonal aspects; (2) Overcoming anxiety: making changes; and (3) Barriers and challenges. The domains, themes and subthemes are shown in Table 2. The themes endorsed by each participant are shown in Table 3. Each theme is presented below and is illustrated with quotations.

Domain 1: Overcoming Anxiety: Interpersonal Processes

The first domain focuses on interpersonal processes germane to the group, which seemed to facilitate (and occasionally hinder) overcoming anxiety. The

Table 2. *Summary of Domains, Themes and Subthemes*

Domains	Themes	Subthemes	Prevalence	
(1) Overcoming anxiety: Interpersonal processes	1.1. An hour of hope and reassurance	Feeling understood	15	
		Talking openly	10	
		Not the only one	12	
	1.2. Comparisons with others	There's often someone worse than you	8	
		Seeing someone a few steps ahead	5	
		Leader is a fellow sufferer	13	
	(2) Overcoming anxiety: Making changes	2.1. Understanding anxiety	Leader had insight	11
			Leader talked too much	3
		2.2. Developing a toolkit	Sharing tips and coping strategies	12
			The concept is simple, the doing is difficult	6
2.3. Recovery as a process		Less need for support from others	5	
		Recovery takes time	10	
		Recovery takes time	7	
		Identifying the need for further support	4	
(3) Barriers and challenges		3.1. Mismatch between expectations and reality	What is a recovery group?	15
			Miracle cure	9
	Lack of goals and structure		5	
	3.2. Airtime	Getting own views across	8	
		One person monopolising the time	14	
	3.3. One size doesn't fit all	Everyone has different needs	13	
		Different stages of recovery	8	
		Irrelevant conversations	7	
		Vetting people	7	
	3.4. Connecting with others	Connecting with others	5	
		Getting to know people	17	
		Sporadic attendance	11	
		Disruptions and distractions	9	
		Connecting with the group leader	6	

Table 3. Themes and Subthemes Endorsed by each Participant

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17
Domain 1: Overcoming anxiety:																	
Interpersonal processes																	
1.1. An hour of hope and reassurance	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x
<i>Feeling understood</i>	x	x	x	x	x	x	x		x	x	x	x	x	x		x	x
<i>Talking openly</i>		x				x			x	x	x	x	x	x		x	x
<i>Not the only one</i>	x			x		x	x		x	x	x	x	x	x	x	x	
1.2. Comparisons with others		x	x	x	x	x	x		x		x			x			x
<i>There's often someone worse than you</i>		x		x		x	x		x		x			x			x
<i>Seeing someone a few steps ahead</i>		x	x		x	x											x
1.3. Leader is a fellow sufferer	x	x	x	x		x		x	x	x	x	x		x	x	x	
<i>Leader had insight</i>	x	x	x	x					x	x	x	x		x	x	x	
<i>Leader talked too much</i>						x		x						x			
Domain 2: Overcoming anxiety: Making changes																	
2.1. Understanding anxiety	x	x		x		x	x			x	x		x		x	x	x
2.2. Developing a toolkit	x	x	x	x		x	x	x	x	x	x		x	x		x	x
<i>Sharing tips and coping strategies</i>	x		x	x		x	x	x	x	x	x		x			x	x
<i>The concept is simple the doing is difficult</i>	x	x	x			x								x			x
<i>Less need for support from others</i>	x			x						x	x			x			
2.3. Recovery as a process	x	x	x	x		x					x			x	x	x	x
<i>Recovery takes time</i>			x	x		x					x			x	x		x
<i>Identifying the need for further support</i>	x	x				x										x	
Domain 3: Barriers and challenges																	
3.1. Mismatch between expectations and reality	x		x	x	x		x	x	x	x	x	x	x	x	x	x	x
<i>What is a recovery group?</i>			x	x	x			x	x	x	x	x					
<i>Miracle cure</i>	x			x			x							x	x		
<i>Lack of goals and structure</i>								x	x	x	x	x		x		x	x

3.2. Airtime	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
<i>Getting own views across</i>	x	x	x		x				x					x	x		x
<i>One person monopolising the time</i>	x		x	x		x	x		x	x	x	x		x	x	x	x
3.3. One size doesn't fit all	x	x	x		x	x			x	x		x	x	x	x	x	x
<i>Everyone has different needs</i>	x	x							x	x		x	x		x	x	
<i>Different stages of recovery</i>									x	x			x	x	x		x
<i>Irrelevant conversations</i>	x		x		x				x	x				x			x
<i>Vetting people</i>	x		x						x			x		x			
3.4. Connecting with others	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
<i>Getting to know people</i>			x						x			x	x	x	x	x	x
<i>Sporadic attendance</i>	x	x	x	x		x	x				x			x			
<i>Disruptions and distractions</i>	x	x	x						x		x						x
<i>Connecting with the group leader</i>		x			x	x			x					x			

majority of participants valued being part of a group and identified a number of helpful interpersonal processes including the hope and reassurance from other group members, making comparisons with people with severe anxiety and the group leader being a fellow sufferer. Participants emphasised the importance and value of these interpersonal processes, often over and above symptom reduction and outcome.

1.1. An hour of hope and reassurance. Being part of a group was experienced as important in overcoming anxiety, because participants felt understood and realised that they were not the only one suffering from anxiety. The groups provided a valuable opportunity to experience “*an hour of hope and reassurance*” (P3) each week and participants found it helpful to listen to each other’s experiences and to be able to support one another.

“It was such a support, you know, to be able to talk about how you felt and listen to others and hear how they had managed to get through the week.” (P11)

The majority of participants valued being part of a group with fellow anxiety sufferers who could understand their situation. There was a sense that talking to people with anxiety was different to talking to family, friends and other health professionals, who perhaps could not fully understand the difficulties and suffering associated with anxiety disorders. This allowed participants to feel supported and support one another.

“I think anxiety is so isolating, you know, you’re inside yourself anyway...in your own head, but...very often your family don’t understand. But being part of a group where everybody understood was...was...it was really comforting and reassuring really.” (P4)

“They understood when I described the situation I was in, they were probably one of the first people other than the doctor that really understood my dilemma.” (P7)

Most participants were able to talk openly with the other group members and sometimes shared experiences that they had never previously discussed. For some,

the telephone enabled them to be less inhibited and talk more freely about themselves and their lives. For these people, the anonymity offered by the telephone and the absence of face-to-face contact meant that they were less concerned by what the other group members thought of them, and this allowed them to be more open.

“I talked on the group about things that I’ve never even mentioned to my friends or family...it [the telephone] probably makes you less inhibited I think. I think you could open up more with total strangers and you’ve got nobody who’s got any...bias involved really.” (P6)

“Because you couldn’t see people’s body language and didn’t know a lot about them, somehow that meant you could be more open with people...I think it was just because it didn’t matter so much about what they thought of you, and because you were anonymous you could be more honest.” (P10)

However, whilst the telephone facilitated sharing experiences for some participants, for others it was a barrier to talking openly.

“At times I was, um, distracted by worrying about what people were thinking of me...I think that was increased because everyone was faceless. I mean because it can be embarrassing...in some ways that might have made it easier, um, them being strangers because you don’t have to see them, but for me if we could have seen each other it might have been easier, because I could have seen people’s body language. It would have been reassuring I suppose um, and that might have made it easier, um...to not spend time thinking about what I was talking about.” (P2)

Despite some difficulties with talking openly, sharing experiences with fellow anxiety sufferers led to the important realisation that anxiety is a common mental health problem. Participants explained that it was reassuring to “realise you’re not the only one” (P6) and that this reduced their sense of isolation.

“When you first suffer from anxiety or panic attacks you think you’re the only one in the world that has them. I mean, finding that so many people have them and experience them is quite a relief.” (P9)

“You feel that you’re not so isolated, so lost, because other people are going through the same thing.” (P11)

1.2. Comparisons with others. Comparisons with other group members were seen as helpful for both putting participants' own experiences into perspective and also for inspiring and motivating them to make changes. For some people, hearing that other people were experiencing symptoms of anxiety that were worse than their own was helpful because it made them appreciate their own circumstances.

“Well at times it made me think that no matter how bad I felt, there was often somebody worse than me, I mean, not that made me feel any better, it just helped open my eyes a bit really and helped me think, well at least it hasn't got as bad as that.” (P6)

“And also just hearing that other people were the same as me, and actually also that err, some people were actually worse than me, that was important...um...it made me appreciate that I can go to work and I can go out and I'm not just all cooped in like some people are... it helped me contextualise my difficulties, it made me realise it could be so much worse, which was a relief...and also motivation because I could see first hand how things could be different for me.” (P2)

The groups offered the opportunity to share experiences with people at different stages of recovery and hear from people who were *“a few steps ahead”* (P3). This was helpful, as it gave participants faith in the recovery programme and inspired them to make changes themselves.

“He's had difficulties but he's managed to overcome it. It's inspiring.” (P5)

“For me a big positive was seeing how over the weeks they were improving and changing...which was quite inspiring for me, to see how things could be different.” (P2)

1.3. Leader is a fellow sufferer. The group leaders' personal experiences and insight into anxiety were highly valued. In comparison to other professionals, the group leaders were perceived as better able to understand the participants' experiences of anxiety and impact that it had on their lives. This insight and understanding made it easier for some participants to talk about their own difficulties with anxiety.

“He [group leader] knew exactly um, he seemed to hit the buttons for me when he spoke to me. He really understood.” (P1)

“I think it also gave him some insight, because he had been anxious himself. Some insight into giving support and understanding how difficult...um, how distressing it is. As I say, it was the first time I had help....so I can't really compare to other people, but he was very understanding, and that....um, that made it easier to talk.” (P2)

“She had experienced it herself so she has the edge on hundreds of professionals.” (P11)

Additionally, it was helpful to hear about the group leaders' experiences of recovery and inspiring to see first-hand that it is possible to recover from anxiety disorders.

“When it's somebody like the group leader, and they say they've done it and they're feeling so much better than they used to, well that's very helpful.” (P9)

However, this experience was not universal. For a few participants, personal disclosures by the leaders were viewed as unhelpful, as they were perceived as taking up time and distracting from the purpose of the group.

“I got the feeling that they wanted to be a team leader because they wanted to offload their own problems...it defeated the objective really because it's supposed to be benefiting us all individually and we were ending up sympathising with her.” (P6)

“She was just talking about her own experiences and it just seemed like she was out for herself.” (P8)

Domain 2: Overcoming Anxiety: Making Changes

The second domain relates to how the recovery groups helped members to begin to overcome anxiety by promoting cognitive and behavioural changes. This included developing a better understanding of anxiety and its symptoms, developing a toolkit of self-help strategies and viewing recovery as a process.

2.1. Understanding anxiety. Many participants reported that the groups gave them a better understanding of anxiety, which in turn made their symptoms less frightening.

“I suppose for the first time I really started to understand what was happening to me and what was causing it...and, err...that was really important for me, because it made it less frightening.” (P2)

“The first group I did it was like a revelation to me because, um, years down the line now I have got a better understanding but at that point I didn’t and it was just a relief to have somebody who could explain what was happening to me and why.” (P13)

In particular, the information provided by the groups made them realise that they were not going ‘mad’.

“You realise that you’re not going insane, and actually that’s just one of the symptoms of anxiety, that feeling that you might be going to lose control and go crazy.” (P11)

“I think it really makes you realise that you’re not a head-case, you’re not crazy and it can happen to anybody.” (P16)

2.2. Developing a toolkit. Participants valued sharing different tips and coping strategies with each other. In particular, they identified relaxation techniques and thought-challenging as useful techniques for overcoming anxiety and described how they were able to “develop a toolkit for coping with my anxiety” (P10). Sometimes this involved reminding participants of strategies they had previously found helpful.

“I had forgotten things that are important...like breathing slowly when you start feeling anxious, it just sort of reinforced things that I knew about already but had just forgotten about really.” (P9)

Developing a toolkit was an important aspect of the group for some participants because it gave them confidence in their ability to cope with anxiety in the future.

“You need coping mechanisms for when you do feel anxious. And to know that, if I’m ever, if I ever feel stressed and anxious again, I think I would know the warning signs now, and would heed them, and put into practice what I’ve learnt.” (P4)

However, some participants explained that although they had learnt some useful cognitive and behavioural techniques for overcoming anxiety, one of the struggles was then putting these strategies into practice. They explained that although understanding the concept was simple, actually making the changes was sometimes difficult. One participant suggested that it would have been helpful to have addressed this issue in the group sessions.

“The philosophy is very simple and it’s very credible, but doing it is a whole different business. And it can be very difficult! And that’s why it’s easy for people, people without anxiety, to say it’s simple, but doing it...the concept is simple, the doing is difficult.” (P3)

“That’s when I think it needed to be taken to the next step. Like, it would have been helpful to talk about some actual diversion techniques and how to um...how to challenge those thoughts. Breaking it all down into smaller steps and actually talking about how to do it.” (P2)

Developing a toolkit for managing anxiety enabled some participants to reduce their need for support from others. These participants explained that the cognitive and behavioural strategies they learnt from the groups meant that they were able to better manage their anxiety independently and relied less on reassurance from friends and family. Some participants also reported a decrease in the frequency of calls made to the No Panic telephone crisis line.

2.3. Recovery as a process. The groups changed some participants’ views of recovery. There was a sense that they began to view recovery as a process that takes time, rather than seeing the groups as a ‘quick-fix’ cure.

“It helped me to learn that...to know that I will recover at some point but that it’s a process I have to go through.” (P11)

“Basically the group gives you a guide and then...um, it can take some time to recover. For you to really ingest what, um, the approach involves.” (P3)

The groups were seen as the first step in the process of recovery and some participants explained that the groups helped them to identify their needs for treatment more clearly. For some, this included highlighting underlying fears and recognising the need for further one-to-one support to make changes and overcome their difficulties.

“I also think it helped me see that I did have a problem with anxiety and that problem needed addressing. The group helped me realise what was wrong and what I needed to do. For me, I needed much more support, more intensity than they could offer me...support to make the changes. So I think the groups gave me a really solid understanding and was necessary for me to identify that I needed one-to-one support.” (P2)

Domain 3: Barriers and Challenges

The third domain focuses on the barriers and challenges experienced by group members. These included a mismatch between expectations of the group and reality, getting enough airtime, addressing individual needs and connecting with others. Some groups were more successful than others in overcoming these challenges. Managing these challenges was also particularly relevant for those participants who did not complete the full 14-week recovery programme.

3.1. Mismatch between expectations and reality. There was a wide range of expectations regarding what the recovery group would involve and the impact it would have on participants’ symptoms of anxiety.

Some participants seemed unclear as to the aims and purpose of the telephone recovery group. One participant, who had completed six sessions of the group programme, asked, *“what is a recovery group?”* (P12). Participants had a range of reasons for joining a recovery group and talked about a number of expectations of

what it would involve. Some explained that because it was called a ‘recovery group’, they were expecting a structured group with target-setting. Others described feeling desperate to find help and were focused on finding a solution to their anxiety problems. There was also a sense that some participants expected the recovery group to be primarily a support group.

“I live by myself so I was hoping to have someone to talk to.” (P5)

“I wanted to be involved with people that were suffering a similar thing to me.” (P4)

A small number of participants talked about how they had hoped that the groups would provide a ‘miracle cure’ for their anxiety. Although many participants recognised that this was unlikely, some had hoped that their anxiety would be cured by the end of the group and were disappointed when it became apparent this would not happen.

“I was really hoping that by the end of the 14 weeks I would be able to go the shop on my own...that I would be cured but it’s not changed my life dramatically if I’m being honest.” (P14)

Some participants described frustration at a lack of goals and structure to the groups. Although the recovery groups are based on a well-developed weekly programme and members are provided with a written outline of each session at the start of the group, some participants reported that the intended programme was not always delivered as planned, which left them feeling confused and frustrated about the purpose of the groups.

“There was no proper structure to it really. It sort of became a support group really, each person saying how they had been doing and problems with this and problems with that and you know and I think that’s what people tend to do. It really just needed tighter control really because we just drifted off.” (P12)

“It’s meant to be about recovery, not just talking about anything and everything.” (P9)

“There was no goal setting at all and I ended up coming away feeling utterly utterly frustrated that I had spent 14 weeks hoping that these goals would get started and they never did...I just didn't feel like I was doing anything focused in terms of my anxiety.” (P14)

3.2. Airtime. A common barrier for participants was ensuring that they had sufficient time to talk about themselves within each session. Many participants relied on the group leader to give everyone the chance to talk, which typically involved the leader allocating each member a set amount of time per session. Although this was sometimes successful, it also put limits on whether people were able to get their views across.

“I didn't always get enough airtime... it always seemed to start with what kind of week we'd had and most people had had a pretty awful week so then they talked about that, but if you've got six people who have spoken about what an awful week they've had, you've got very little time left yourself...sometimes it would be 40 or 50 minutes before I got the chance to say anything.” (P17)

“By the time it had come round to us saying what we wanted to say it was um...time for you know the group to finish. It was really frustrating.” (P8)

“It was just quite hard to find your voice, or make your voice be heard.” (P14)

For some participants, having sufficient time to speak was felt to be particularly important at the start of the recovery programme, whereas for others, not having ample time to talk about their anxiety became increasingly frustrating as the group progressed.

“It was difficult especially at the beginning, because it was all new and we all wanted to ask questions. It was just so frustrating, they would go on and on and on and you just have to sit there and listen.” (P16)

“You couldn't get a word in edgeways, you didn't get much of a chance to talk at all.” (P5)

This problem was particularly difficult when one group member monopolised the conversation. Although many groups relied on the leader to ensure that this did

not happen, it seemed that this was not always managed successfully, and participants were left feeling frustrated as they felt unable to interrupt over the telephone.

“She was someone who had a louder voice than most people. And I was getting a bit annoyed because I was thinking, I want to speak but I can’t. And it seemed to be very much that particular voice, and it was quite, um...I felt quite oppressed by it.” (P15)

“It’s very hard when you can’t see people I suppose...like....it’s very hard when you can’t see them to like, um, cut them off.” (P4)

“When you’re on the phone I think it’s more frustrating. It’s hard when you can’t see someone and they’re talking all the time and you’re just sat there...well festering really and you don’t want to tell them to shut up, do you?!” (P8)

3.3. One size doesn’t fit all. Some participants reported that the group format meant that their individual needs were not addressed. This often meant that the groups were experienced as generic and some participants found the conversations irrelevant to their situation.

“I think that sometimes the sessions were just too generic...um, and that meant that people’s specific requirements couldn’t really be attended too. I...um, generic approaches can give some support but one size doesn’t always fit all.” (P2)

The mix of people in the group often seemed to determine whether individual needs could be met, with groups being viewed as more successful when members had a lot in common, as this meant participants could relate to what was being discussed. In particular, participants identified that it was sometimes difficult to have in-depth discussions about relevant topics due to the range of presenting problems in the groups. This meant that the groups were sometimes experienced as only touching the surface of anxiety.

“It covers such a wide area you know...anxiety, depression, OCD....and then of course you get into phobias then! It’s so wide-ranging then and you can only touch the surface really.” (P1)

“We were such a mixed group, with mixed problems like OCD, GAD, depression so you can’t have the same targets, you can’t have the same sort of structure there.” (P12)

For some participants it was challenging to be with people at a different stage of recovery and some found hearing other people’s experiences depressing. They explained that it was unhelpful to focus solely on the problem, without talking about strategies and solutions. Some participants felt guilty discussing their own difficulties when they perceived that the other group members’ problems were worse than their own.

“We all had anxiety to a degree, but some are more err...at a more progressive stage than others. And that is not always helpful...they would just use the group as a sort of sounding board to air all their problems, and that wasn’t always helpful if you were having a bad day, because you don’t want to hear things that aren’t relevant, about problems not related to the anxiety...you want to be talking about what would help.” (P10)

“It made me feel worse, because the people that I was...in some ways I felt guilty because of what they were going through and I didn’t see me as being as bad as that....I thought that I should be able to, if these people could cope with all this, what have I got to complain about, because what I’ve got is nothing really compared to that. And that made me feel bad about myself.” (P13)

Although participants were aware of the challenges of putting together a successful group, a number suggested that it would be helpful for people to be vetted to enable the sessions to be more specific and to ensure that their individual needs could be met.

“It would be good to vet people...so possibly very small groups who are really serious and share a common thing...serious about the groups, serious about getting better and have similar symptoms, or experiences.” (P3)

3.4. Connecting with others. Although the medium of the telephone was experienced as facilitating openness, it also sometimes made it difficult to form meaningful connections with others. For some participants, the absence of face-to-

face contact and not knowing when to talk made it difficult to get to know the other group members.

“It is a bit strange on the telephone. You know, you never really know when to talk, when not to talk, um...you know, when to say anything and when not to say anything...it was more distant, so you couldn't connect as well to people, to get to know them.” (P4)

“You can't see people's reactions, and you can't look at people and you can't see...like you might say something and it might upset somebody and you can soon see if you're face-to-face where somebody is coming from, whereas it's much harder to do that over the phone.” (P12)

One of the consequences of the difficulties in connecting with the other members was that there were fewer group conversations and instead the focus was on a series of one-to-one conversations with the group leader.

“I think face-to-face gives you a chance to get a better feel of the person and for other people to contribute. [On the phone] it was more like a series of one-to-one discussions...because it's harder to step in when you can't see someone...so generally it was a dialogue between the facilitator and one other person and the other people...it wasn't like...occasionally I did try and come in but that didn't really work.” (P3)

However, this experience was not universal, and some participants found it easier to overcome the barrier in connecting with the other members.

“I think you can interact with people in different ways, I mean I think you can tell from people's voices what you're going to, some that you're going to get on with better than others I think. You can tell that.” (P6)

A particular difficulty in forming and maintaining a connection with the other group members was groups “fizzling out” when some members gradually dropped out week-by-week. This was particularly relevant for those participants who valued the connection with others and tried to maintain the contact with the group members at the end of the recovery programme.

“That’s what was so difficult with that last group that fizzled out, because you can’t keep in touch with people. And it was just all left all up in the air, it was a complete anti-climax really, I was left feeling quite deflated by it all really.” (P6)

A further barrier to connecting with others was the distractions and disruptions that came with taking part in a group over the telephone. Participants described a number of distractions and disruptions that made it difficult to build up a flow of conversation and maintain continuity from week-to-week. These included group members being interrupted by family members or the doorbell, and the need for repetition due to some members having difficulties in hearing what was being said over the telephone.

“This one gentleman, he was a little bit hard of hearing as well and everything had to be said twice, you know what I mean...and some people didn’t understand things, and other people went off to answer the door...lots of disruptions.” (P1)

Some participants also highlighted a number of issues in forming a strong connection with the group leader. The leaders could sometimes appear rushed over the telephone and some participants thought that the leader didn’t fully attend to their needs. This became particularly problematic when participants were experiencing difficulties in the group as it left them feeling uncared for.

“The group leader, he said to me that I didn’t fit in with his group. And he asked me whether I wanted to continue. And when I said I wanted to continue, he said it would be better to wait and join the next one! So I took offence at that and dropped out of the group.” (P5)

“I felt as though she was often quite rushed and she had to go on and do another group after ours and I always had a sense of that. And sometimes she would come in just a bit late and she just always seemed a bit rushed, she was always going somewhere and that meant she had to sometimes cut conversations short.... it made a difference to how much I connected with her because I didn’t feel that she was that interested in me, or us.” (P14)

Discussion

Overall, views of the No Panic telephone recovery groups varied and participants described a mixed picture of both positive and negative experiences. The majority highlighted the benefits of taking part in a recovery group, despite experiencing continued high levels of anxiety, and tended to place greater emphasis on the interpersonal aspects of the group rather than on symptom reduction. Most valued the support they received from the other group members and the group leader and highlighted that this was important in their recovery from anxiety. The groups were also experienced as helpful in providing information about anxiety and developing participants' understanding of their difficulties, as well as allowing them to share coping strategies and techniques. However, participants described some barriers and challenges that prevented them from making full use of the groups, including forming meaningful connections over the telephone, having enough time to talk about their experiences, and ensuring that their individual needs were addressed.

The Importance of Interpersonal Processes

Participants valued a number of interpersonal factors including feeling understood, sharing experiences and the group leader having insight, over and above strategies for reducing their anxiety. This is consistent with evidence that indicates that 'non-specific' factors, common across a range of psychotherapy interventions, contribute more to treatment outcome than the effects associated with specific therapeutic techniques (Ahn & Wampold, 2001; Wampold, 2010). For example, the quality of the therapeutic relationship has been shown to significantly predict treatment outcome across a range of settings, diagnoses and therapeutic modalities (Horvath & Bedi, 2002; Norcross, 2002, 2010). The importance of empathic listening has also been highlighted as being therapeutic (Bohart & Greenberg, 1997;

Elliott, Bohart, Watson & Greenberg, 2011; Rogers, 1975). In this study, participants found that groups were more successful when they formed a meaningful connection with the group leader and felt listened to and understood by both the leader and other members.

In addition, for most participants, the group format also increased their sense of feeling supported and understood by others in a similar situation. The role of social support in reducing the negative impact of anxiety on quality of life has been well documented (e.g. Goldberg, Rollins & Lehman, 2003; Helgeson, 1993; Panayiotou & Karekla, 2013). It is likely that the perceived social support received by participants from the other group members and the leader was beneficial in improving wellbeing and overall quality of life, even if it did not directly impact on the anxiety symptoms themselves. This is in line with previous findings which have indicated that social support has a direct positive effect on quality of life even when it does not impact on the negative aspects of anxiety (Panayiotou & Karekla, 2013).

Participants described a number of interpersonal processes consistent with Yalom and Leszcz's (2005) conceptualisation of therapeutic factors in group psychotherapy. Yalom and Leszcz (2005) propose that recognition of shared experiences and feelings helps remove a sense of isolation, validate people's experiences and raise self-esteem. Groups can also instil hope, and group members can be inspired and encouraged by another member in mixed groups with members at varying degrees of recovery. Similar themes were identified in this study and participants highlighted the importance of being able to form connections with other anxiety disorder sufferers in order for the group to be helpful. When this was successful, the group members were able to learn from each other and disclose

experiences that they had been unable to share previously with friends, family and other mental health professionals.

Cognitive and Behavioural Changes

The psychoeducation and information provided during the groups allowed participants to develop a new understanding of anxiety. Understanding the physical symptoms of anxiety enabled them to change the interpretation and meaning of the symptoms, for example, realising that they were not a sign that they were going to die or go 'mad'. This change in meaning was important in terms of reducing distress and is in line with cognitive models of anxiety disorders (e.g. Clark, 1996).

Participants described how these cognitive changes were an important motivation for making behavioural changes, e.g. reducing avoidance, but also highlighted that making changes could be difficult. Research in face-to-face CBT for anxiety has found that high quality homework, especially tasks which focus on making changes (e.g. behavioural experiments) predict treatment outcome (e.g. Cammin-Nowak et al., 2013). Therefore, the recovery groups may benefit from including structured homework tasks to support people to make cognitive and behavioural changes.

Given the long duration and severity of anxiety reported by the majority of participants in this study, it was perhaps not surprising that the recovery groups did not always result in reduction of symptom severity. Instead, some participants recognised that the groups were a useful first step on the road to recovery and described how the groups highlighted a need for further help. This is in line with the finding that psychoeducation can be a useful first step for reducing distress and anxiety symptoms (Donker, Griffiths, Cuijpers & Christensen, 2009). Similarly, peer support is particularly valued in the early stages of treatment of mental health

problems (Repper & Carter, 2011). A stepped-care approach to treating anxiety disorders is recommended (NICE, 2011) and the recovery groups may provide an initial low-intensity intervention that enables recipients to recognise their difficulties and identify the need for further support, e.g. in a one-to-one or face-to-face setting.

Transdiagnostic Implications

The majority of participants reported symptoms from more than one anxiety disorder and each recovery group comprised a heterogeneous mix of problems. Previous research has demonstrated the effectiveness of transdiagnostic CBT for multiple anxiety disorders in traditional face-to-face settings, in groups and over the internet (Barlow et al., 2004; Erickson, 2003; Erickson et al., 2007; Garcia, 2004; McEvoy et al., 2009; Norton, 2008; Norton & Barrera, 2012; Norton & Hope, 2005; Titov et al., 2011). The findings of this study suggest that a transdiagnostic group treatment for anxiety may also be effective for some people when delivered over the telephone. However, for many participants, the mix of the people in the group was an important factor in whether the group was experienced as helpful or not.

Although research has indicated that the composition of anxiety disorders in a group does not influence outcome (Chamberlain & Norton, 2013), the findings of this study suggest that when the diagnostic composition is too broad, conversations can be experienced as lacking in depth and meaning and, in some cases, be irrelevant.

Further research is needed to explore this issue in transdiagnostic group treatments.

Barriers and Challenges of a Telephone-Delivered Group

A previous narrative review highlighted a number of potential challenges in delivering successful telephone-administered therapy (Brenes, Ingram & Danhauer, 2011). These included a lack of control over the environment, concerns about privacy and confidentiality, the development and maintenance of the therapeutic

alliance, ethical and legal issues, managing crisis situations and challenges for the therapist delivering therapy over the telephone. The current study highlighted a different set of barriers and challenges from the recipients' perspective, some of which were more successfully overcome than others. These included getting enough airtime, forming a meaningful connection with others, and addressing individual needs.

Having enough time to speak, particularly when an individual is monopolising the conversation, has been identified as a challenge in face-to-face group CBT (Morrison, 2001), and may be particularly important when the intervention is delivered by telephone. The absence of non-verbal cues made it difficult for people to know when they should and should not speak, and participants became frustrated when they did not have enough time to share their views. This barrier was particularly pertinent when the groups lacked goals and structure. The recovery group was the first experience of a psychological therapy for many participants, and there was a sense that some did not fully understand what it would involve. The lack of a clear, coherent programme added to participants' confusion over when to speak and what to talk about, and may have further contributed to their experience of not having enough time to talk or feeling that one person monopolised the conversation. Implementing an intervention as planned is often a challenge in face-to-face group therapy due to time limitations and the individual needs of group members (Morrison, 2001) and it is possible that these factors are increased when a group is delivered by volunteers over the telephone. Further research is needed to examine these issues.

Delivering the group over the telephone increased access to social support and, in some cases, the increased privacy and anonymity offered by the telephone

facilitated therapeutic interpersonal processes, as it enabled participants to talk openly about sensitive issues. However, the absence of face-to-face contact hindered the formation of meaningful connections for some participants, who felt awkward and uncomfortable talking to the other group members and the leader, resulting in conversations that were experienced as distant and superficial. Establishing an emotional bond and talking openly are central tenants of a strong therapeutic alliance (Horvath & Greenberg, 1995) and previous research into telephone-administered therapy has questioned whether the absence of non-verbal communication may impact on the therapeutic relationship (Haas, Benedict & Kobos, 1996; Stamm, 1998). Further research is needed to explore how holding groups over the telephone impacts on the development and maintenance of connections with other group members and on the therapeutic alliance.

Limitations

This study has a number of limitations. Although the sample size was adequate for qualitative research (Willig, 2008), the small sample size and low response rate (29%) means that the findings may not be representative of the broader membership of No Panic members or be generalisable to the wider population of people with anxiety problems. Participants were also drawn from a relatively small number of telephone recovery groups. The groups are typically adapted to fit the needs of the individual group members and therefore the extent to which the findings apply to other telephone recovery groups is unclear. Furthermore, this study focused on the experiences and views of people who had taken part in a unique transdiagnostic telephone group, thus generalisations to other similar services and populations can only be made tentatively.

Interviews for qualitative research are typically administered face-to-face; however, in this study they were conducted over the telephone in keeping with the No Panic ethos for encouraging access and preserving anonymity. There were a number of challenges in conducting the interviews over the telephone, which may have impacted on how open some participants were able to be and the richness of their descriptions of their experiences. Furthermore, the interview required participants, who were often still experiencing significant symptoms of anxiety, to reflect on a process that was complex and required a high degree of insight. This may have been particularly challenging over the telephone.

Although participants appeared to talk openly about their experiences, it is possible that they felt constrained about fully expressing any negative opinions of the recovery group. Furthermore, relying on retrospective recall of events (some of which occurred six-months previously) may have influenced participants' views of the groups and may have been a potential source of bias (Giorgi & Giorgi, 2003). However, on the whole, participants appeared to be able to recall in detail aspects of the groups relevant to this study and were able to articulate both positive and negative experiences.

Implications for Service Delivery and Future Research

The findings have a number of potential clinical and research implications. First, this study highlights the importance and value of individuals with anxiety problems forming meaningful connections with other sufferers. Although the telephone may be a cost-effective way of engaging hard-to-reach clients in therapy, further research is needed to determine how to ensure that people feel connected and part of a group. It may be that the initial group sessions need to be longer (for example two hours) in order to give people the opportunity to get to know each other

and begin to form relationships with one another. Furthermore, it may be important to find a method of encouraging group discussions around a topic, rather than relying on the group leader to have a series of one-to-one conversations with each member in the group. Ensuring that the groups follow a set structure may help encourage this.

Secondly, given some of the challenges of delivering a transdiagnostic group over the telephone, organisations designing such interventions may benefit from introducing a selection process. As suggested by a number of participants, ‘vetting’ people before they begin a group may reduce drop-out rates and may help to ensure that individuals are ready to begin a CBT-informed intervention and make changes. Future research is necessary to explore the different characteristics of people who benefit from support groups in comparison to active therapy.

Thirdly, the leader being a fellow anxiety sufferer both facilitated and hindered the therapeutic processes. Many low-intensity interventions are intended to be delivered by practitioners or volunteers with relatively little training, including peer supporters (Bennett-Levy et al., 2010). The No Panic recovery groups were run by trained volunteers, many of whom had personal experiences of anxiety. The experiential knowledge of the group leaders placed them in a unique position compared to other professionals and fostered the therapeutic processes of the groups through empathic listening and mutual understanding, similar to other findings in the peer support literature (Borkman, 1990; Pistrang, Jay, Gessler & Barker, 2012, 2013). However, occasionally the leaders talked too much about their own experiences, which detracted from the perceived purpose of the group. It is important for peer supporters to have sufficient distance and resolution of their own problems in order to provide effective support (Pistrang et al., 2013; Repper & Carter, 2011). Similarly, research has indicated that therapist self-disclosure in

traditional face-to-face therapy is most useful when the therapist discloses issues that are mostly resolved, rather than those which continue to be a struggle (Knox & Hill, 2003). These findings have clinical implications for the training and selection of group leaders. In face-to-face therapy, therapist self-disclosure also has differential effects depending on the nature and quality of the therapeutic alliance; self-disclosure is more likely to be perceived as unhelpful in the absence of a strong therapeutic relationship (Gibson, 2012; Henretty & Levitt, 2010). Further research is needed to explore whether the telephone influences group members' experiences of self-disclosure by the leader, particularly when there are difficulties in establishing a strong therapeutic relationship.

Finally, further research is needed to systematically evaluate telephone-delivered groups using quantitative outcome data to demonstrate the effectiveness of the intervention in improving anxiety symptoms. Further qualitative research exploring the experiences and views of the group leaders would also be valuable.

Overall, the findings of this study indicate that a telephone-delivered group CBT intervention shows promise and has potential value as a first step in the treatment of anxiety disorders. While future research is needed to establish the effectiveness of such interventions in reducing anxiety symptoms and improving quality of life, therapeutic interpersonal processes such as feeling understood, reduced isolation and increased hope, should not be overlooked. Further research is needed to understand the impact of delivering group CBT over the telephone, in order to guide the delivery of similar low-intensity interventions for anxiety.

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Part III: Critical Appraisal

Introduction

This critical appraisal considers the processes and challenges of conducting the research reported in Part II. First, the process of conducting semi-structured interviews will be discussed and the impact on both the participants and the researcher will be considered. Secondly, the benefits and challenges of working with an external user-led organisation will be outlined. In the final section, issues related to the delivery and outcome of low-intensity interventions will be considered.

Interviews

Qualitative research can capture complex and rich phenomena and is particularly suited to examining the processes involved in under-researched therapeutic interventions (Barker, Pistrang & Elliott, 2002; Elliott, 2010). However, there were challenges associated with both using semi-structured interviews to gather information and with conducting the interviews over the telephone.

Challenges of Using Semi-Structured Interviews

Semi-structured qualitative interviews allow researchers to gain an in-depth account of the topic of interest (Barker et al., 2002; Patton, 2002). Although this approach to data collection enabled participants to emphasise the interpersonal aspects of the recovery groups that may have been overlooked in standard quantitative outcome research, it was sometimes challenging to use the interview schedule flexibly and to ensure that I did not switch into a clinical mode of interviewing.

Semi-structured interviews are designed to be used flexibly in order to allow the participant to tell their story whilst also enabling the interviewer to cover the main relevant areas (Barker et al., 2002). I attempted to use the interview schedule as a guide and favoured open questions throughout the interview in order to allow

participants to talk about what they thought was relevant. However, in the initial interviews, I became aware that I was relying heavily on the structure of the interview schedule and using fewer follow up questions and probes. It was helpful to scrutinise the initial transcripts with my supervisor to highlight times when I could have been less rigid in my inquiries and to identify areas where it would have been useful to clarify participants' responses. This enabled me to modify my interviewing technique and as the research process continued I became more skilled in using the schedule flexibly.

There is a clear distinction between therapy and research interviewing styles, as clinical interviewing is usually designed to bring about change (Barker et al., 2002). I was aware of this issue prior to beginning the research, but naively was not expecting it to be a challenge as my focus was on finding out about participants' experiences of the recovery groups. However, due to the anxiety that participants were still experiencing and the content of the interviews (e.g. exploration of the problem and focusing on helpful and unhelpful aspects of the intervention), I sometimes found myself switching into a clinical interviewing style. This was particularly noticeable when I thought participants were seeking reassurance about their symptoms or describing behaviours which may have been maintaining the problem. When reviewing the transcripts, I noticed that in these circumstances, I occasionally began to use socratic questioning (questions which the recipient has the knowledge to answer and which aim to guide them to widen their perspective and to discover new meanings; Padesky, 1993) to explore these issues with participants in attempt to bring about change (e.g. 'what were the implications of avoiding that?'). This issue added an additional level of complexity to the interviews. I found supervision useful in managing this issue and I think utilising practice interviews

would have been valuable for developing my research interviewing technique prior to beginning the study. Additionally, it would have been beneficial to have the option to feed back any information of concern regarding participants directly to their mentors at No Panic.

Throughout the interviews I tried to minimise any power imbalance between myself and the participants. Initially I considered introducing myself from No Panic, as I wanted participants to feel comfortable talking to me. However, on reflection, it was more helpful to explain that I was a trainee clinical psychologist from UCL, who was working with No Panic. I found that this helped participants speak more openly about their experiences of the recovery groups, perhaps because they viewed me as an ‘outsider’ from No Panic.

The Process of Conducting Telephone Interviews

In contrast to most qualitative research which typically involves face-to-face interviews, all of the interviews were conducted by telephone. This was in keeping with No Panic’s ethos and allowed me to interview people who would have struggled to attend a face-to-face interview due to their anxiety difficulties, as well as enabling me to recruit participants from across the UK. However, using the telephone was not without its challenge and it was occasionally difficult to facilitate reflection and explore the subtleties and nuances of participants’ experiences in the absence of face-to-face contact. These issues were more pronounced when interviewing those people who were still experiencing severe symptoms of anxiety.

I was aware of the importance of building rapport with the interviewees in order to put them at ease and allow them to talk openly and honestly with me about their experiences. This was sometimes challenging over the telephone where I could not rely on non-verbal cues to communicate. Previous research has emphasised the

importance of both verbal and non-verbal cues in high quality clinical encounters (Watson, 2002) and I initially found it challenging to both communicate effectively with the participants and interpret their verbal responses in the absence of visual cues. Particularly in the early stages of interviewing, I noticed that I sometimes forgot that the participant could not see me or my facial expressions, e.g. I noticed myself nodding to encourage a participant to expand on an idea, rather than verbally asking them to continue talking. Although I was able to encourage participants to talk openly, in order to obtain rich data I found that I had to be transparent about my questions and actions. Explaining pauses in conversations and seeking regular feedback have been highlighted as key processes in overcoming some challenges in telephone-delivered therapy (Lovell, 2010) and were also pertinent in conducting the telephone interviews. For example, I found it helpful to explain any pauses or silences in the conversations while I was thinking about the next question or writing down an important phrase. It was also useful to use lots of additional verbal encouragement (e.g. 'uh-huh' and 'I see') and regular summaries and reflections to ensure that the participants felt heard and understood.

A further challenge was finding a balance between building rapport and gathering information. This was a complex task, particularly as many of the participants experienced chronic and severe anxiety symptoms which were often palpable during the telephone interview. I was mindful of wanting to put participants at ease and allowing them to tell their stories, whilst also ensuring that I was able to ask them questions relevant to the recovery groups. I found it helpful to give participants an overview of the types of questions that I would be asking prior to the interview, so that they were aware of the purpose of the conversation. This also reduced the likelihood of the interview shifting into a more social or conversational

style, which has been previously highlighted as a potential challenge in telephone-delivered interventions (Haas, Benedict & Kobos, 1996).

Epistemological and Personal Reflexivity

The process of declaring and reflecting on one's epistemological and personal beliefs is central in credible qualitative research, as the researcher is intrinsically involved in both the research process and outcome (Dowling, 2006; Etherington, 2004; Willig, 2008). Throughout the research process I attempted to use 'reflexive bracketing' to reduce the influence of my beliefs (Ahern, 1999).

Prior to beginning the interviews, I held a view that cognitive-behavioural therapy (CBT) was an effective treatment for anxiety disorders. I also believed that being part of a group could be a powerful therapeutic experience, especially for people who may be isolated and distressed by mental health difficulties. I therefore thought that people would have broadly positive experiences of the No Panic recovery groups. In an attempt to reduce the influence of these beliefs on the research, I explicitly asked participants about both helpful and unhelpful aspects of the recovery groups and also attempted to recruit people who had dropped out of the groups or attended sporadically, to ensure that a range of experiences could be heard. During the interviews I tried to take a stance of 'curiosity' and attempted to avoid summarising participants' experiences in a way that may have veered towards leading them to focus on particular aspects of their experiences.

Throughout the course of the research I became aware that my views shifted and I started to become more open to the 'downsides' of group interventions. I also began to consider the concept of 'outcome' more broadly, as going beyond symptom reduction but also encompassing increased quality of life, for example through social interactions.

It is also important to consider the impact of the research on the participants. Many participants indicated that it had been helpful to have the opportunity to reflect on the recovery groups with an ‘outsider.’ For some participants, it was validating to be able to explain how far they had come in overcoming anxiety, whilst for others it was valuable to be able to voice the difficulties they had experienced with the groups. Although a small number of participants became upset and tearful while talking to me about their experiences, they indicated that it was cathartic to be able to talk about their struggles with anxiety.

Working With a User-Led Charity

Service-user involvement in the planning and development of services is stipulated by the Department of Health, and service users or their representatives have a right to be involved in the planning and development of services (Sheldon & Harding, 2010). Working with service-users has a number of advantages, both in terms of developing clinical services and also in research (Beresford, 2007; Tait & Lester, 2005). Users are experts about their own illness and need for care and therefore can provide important perspectives regarding the understanding of mental distress and the experience of illness, service use and barriers, stigma and the wider context of living with mental health difficulties (Tait & Lester, 2005). No Panic is predominantly a user-led charity, with 95% of the governance and management team being user-led. This had rich advantages for the research process but a number of obstacles were also encountered.

Developing a strong working relationship with No Panic was crucial to the success of the project. The importance of groundwork in conducting research with external organisations should not be underestimated (Barker et al., 2002) and spending time forming connections with key people within No Panic in the early

phases was valuable at later stages of the research process. The first step in negotiating access for research in applied settings is to approach the ‘gatekeepers’ and it is usually useful to start at the top of the setting (Cowen & Gesten, 1980; Taylor & Bogdan, 1998). I had a prior working relationship with one of the patrons of No Panic, who was able to introduce me to the CEO to discuss the possibility of working with them to evaluate the telephone recovery groups. Having an existing association with someone whose opinion was valued within the charity was extremely helpful in initially forging links with the gatekeepers (Cook & Campbell, 1979; Taylor & Bogdan, 1998). At this stage of the process, I spent a number of days visiting No Panic to meet key people and to observe the ways in which the organisation worked. I also attended and spoke at their annual conference. Although this was time consuming, I think it was crucial in gaining the trust of the charity, particularly as research in external settings can often arouse suspicion (Hardy, 1993; Weiss, 1972). Visiting in-person, rather than relying solely on communicating via telephone or email, helped lay the foundations for a collaborative working relationship and allowed us to discuss openly any concerns the charity had about the research.

In addition to forming a working relationship with No Panic, a further priority was to develop a shared understanding of the purpose and aims of the project. When I initially approached No Panic, they already had a number of interesting ideas for research, including finding out more about recipients’ views of the recovery group. It was valuable to be able to work with members of the organisation who had experience of anxiety and who had taken part in a recovery group in order to design a research study that would produce meaningful and useful findings, and I found it useful to discuss my preliminary ideas with them. However, I was aware that we

occasionally held different perspectives regarding the aims and purpose of the research. For example, the management were driven by a motivation to be able to provide research findings relevant to external funding bodies, whereas the group leaders and members were more interested in whether recipients enjoyed being part of a recovery group. Whilst I was keen to produce a project that encompassed No Panic's aims, I was also aware of some of the practical limitations imposed on the research e.g. limited time and resources. At this stage of the research process it was helpful to draw on the idea of 'collaborative empiricism' from CBT theory – the idea that the therapeutic relationship is an equal partnership, where the client is an expert in their own experience and the therapist brings skills and knowledge of psychological theory and techniques (Beck, 1976; Kuyken, Padesky & Dudley, 2009). I took a similar position with developing the research project, viewing No Panic as having invaluable knowledge about anxiety and the recovery groups, whilst I could bring research skills and expertise to the partnership. From this, I was able to draft a written research proposal based on our shared goals, which clearly outlined the objectives of the project and highlighted the roles and responsibilities for both No Panic and myself.

Guidelines for service-user involvement highlight the importance of involvement being meaningful and useful and of making special efforts to reach out to those who rarely get heard (Sheldon & Harding, 2010). An advantage of working with a user-led organisation is that these priorities are already part of their culture, and therefore No Panic were particularly supportive of my attempts to recruit people who had dropped out of the groups, as well as talking to those people who had completed the full 14-week course. However, my skills and background in research meant that I had different ideas about the process of recruitment to ensure that it was

non-coercive and as representative as possible of the wider sample. Understandably, No Panic had less knowledge about ethical processes and data collection and at times I found it particularly challenging to be reliant on an external organisation for support for recruitment. It would have been helpful to have referred back to the research proposal more frequently throughout the duration of the research so that we could review and, if necessary, update the responsibilities that we each held regarding recruitment.

It is important to be aware of pre-existing organisational tensions when conducting research in applied settings (Hardy, 1993). Shortly after beginning the research, No Panic began to undergo considerable internal stress and change which intensified during the research process. This likely exacerbated the challenges I encountered and highlighted the importance of having clear common aims and objectives when conducting research with external organisations. It may have been helpful to have been more transparent regarding my time-frames for data collection and analysis from the outset, so that No Panic were clear what my expectations were from them.

Low-Intensity Interventions

The No Panic telephone recovery groups can be conceptualised as a low-intensity transdiagnostic CBT intervention for anxiety. With the recent introduction of Improving Access to Psychological Therapies (IAPT) services in the UK, there has been an increased level of interest in the effectiveness and acceptability of low-intensity treatments for common mental health problems (e.g. Bennet-Levy, Richards & Farrand, 2010). In IAPT services, outcome is commonly assessed using a set of standardised questionnaire measures. Similarly, in the literature review reported in Part I, outcome was considered in terms of clinical significance and statistically

significant reductions in self-reported symptoms. Whilst symptom reduction and clinically significant change is important in conceptualising outcome, it is likely that a similar quantitative approach used in relation to the No Panic recovery groups would not have captured the depth and breadth of participants' experiences.

Although many participants did not verbally report symptom reduction, they did highlight a number of therapeutic benefits that they obtained from being part of the recovery group. As low-intensity interventions are often encompassed within a stepped-care model of care, it may be important to consider outcome more broadly when evaluating the effectiveness of such interventions. For example, in the study reported in Part II, a key outcome for some participants was identifying the need for further help. Within a stepped-care model, this could be viewed as a 'successful' outcome, and it may be important for future quantitative research into low-intensity interventions to consider this alongside symptom reduction.

As highlighted in Part I, there is an emerging evidence base indicating that therapy delivered by telephone can be effective in reducing symptoms of anxiety and depression. The study reported in Part II contributes to, and expands, this evidence base. However, further research is needed. The terminology within the field is often complex and it is sometimes unclear whether an intervention delivered by telephone is classed as low-intensity. A number of participants in the study reported in Part II indicated that they did not experience the groups as 'low-intensity', as they required hard work and commitment. This is similar to other findings which have indicated that the term low-intensity refers more to a reduction in therapist resource rather than a reduced intensity for the recipient (NICE, 2011).

By definition, low-intensity CBT interventions are designed to be delivered by people who are not necessarily trained to deliver traditional face-to-face therapy,

for example, people in the voluntary sector or peer supporters (Bennett-Levy et al., 2010). Although this has raised concerns about the de-professionalization of the delivery of CBT, it is also recognised that the ability to engage and support the recipient of the intervention is more important than the professional background of the person offering the support (Gellatly et al., 2007; Williams & Martinez, 2008). Prior to conducting the interviews, I had the opportunity to listen in to a full 14-week recovery group. This enabled me to see first-hand the nature and the content of the intervention. Although the group leader seemed empathic, warm and knowledgeable, there were times when I noted that they responded differently to the group members compared to a trained CBT practitioner. For example, as a trainee clinical psychologist, I found it frustrating to observe group members' descriptions of unhelpful cognitions or maintaining behaviours either go unchallenged, or in some cases, even encouraged by the group leader. Furthermore, a small number of the group members appeared to be experiencing severe mental health difficulties (e.g. reporting suicidal intent or periods of depersonalisation) that the leader did not have the training and experience to recognise and respond to. Although low-intensity interventions are intended for people with mild to moderate psychological disorders, people who deliver such interventions may be faced with some complex cases which are inappropriate for their level of training. This is a challenge for low-intensity interventions and concerns have been raised about clinical governance and how to provide adequate training and supervision for people without a professional mental health background (Richards, 2010; Shepherd & Rosairo, 2008).

In addition to limited training, the No Panic group leaders were also fellow anxiety sufferers. Peer supporters can add unique value to low-intensity interventions as they often have experiential knowledge of mental health problems

(Lawn et al., 2010; Repper & Carter, 2011). In the study reported in Part II, participants found it valuable to have a group leader who was a fellow anxiety sufferer because they had first-hand experience of anxiety. Participants explained that it was inspiring to hear the leaders' experiences of recovery, either in terms of symptom reduction or building a meaningful life. However, in my observation of the group, I noted that the leader sometimes appeared to find it hard to step back and distance themselves, particularly when the content of the group conversations was emotionally salient. Ensuring that people are sufficiently recovered and distanced from their own psychological problems is important when selecting and training group leaders. The optimal level of training and support for peer supporters has been debated, and further research is needed to determine how to provide training in areas such as boundary setting and use of self-disclosure, whilst avoiding over professionalism (Pfeiffer, Heisler, Piette, Rogers & Valenstein, 2011; Pistrang, Jay, Gessler & Barker, 2013; Repper & Carter, 2011).

Conclusions

Despite the obstacles and challenges outlined above, a qualitative approach allowed me to examine the experiences of recipients of a group CBT intervention delivered by telephone. Throughout the research, I developed my understanding of the conceptualisation of outcome, and how organisational factors can influence the research processes. Although there were challenges in using telephone interviews and working with a user-led organisation, they were mostly successfully overcome and the research enabled me to see a rich range of experiences of the groups. This is a rapidly developing area, and the role of interventions delivered by telephone, both individually and by group, is worthy of future research and exploration.

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Appendix A:
Rating Criteria for the EPHPP Tool

For each of the six components A – F, use the following descriptions as a roadmap.

A: SELECTION BIAS

Strong: The selected individuals are very likely to be representative of the target population (Q1 is 1) **and** there is greater than 80% participation (Q2 is 1).

Moderate: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); **and** there is 60 - 79% participation (Q2 is 2). ‘Moderate’ may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can’t tell).

Weak: The selected individuals are not likely to be representative of the target population (Q1 is 3); **or** there is less than 60% participation (Q2 is 3) **or** selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B: DESIGN

Strong: Will be assigned to those articles that described RCTs and CCTs.

Moderate: Will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.

Weak: Will be assigned to those that used any other method or did not state the method used.

C: CONFOUNDERS

Strong: Will be assigned to those articles that controlled for at least 80% of relevant confounders (Q is 2; or Q2 is 1).

Moderate: Will be given to those studies that controlled for 60–79% of relevant confounders (Q is 1 and Q2 is 2).

Weak: Will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1 and Q2 is 3) or control of confounders was not described (Q1 is 3 and Q2 is 4).

D: BLINDING

Strong: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); and the study participants are not aware of the research question (Q2 is 2).

Moderate: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **or** the study participants are not aware of the research question (Q2 is 2); **or** blinding is not described (Q1 is 3 and Q2 is 3).

Weak: The outcome assessor is aware of the intervention status of participants (Q1 is 1); and the study participants are aware of the research question (Q2 is 1).

E: DATA COLLECTION METHODS

Strong: The data collection tools have been shown to be valid (Q1 is 1); and the data collection tools have been shown to be reliable (Q2 is 1).

Moderate: The data collection tools have been shown to be valid (Q1 is 1); and the data collection tools have not been shown to be reliable (Q2 is 2) or reliability is not described (Q2 is 3).

Weak: The data collection tools have not been shown to be valid (Q1 is 2) or both reliability and validity are not described (Q1 is 3 and Q2 is 3).

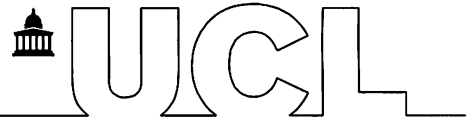
F: WITHDRAWALS AND DROP-OUTS

Strong: Will be assigned when the follow-up rate is 80% or greater (Q2 is 1).

Moderate: Will be assigned when the follow-up rate is 60 – 79% (Q2 is 2 or Q2 is 5 (N/A)).

Weak: Will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q2 is 4).

Appendix B:
Ethical Approval from the UCL Research Ethics Committee



Professor Nancy Pistrang
Research Department of Clinical, Educational and Health Psychology
UCL

16 September 2011

Dear Professor Pistrang

Notification of Ethical Approval

Ethics Application: 3260/001: "Don't suffer alone – just pick up the phone": evaluation of no panic telephone recovery groups

I am pleased to confirm that your study has been approved by the UCL Research Ethics Committee for the duration of the project i.e. until September 2013.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: <http://www.grad.ucl.ac.uk/ethics/> and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events

For non-serious adverse events you will need to inform Helen Dougal, Ethics Committee Administrator (ethics@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes for the research.

Yours sincerely



Sir John Birch
Chair of the UCL Research Ethics Committee

Cc: Anna Coughtrey

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Appendix C:
Participant Information Sheet



Anna Coughtrey, Trainee Clinical Psychologist
Dr. Nancy Pistrang, Reader in Clinical Psychology
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“Don’t Suffer Alone, Just Pick Up the Phone”: Evaluation of No Panic Telephone Recovery Groups

Information Sheet for Participants

We would like to invite you to participate in this research study. You should only participate if you want to. Before you decide whether you want to take part, it is important for you to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is this study about?

We would like to find out about people’s experiences of the No Panic telephone recovery groups. We are interested in hearing from both people who take part in the recovery groups and those that chose not to. In particular, this study will look at what is helpful or unhelpful in reducing symptoms of anxiety and improving psychological wellbeing. We hope that this research will help us better understand how best to support people with anxiety disorders.

Who can take part?

We are asking anyone who has signed up to take part in one of the No Panic telephone recovery groups to participate in this study. We are also asking No Panic members who did not complete the full course so that we can compare the experiences of those who took part in a recovery group with those who did not.

What does taking part involve?

If you decide to participate in this study, you will be given a copy of this information sheet to keep and you will be asked to sign a consent form. We would like to invite you to take part in a telephone interview. This will take up to 60 minutes to complete and can be arranged at a time which is convenient for you. We will ask you some questions about your experiences of the group and what you found helpful and unhelpful. We are also interested in hearing from people who did not complete all of the sessions. With your permission, we will audio-record the interview so that we do not miss anything important that you say.

Choosing to take part in this study will not influence the support you receive from No Panic in any way, and you will be able to join or leave the telephone recovery groups at any time, just like you would if you were not taking part in this study.

What are the risks and benefits of taking part?

Although it is unlikely, it is possible that you will find it upsetting to talk about your anxiety and your experience of the recovery groups. Should this occur, you can take a break, or stop the interview at any time. You will not have to answer any questions you do not feel comfortable answering.

You may find talking about your experiences interesting and helpful, giving you the chance to reflect on your experiences of the course. We also hope that the information we learn from the study will be of interest to you, as well as benefiting other people who are in a similar position to you.

Confidentiality and anonymity

The interview will be confidential and the data will be collected and stored in accordance with the Data Protection Act 1998. Electronic data will be encrypted and password protected. The audio-recordings will be transcribed and all identifying information will be removed from the interview transcripts. Any reports or publications resulting from the study will not reveal your identity and any quotations we use will be anonymous.

What will happen to the results of the study?

The results of the study will be written up as part of the researcher's Doctorate in Clinical Psychology at University College London and may also be submitted for publication in a scientific journal. A summary of the results will be sent to everyone who participated in the study. It is hoped that the findings of this study will contribute towards an understanding of how best to support people with anxiety disorders and reduce their symptoms and improve their quality of life.

What do I do now?

If you would like to take part in this study or if you have any questions, please contact Anna Coughtrey by telephone (07736 282349) or by email (anna.coughtrey.10@ucl.ac.uk).

For your information

You do not have to take part in this study if you do not want to. If you decide to take part, you are still free to withdraw at any time without giving a reason, and this will not affect the support you receive from No Panic.

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 3260/001

Appendix D:
Consent Form

“Don’t Suffer Alone, Just Pick Up the Phone”: Evaluation of No Panic Telephone Recovery Groups

Informed Consent Form for Participants

Thank you for considering taking part in this study. Please complete this form after you have read the Information Sheet and listened to an explanation of the study. If you have any questions arising from the Information Sheet or the explanation given, then please ask the researcher before deciding whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

Participant’s Statement

I agree that:

- The research study named above has been explained to me to my satisfaction and I agree to take part in the study.
- I have read the notes written above and the Information Sheet and understand what the study involves.
- I understand that my interviews will be audio-recorded and I am aware of, and consent to, the use of the recordings for the purposes of the study.
- I am aware that the information that I submit may be published as a report and I will be sent a summary report.
- Confidentiality and anonymity will be maintained at all times and it will not be possible to identify me from any publications.
- I understand that I am free to withdraw from the study at any time without giving a reason, and that this will not affect the support I receive from No Panic.
- I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

**I confirm that I agree with the above points and consent to take part in this study:
YES/NO**

Date:

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 3260/001

Appendix E:
Invitation Letter

Dear X,

We are writing to you because we would like to find out about people's experiences of the No Panic Telephone Recovery Groups. We are currently evaluating the groups with University College London in order to improve the service that we deliver. We are interested in hearing your views, even if you chose not to take part in a group. We hope that this research will help us better understand how best to support people with anxiety disorders.

We would like to invite you to take part in a telephone interview. This will take up to 45 minutes to complete and can be arranged at a time which is convenient for you. We will ask you some questions about your experiences of the group and what you found helpful and unhelpful. We are also interested in hearing from people who did not complete all of the sessions. With your permission, we will audio-record the interview so that we do not miss anything important that you say.

We have enclosed an information sheet with further information about the study. We would be grateful if you could return the attached reply slip to indicate whether you would be interested in taking part in this research and return it in the stamped addressed envelope. If you are willing to take part in the study please also return the enclosed consent form. If you have any questions please contact Anna Coughtrey by telephone (07736 282349) or by email (anna.coughtrey.10@ucl.ac.uk).

Many thanks,

Anna Coughtrey and Joanne Garvey

Reply Slip

NAME: _____

Please tick one of the following options:

I do not wish to take part in an interview about the No Panic Telephone Recovery Groups

I am willing to take part in an interview about the No Panic Telephone Recovery Groups

If you are interested in taking part in the study, please complete the following information:

Contact telephone number: _____

Email: _____

Preferred time to call: _____

Appendix F:
Semi-Structured Interview Schedule

Semi-Structured Interview Schedule

Introduction

I'm going to ask you a few questions about your experience of taking part in a No Panic Telephone Recovery Group. The interview should take no longer than 45 minutes, but please tell me if you would like to take a break or stop altogether. If you don't want to answer any of the questions, let me know and we can go on to the next one. Are you happy to continue?

Topics to cover

Background/Overview

- **Overall, what was the telephone recovery group like for you?**
 - Prompts:
 - How was it similar or different to previous help you have had?
 - How long ago did your group finish?
 - How often did you attend?
 - How are you doing now, in general?
- **What led you to join a telephone recovery group?**
 - Prompts:
 - Whose idea was it?
 - How did you find out about the telephone recovery groups?
 - What did you think the groups would involve?
 - What were your thoughts about whether they would be helpful for you?
 - What made you decide to do it now?

Mode of Delivery

- **What was it like taking part in a group over the telephone?**
 - Prompts:
 - What did/didn't you like?
 - What was more/less helpful?
 - How could it be improved?
 - How do you think it compares to face-to-face?

Group Aspect

- **What was it like being part of a group?**
 - Prompts:
 - What did/didn't you like?
 - What was/wasn't helpful?

- How could it be improved?
- How did you feel about the other group members?
- What was it like having conversations as a group?
- How did you decide what to talk about/work on?
- What was it like hearing other people's experiences?
- How much opportunity did you get to talk about your experiences?
- How did people react to that?

Facilitator

- **What was your facilitator like?**

- Prompts:

- What was their role?
- How helpful/unhelpful did you find them?
- How much did they talk about their own experiences? How helpful/unhelpful did you find this?
- Do you feel that you have learnt anything from working with [facilitator]?
- How similar/different were they to other professionals?
- What qualities do you think are important in a good facilitator?
- Did you agree/disagree with what [facilitator] said? What was this like?

Changes

- **What changes, if any, have you noticed in yourself since being in the telephone recovery group?**

- Prompts:

- Are you doing, feeling, or thinking differently from the way you did before?
- Has anything changed for the better/worse?
- When did that change occur?
- Is it what you expected?
- How important were the changes?
- In general, what do you think caused the changes? (including things outside of the group).
- Who noticed?
- Is there anything you wanted to change that hasn't?
- Has the recovery group changed how you view yourself/ your anxiety problems?

Helpful and Unhelpful Aspects of the Telephone Recovery Group

- **What did you find most helpful about the telephone recovery group?**
 - Prompts:
 - What was it about X that was helpful?
 - How did you know it had been helpful?
 - Any specific things that were taught or that happened, which were most helpful?
 - Any specific session that was most helpful?
 - Anything that was difficult/painful but helpful?
 - What was the most helpful thing that the group taught you? Are you still using any of the ideas now?
 - Was anything missing?

- **What did you find least helpful or unhelpful about the telephone recovery group?**
 - Prompts:
 - What was it about X that made it less helpful/unhelpful?
 - How did you know it had been less helpful/unhelpful?
 - Any specific things that were taught or that happened which were less helpful/unhelpful?
 - Any specific sessions that was less helpful/unhelpful?
 - What was the biggest problem/difficulty/challenge?
 - What made it difficult to do things differently?
 - Was there anything that you hoped would be helpful, but wasn't? Do you have any ideas why things didn't work out?
 - What would have made it more helpful?

For participants who left the group/attended sporadically:

Continuing/Leaving the Group

- **How did you decide whether or not to continue with the group?**
 - Prompts:
 - What influenced your decision?
 - Were there any times when you thought about leaving the group?
 - Were there any moments that you saw as a 'turning point'?
 - How certain were you?

- Were there any specific sessions/practical considerations/something another group member or facilitator said or did that influenced your decision?
- Was there anything that could have made it easier for you to continue?

Closing the Interview

- **Is there anything you would change about the recovery group?**
- **Would you recommend the groups to a friend? What would you say to them?**
- **Is there anything else you'd like to add?**

We've now come to the end of the interview. Thank you for taking the time to answer my questions. I have just a few more things to ask you:

- Would you like a summary of general findings at the end of the study?
- What would be the best way to send that to you?
- Are there any important questions that you think we missed out?
- Would you like to ask any questions or make any comments now that the interview is over?
- If you think of any questions then please get in touch using the details on the consent form.

Probes to follow-up questions:

- What was that like?
- How did that work?
- Had you thought of doing that before?
- Had you talked about these things before?
- How did you experience that?
- Did it make any difference?
- What was the impact on you?
- Were you expecting that to happen?
- What did that mean for you?
- What influenced your decision?

Appendix G:
Example of Developing Initial Codes

Excerpt from Transcript of Interview 14

Interviewer (I): What was it like being part of a group?

Participant 14 (P): Um it was really good, I liked that. We all supported each other...I always wondered how people had got on during the week, so that was good. Um, yeah, there were a few characters who I just didn't really connect with, but that was fine, that's normal I think. Yeah it was good.

I: Mm ok, so you liked being in a group and supporting each other...could you say a bit more about that?

P: Err really supportive and keen to find out how they were getting on and always looking forward to hearing how they'd been...some of the stuff that was helpful was that I felt that I got quite a lot of reassurance, that I would get through it and I wouldn't always feel like this, um and I needed that. I kind of connected with one person from each group and I've kept in touch with them, so it's nice to make friends, and I always looked forward to hearing how they were. I liked the...sharing of stories and sharing of where we were at and just being interested in everyone's lives, I found that really good. The continued support that I wasn't alone and that other people were suffering, um I found that useful too.

I: Ok, so you liked being able to connect with the group and form friendships and you found that supportive?

P: Yeah but then in both groups there were one or two people who were just like 'oh god.'

I: Yeah, could you tell me a bit about what that was like?

P: Yeah they might have been there for different reasons...the wrong reasons I think. In the first group there was someone there because they were lonely and I'm not sure that anxiety was really the point of why they were there, and they were talking about lots of things that were nothing to do with anxiety. They couldn't connect with the rest of the group, and you would say something and then it would just be back to them. They just wanted it to be all about them.

Initial Annotations

*Liked the group format
Supporting each other
Didn't connect with everyone*

*Feeling supported
(?and being supportive)
Reassurance
Making connections and forming friendships, sharing stories
Not alone, ?reduced isolation?*

One or two difficult characters?

People there for the wrong reasons, talking about things not relevant to anxiety, difficulties connecting

Initial Codes

*Supporting each other
Connecting with others
Difficult characters*

*Feeling supported
Reassurance
Connecting with others
Making friends
Sharing stories
Not alone*

Difficult characters

*Difficulties connecting
Talking about nothing to do with anxiety
People wanted it to be all about them*

Appendix H:
Coding Index

Coding Index

Note: The coding index was developed inductively from the interview transcripts. The codes and sub-codes are shown below.

1. Feeling Supported

- 1.1. An hour of hope and reassurance
- 1.2. Feeling understood
- 1.3. Sharing experiences
- 1.4. Talking openly
- 1.5. Not the only one
- 1.6. Less isolated

2. Connecting with Others

- 2.1. Getting to know group members
- 2.2. Getting to know the group leader
- 2.3. Making friends
- 2.4. Forming connections
- 2.5. Absence of body language
- 2.6. Disruptions and distractions
- 2.7. Groups fizzling out
- 2.8. Losing contact

3. Comparisons with Others

- 3.1. There's often someone worse
- 3.2. Seeing someone a few steps ahead.
- 3.3. Motivation
- 3.4. Inspiration
- 3.5. Perspective

4. Leader is a fellow sufferer

- 4.1. Leader understood
- 4.2. Leader insight
- 4.3. Others don't understand
- 4.4. Leader talked too much

5. Understanding anxiety

- 5.1. Provided information
- 5.2. Not going mad
- 5.3. Anxiety less frightening

6. View of recovery

- 6.1. Recovery takes time
- 6.2. Recovery is a process
- 6.3. Need for further support

- 6.4. Need one-to-one
- 6.5. Recognising the problem

7. Developing a toolkit

- 7.1. Tips and strategies
- 7.2. Managing symptoms
- 7.3. Making changes
- 7.4. Easier said than done
- 7.5. Less reliance on others

8. Expectations

- 8.1. What is a recovery group?
- 8.2. Purpose of group
- 8.3. Miracle cure
- 8.4. Structure
- 8.5. Goals

9. Everyone has different needs

- 9.1. Specificity
- 9.2. Relevance
- 9.3. Vetting people
- 9.4. Different stages of recovery
- 9.5. Mix of the group

10. Airtime

- 10.1. Getting own views across
- 10.2. Wanting more time to talk
- 10.3. One person monopolising the time
- 10.4. Time-keeping
- 10.5. Keeping on track
- 10.6. Reliance on the leader

Appendix I:
Example of Chart Entries

Note: This is an excerpt from a chart developed in the fifth stage of analysis, based on the coding index. This chart is for Code 10 (“Airtime”) and it’s six constituent subcodes.

<i>Code 10: Airtime</i>						
Participant number	10.1. Getting own views across	10.2. Wanting more time to talk	10.3. One person monopolising the time	10.4. Time-keeping	10.5. Keeping on track	10.6. Reliance on the leader
1	Hard because everyone wanted to talk (p.2, 3)	Wanted to focus more on own symptoms but ran out of time (p.3, 9, 11)	Some people needed more attention (p.1) and took up a lot of time (p.2, 9)	People took up too much time so always running out of time (p.3)	Leader tried to stick to weekly topics and kept people on-subject (p.2-3, 5, 9)	Leader divided up the time (p.2)
2	Someone demanded attention which meant couldn’t focus on own problems (p.1)	Not much time each week, only 60 minutes (p.4)	Someone demanded attention (p.1) Someone talking endlessly (p.5-7)			Leader went round and asked each person in turn (p.4)
3 (etc.)						

Appendix J:

Example of Table of Final Themes

Note: This is an excerpt from a table developed in the final stages of data analysis summarising the relevant information for one subtheme (“Getting own views across”) of Theme 3.2. “Airtime”.

Domain 3: Barriers and Challenges

Theme 3.2. Airtime

Subtheme: Getting own views across

Participant number	Location in transcript (page and line numbers)	Example quotations
P1	p2.,44-45 p3.,2-3 p3., 23-26	<i>“It was hard because some people just needed so much time, so, err, it was sometimes hard to get my views across.” (p3.,2-3)</i>
P2	p8.,4-8	<i>“There were up to eight people in the group and the sessions only last for sixty minutes so you don’t get much airtime...um, I can’t do the maths but obviously it’s not very many minutes each...um, and especially when it’s all new information and you want to really get to grips with it.” (p8.,4-8)</i>
P3	p2.,1-2 p5.,39-42	<i>“So you get out of it, like, five or ten minutes of whatever the common wisdom was and then you’d probably get, you know, your five or ten minutes of your own.” (p2., 1-2)</i>
P5	p3.,1-2 p3.,14-16 p4.,34	<i>“I wanted to talk. And sometimes it was annoying because I didn’t get very much time to talk.” (p3.,14-16). “You couldn’t get a word in edgeways. You didn’t get much of a chance to talk at all.” (p4.,34)</i>
P8	p1.,16-17	<i>“Yeah by the time it had come round to us saying what we wanted to say it was um...time for you know the group to finish. It was really frustrating.” (p1.,16-17)</i>
P14	p3.,30-31 p3.,38	<i>“So it felt um, it was hard to be seen on the phone. It had to be quite, um, clumsy, just to get in.” (p3.,30-31) “It was just quite hard to find your voice, or make your voice be heard.” (p3.,38)</i>
P15 (etc)		

Appendix K:
Example of Respondent Validation Summary

Dear X,

You recently took part in a research interview about your experiences of the No Panic telephone recovery groups. Thank you very much for taking the time to talk to me about your experiences.

Enclosed is a summary of what I think were the main themes of your interview. I would like to invite you to provide feedback on this summary, including its accuracy and the extent to which it captures the things that were important to you about the recovery groups. Please feel free to comment on any aspect of the summary, to point out anything I may have missed and to add any additional points that you have thought of since we spoke.

You do not have to provide any feedback if you do not want to. If you would like to, please write your comments on the feedback sheet enclosed and return it in the envelope provided. Alternatively, you can email me at anna.coughtrey.10@ucl.ac.uk, telephone me on 07736 282349 or call the No Panic office on 01952 680460.

Thank you very much again for kindly contributing to our research.

Yours sincerely,

Anna Coughtrey
Lead Researcher

Joanne Garvey
Chief Executive Officer

1. How accurate do you think the summary of your interview is? (Please circle)

Extremely Mostly Somewhat A little Not at all

2. To what extent does the summary capture the things that were important to you about the No Panic telephone recovery groups? (Please circle)

Extremely Mostly Somewhat A little Not at all

3. Is there anything missing from the summary that you think is important?

4. Have you thought of anything else since the interview that you would like to add?

5. Any other comments?

Note. This is the summary sent to Participant 3.

Summary of themes from your interview

1. Connecting with others

- You described how you had a lot in common with one group member and she was very encouraging to you. You hoped to establish a one-to-one link with her after the group but this wasn't possible.
- You explained that the advantage of being in a group was being able to learn from other people's experiences.
- Although you had a connection with two or three group members, the group did not always feel 'coherent.' In particular there was one person who 'mopped up a lot of time.'

2. Dialogues between the facilitator and the group

- In general, you did not have many conversations as a group. Instead, the facilitator would give a small amount of 'textbook guidance' and then the rest of the time would usually consist of 'a series of one-to-one's' between the facilitator and the group members.
- Sometimes you thought that these conversations 'dragged on' and were not always relevant and it felt like time was being wasted.
- You explained that compared to face-to-face groups, it is harder to 'step in' and start a group conversation over the telephone.

3. Distractions

- You spoke about some distractions and disruptions to the group. These were occasionally caused by technical glitches on the phone. Also sometimes people couldn't hear so things had to be repeated. You also described how there was sometimes a background deep breathing sound which was distracting.

4. Different people need different things

- We talked about how different people need things at different times and it can be difficult to put a group together.
- You explained how in the early stages people need a lot of reassurance about their symptoms but that it's not always helpful to hear people moaning about their symptoms.
- In the later stages it can be helpful to see someone a few steps ahead of you because it is 'reassuring to see someone who got to the hell of it and survived.'

5. Relief and reassurance

- You explained that when you were feeling anxious you would look forward to the group sessions because you hoped to get some sort of relief or reassurance.
- Your group leader was reassuring. He was always very positive and you thought he believed in the approach.

- You described the groups as ‘an hour where there is hope and reassurance’.

6. Feeling understood

- It was important to you that the group leader had personal experience of anxiety. You explained that you thought this meant he understood what you had been through. It also gave you hope that you could get better.

7. Evidence of success

- We talked about how it is always helpful to hear about techniques that other people have found useful.
- You explained that although you had heard about some of the techniques before (like the breathing, relaxation and changing thinking patterns), it’s always useful to hear it again, especially from someone who has recovered because you’re ‘trying to have faith in those techniques.’
- You said it might have been helpful to hear some ‘success stories’ from people who have completed recovery groups in the past.

8. Process of Recovery

- When you first joined the groups you were very hopeful that you would ‘get out of the nightmare.’
- You explained that as the group went on you realised that it takes time to learn new things.
- You said that you saw the group as giving you a guide to recovery, but recovery is a process and takes time; there is no ‘quick-fix.’
- We talked about how recovery can be hard and takes a lot of ‘guts, courage and self-belief.’
- It was sometimes hard to put things into practice, particularly tackling negative thinking. You said ‘the concept is simple, the doing is difficult.’ It might have been helpful to have more discussions about how to address the issues of thinking.
- For you, realising that ‘the only way out is through’ was the first step in getting better.

9. Improvements

- You explained that you don’t get into ‘a frenzy’ with anxiety any more and you have been able to face your fears.
- We talked about how your group leader gave you a lot of encouragement and helped you realise that ‘however uncomfortable it is, I can do what I set out to do.’
- You said that your partner has also noticed an improvement.
- Although you have been able to face your fears, you still suffer from a lot of the symptoms of anxiety.