Linking professional and self-help resources for anxiety management: a community project

CLIVE G. LONG, BA, MSc
Principal Psychologist, Coventry District Health Authority

VICTORIA BOURNE, BA
Assistant Officer in Charge, Kingston Lane Hostel, Teddington

SUMMARY. The first two years of an anxiety management project involving close liaison between general practitioners, clinical psychologists and a self-help group is described. The apparent benefits of this programme to clients in terms of prompt delivery of service and symptom and medication reduction are discussed. In the light of this a model that combines the benefits of the self-help movement with an appropriate level of professional support is advocated as a viable referral option for the large number of patients with anxiety related problems that present to general practitioners.

Introduction

THE majority of psychological problems for which people seek help are dealt with at the primary care level by the general practitioner.[1] In a recent survey general practitioners felt that 28% of their consultations involved patients with psychological problems and that 19% of consulting patients warranted treatment for these problems.[2] The survey also found that clinical psychologists were seen by general practitioners as essentially offering a therapeutic service for anxiety related problems. However, 70% of doctors were dissatisfied with existing services because of the long delays between referral and appointment, and this is at a time when widespread concern about benzodiazepine dependence[3] has placed general practitioners under increased pressure to provide non-drug interventions for anxiety related problems.

One possible solution to this dilemma is the employment of clinical psychologists in general practice to run anxiety management courses.[4] However, this may not represent the optimum use of a psychologist's time.[5]

An alternative solution is referral to one of the many self-help groups which have developed since the 1960s in response to disillusionment with existing services and the decline of supportive social institutions.[6] Successive governments have encouraged self-help groups as part of a wider policy towards community care.[7] Self-help groups have been praised for providing a safe meeting place for members to express their concerns[8] and for facilitating the development of new coping methods and successful patterns of living.[9]

Nonetheless the predominantly positive response to the self-help movement has been qualified by reservations regarding its ability to deal autonomously with certain problem areas and many have argued a case for increased accountability and professional monitoring in order to safeguard against organizations who fail to fulfil their stated objectives or to meet members' needs. The fact that self-help groups are free to exercise an arbitrary set of controls means that extreme group pressure can result in ostracism or rejection[10] and there is a danger of groups becoming too cliquish, inward looking or dominated by one particular individual.[11] Landau-North[12] sees the risk of certain conditions being wrongly treated or left unattended as one of the many justifications for bringing self-help groups into a planned system of care. Other benefits of professional involvement include programmed treatment, advice, resources and referrals.

This paper describes the results of an ongoing experiment in collaboration between primary care professionals and a self-help group for anxious/agoraphobic clients. The experiment involved the use of an anxiety management course with small groups of anxious patients.

Method

The project

In 1984 the Coventry District Psychology Department was approached by a local self-help group for agoraphobics who wished to extend the help offered to its clients. Following this initiative work was begun on a new multi-purpose care centre funded by a Manpower Services Commission grant and housed in church premises. Its activities were to include services for the local elderly, weight and smoking reduction groups and an advice centre dealing with welfare, legal and consumer problems. Its major aim, however, was to provide therapeutic services for those with anxiety-related problems, thus combining the best aspects of the self-help philosophy with professional support and guidance.

This model for therapeutic services had two essential features: the willingness of a self-help group to allow non-sufferers to work with them and the idea that therapy would be conducted with the knowledge and approval of the client's general practitioner. While wishing to adhere to many of the ideological standpoints of the self-help movement professional input was seen by the psychology department as essential for the selection and training of staff and for the monitoring of progress.

Two project leaders worked closely with the leader of the agoraphobic self-help group. In addition to fulfilling Manpower Services Commission requirements for employment the project leaders had to have a relevant first degree, an interest or career ambitions in the health or social services and relevant work experience.

The project leaders were trained in the running of an anxiety management (coping skills) group by the district psychology department. Some training in interviewing/assessing potential candidates for an anxiety management course was also given but in order to help ensure appropriate selection all local general practitioners were circulated with detailed descriptions of the group courses and the type of patient who would be suitable. All self referred patients were given a detailed description of the course and a consent form to take to their general practitioner, thus providing a check on help being inappropriately offered to clients by workers with limited clinical experience. This also served to extend the support network of the staff at the centre.

The anxiety management course

All clients joined a group of up to eight members. The anxiety management course (developed by C.G.L.) consisted of eight one

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and a half hour sessions held over eight weeks. The course emphasized self-control procedures and provided information about anxiety, goal setting and self reinforcement, progressive muscle relaxation and meditation techniques, cognitive restructuring and personal problem solving skills. Homework assignments involving self monitoring and the practice and implementation of these skills were set. Each session was carefully structured to include homework review, didactic presentation and group discussion elements.

While individual responsibility for progress was emphasized during the session, mutual support from group members was encouraged after the session had ended. Care centre premises were made available for those individuals who wished to continue to meet for exposure work related to their goals. Others opted for the more supportive environment of the original self-help group.

Follow up sessions were held one month, three months and six months after the original course.

Evaluation

The value of the anxiety management course was assessed by the following methods:

1. A service evaluation questionnaire completed by the clients after the course to assess their satisfaction.

2. Relevant self-report symptom questionnaires completed by the clients before and after the course and at the six months follow up: the general health questionnaire,[13] the self rating depression scale,[14] the self rating anxiety scale,[15] and a symptom questionnaire[16] that measures somatic (for example, hyperventilation), behavioural (for example, social avoidance), and cognitive (for example, worrying) aspects of anxiety.

3. Semi-structured interview with the clients at the six months follow up to assess individual progress in terms of use of medication and visits to the general practitioner.

4. Postal questionnaire sent to the referring agents 18 months after the start of the project to assess their satisfaction with the course.

Results

Over the first 18 months of the project 143 clients were referred to the centre. Over half of the clients (54%) were referred by general practitioners, 21% were referred by psychiatrists, 5% by the social services, 4% by self-help groups and 16% were self referred. The average age of the clients was 42 years with a range of 20–65 years; 86% were women and 14% men (sex ratio 6:1).

Of these 143 clients 106 (74%) completed an anxiety management group course. Of the 143 clients 73% were taking benzodiazepine drugs and 14% antidepressant medication; only 13% were not taking any medication.

Client satisfaction

The response of the clients to an eight item service evaluation questionnaire was uniformly favourable — 64% of the 106 clients responding were very satisfied with the service they received at the centre and 32% were mostly satisfied. The majority (80%) felt that the course had helped them to deal more effectively with their problems while 78% felt that the course had met most or almost all of their needs and 86% stated that they would return to the centre if they needed help again in the future. Of the sample 22% felt that only a few of their needs had been met, perhaps illustrating the number of problems and chronic nature of some of the difficulties experienced by this group. Thirty five clients (33%) would have appreciated a longer course and a minority (12%) expressed disappointment at the lack of immediate change or a cure.

Most clients (86%) had heard about the centre via their general practitioner but only 5% would have wished to have attended a National Health Service hospital outpatient department for their treatment. Clients listed the main advantages of this type of help as the informality, the friendly atmosphere and the chance to meet others with similar problems.

Questionnaire measures

Table 1 shows that there was an overall reduction in self-reported symptomatology for clients after the anxiety management course and again at the six months follow up. This overall positive trend encompassed both the more modest numbers of those who made a clinically significant improvement and those who derived no benefit from treatment. Thus, for example, while 20% of the sample had made a clinically significant improvement six months after the course as judged by the symptom questionnaire, 23% showed no change in self-reported anxiety symptomatology. Further, of the 20% of the sample classified as depressed by the self rating depression scale before the course, only half had scores within the normal range at follow up.

Follow up interview

Eighty-two of the 106 clients (77%) attended the follow up interview six months after the course. Although those returning would be more likely to be the most satisfied and the better adjusted clients a change in the clients' use of medication was evident. None of the 82 clients had increased their use of medication — one third had stopped taking medication completely with the help of their general practitioner and a further 23% had reduced their dosage by 50% on their own initiative. Further, there had been a marked change in the frequency of appointments with general practitioners — 56% of the 82 clients visited every three months after the course compared with 36% before the course, 17% visited every month compared with 27% and only 5% each week compared with 9%. Thirty two per cent of these clients visited their doctor three times a year or less after the course compared with 22% before the course.

Referring agent evaluation

All 42 medical practitioners who had referred clients to the centre were sent a brief evaluative questionnaire. There were 21 replies, 15 from general practitioners and six from consultant psychiatrists (50% response rate). Of the medical practitioners who replied 80% felt that the course had been of help in reducing their patient's anxiety symptoms and had aided their attempts to reduce tranquillizing medication. A similar percentage felt that patients they had referred had contacted them less frequently following group therapy. All the practitioners were prepared to consider sending their patients to the centre.

Table 1. Mean scores on the four questionnaires before and after the anxiety management course and at the six months follow up.

Questionnaire	Before course (*n* = 143)	After course (*n* = 106)	Six months follow-up (*n* = 82)
General health questionnaire	15.5	13.0	11.8
Self rating depression scale	43.7	40.6	36.6
Self rating anxiety scale	47.9	43.7	39.1
Symptoms questionnaire			
Somatic	2.3	1.9	1.6
Behavioural	3.5	3.0	2.5
Cognitive	4.0	3.4	3.0

Thirteen doctors made comments on how the service could be improved: first through greater liaison — feedback to the doctor, timetables announcing new groups, more detailed guidelines on the sort of patients who would benefit — and secondly through expanding the service offered — more sessions for clients, more individual counselling, more centres.

Discussion

This report describes a successful fusion of professional and self-help initiatives for agoraphobic and anxious clients. The project has enabled patients to be referred between the two systems of care in a way that capitalizes on the lessons learnt from personal experience of the problem and recent treatment developments. For the clinical psychologist it would seem that time devoted in this way to the training and monitoring of well selected personnel is an efficient means of providing more immediate help to large numbers of anxious patients.

The effectiveness of the intervention reported here must be viewed against the selected nature of the sample and the pattern of crisis and remission that characterizes the natural history of most psychological disorders.[17] Furthermore as Freeman and Button[17] point out, it is difficult to interpret reductions in consulting and prescribing rates after referral for psychological help unless contemporary trends for different group practices are known. However, given the apparent improvement of a number of patients across different measures (self-reported symptom reduction, fewer medical consultations, less use of tranquillizing medication) and their reported satisfaction with the help received, it would seem that such a model provides a viable alternative referral option for general practitioners faced with the long waiting lists of local departments of clinical psychology. The fact that a minority are not helped by therapy is perhaps a reflection of the chronicity of some cases and indicative of the need for more careful selection of patients for interventions of this type.

Finally, it is apparent that there are many ways in which self-help groups can extend and improve their range of activities without inappropriate domination by professional advisers. Robinson,[18] reviewing the benefits of self-help programmes, states that rather than being seen as stop-gap services they should be the mainstream of any maintenance programme. However, an historical look at the self-help movement serves to emphasize the transient nature of many self-help groups and the fact that self-help as an ideal form (with democratic participation by all members) is difficult to maintain.[19] Self-help groups that focus on change to the self (like those for agoraphobia) require great commitment by members to the group and its aims if change is to be effected and maintained and if local initiatives are to flourish.[20] Groups that depend for their maintenance on the charisma and commitment of a few individuals must evolve or fade away. One way forward is to develop management committees and seek professional advice and support in order to demonstrate improved organization to potential funders.

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Address for correspondence

C.G. Long, Principal Clinical Psychologist, Walsgrave Hospital, Clifford Bridge Road, Coventry CV2 2DX.

Stroke and alcohol consumption

A retrospective case–control study was conducted to investigate a possible association between alcohol intake and stroke. Recent alcohol consumption (reported) and biochemical and haematologic markers of alcohol intake were studied for 230 patients with stroke (20 to 70 years old) and compared with data on controls matched for age, sex and race. A single estimate of current intake was used as a measure of alcohol consumption.

Among men, the relative risk of stroke (adjusted for hypertension, cigarette smoking and medication) was lower in light drinkers (those consuming 10 to 90 g of alcohol weekly) than in non-drinkers (relative risk 0.5), but was four times higher in heavy drinkers (consuming >300 g weekly) than in non-drinkers. Because very few women in the study drank heavily, it was not possible to determine whether heavy alcohol intake influenced the risk of stroke in women. With increasing serum concentrations of the biochemical markers of alcohol intake (aspartate aminotransferase, uric acid and gamma-glutamyl transferase), similar trends were observed in the relative risk of stroke. Only the erythrocyte mean cell volume did not follow this pattern.

The authors conclude that heavy alcohol consumption is an important and underrecognized independent risk factor for stroke in men, but the data are not adequate to settle the issue for women.

Source: Gill JS, Zezulka AV, Shipley MJ, *et al.* Stroke and alcohol consumption. *N Engl J Med* 1986; **315:** 1041-1046.