Running head: EFFECTIVENESS OF GROUP COGNITIVE BEHAVIOURAL INTERVENTION

EFFECTIVENESS OF GROUP COGNITIVE BEHAVIOURAL INTERVENTION IN REDUCING ANXIETY IN IRISH PRISONERS: QUANTITATIVE AND QUALITATAIVE ANALYSIS

07149981

Small Scale Research Project

Doctoral in Clinical Psychology

Department of Psychology

Trinity College Dublin, Dublin

Table of Contents

Abstract

Anxiety disorders are among the most common problems for sentenced prisoners. Although anxiety management programmes have been conducted in Irish prisons, the effectiveness of these interventions in lessening prisoner anxiety has not been evaluated. To establish an evidence base, a pilot study assessed the effectiveness of four transdiagnostic GCBT anxiety management programmes in a sample of Irish prisoners. Quantitative data was collected by retrospective review of the medical files (medication details) and psychological records (pre- and post-intervention measures of anxiety, as measured by the Beck Anxiety Inventory) of twenty male programme participants (aged 23-71). A Wilcoxon-signed Ranked Test revealed a significant difference between pre- and post-intervention measures of anxiety ($z = -3.022$, $p > 0.05$, two tailed). Semi-structured interviews with eight male participants (aged 30-38) permitted an in-depth examination of prisoners' experiences of the programme. Thematic analysis of the data identified education and coping skills acquisition as the most valued aspects of the programme content, while breathing and muscle relaxation were the most frequently applied coping techniques outside of sessions. The lack of opportunity to discuss private issues and insufficient session time were stated drawbacks. When asked how the group could be improved, suggestions included incorporating a drama component and improving features of the treatment setting. This study suggests transdiagnostic GCBT anxiety management may play a valuable role in reducing prisoner anxiety. It also provides considerations for future programme planning.

Anxiety disorders describe a group of illnesses characterised by overwhelming anxieties and fears that are chronic and unremitting (Craske, 2003). They include panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD) and phobias. Anxiety disorders have a high frequency in the general population worldwide (Lepine, 2002), cause marked personal suffering and are associated with significant morbidity and mortality (Nash & Potokar, 2004).

Cognitive Behavioural Therapy (CBT) is the intervention most widely applied to treat anxiety disorders (Deacon & Abramowitz, 2004). CBT is a short-term, solution-focused therapy, which integrates behaviour modification and Cognitive Therapy. CBT is thus, based on the assumption that anxiety develops from (a) distorted beliefs involving an overestimation of threat and danger; and (b) behavioural avoidance of the feared stimuli (Zeyfert & Becker, 2007). Thus, CBT for anxiety aims to modify erroneous thoughts about anxiety and reduce behavioral avoidance. Therapeutic techniques commonly include, questioning and testing unhelpful assumptions or thoughts, gradually facing activities which may have been avoided and relaxation and distraction.

There is a wealth of research showing the efficacy of CBT as a one-on-one intervention for anxiety. Indeed, a recent review found that CBT was highly effective in treating GAD, panic disorder, social phobia and PTSD (Butler, Chapman, Forman & Beck, 2006). Additionally, the efficacy of CBT for anxiety as being at least as effective as alternative approaches to treatment, such as drug therapy or interpersonal therapy, is well established (Stanley, Beck & Glassco, 1996).

Although originally developed as an individual therapy, CBT has more recently been delivered via group-format. Research examining the effectiveness of group CBT (GCBT) has been largely disorder specific (Erickson, Janeck & Tallman, 2002). Such studies have indicated the efficacy of GCBT for GAD (Gould, Otto, Pollack & Yap, 1997), panic disorder (Petrocelli, 2002; Otto, Pollack, Penava, Zucker, 1999; Peneva, Otto, Maki & Pollack, 1998), social phobia (Stangier, Heidenreich, Peitz, Lauterbach & Clark, 2003; Otto, Pollack, Gould, Worthington, McArdle & Rosenbaum, 2000), OCD (Anderson & Rees, 2007) and PTSD (Beck,

Coffey, Foy, Keana & Blanchard, 2008). In addition, Petrocellie's (2002) GCBT meta-analytic study demonstrated the effectiveness of this approach in treating social phobia and panic. While certain comparative studies have found individual CBT more effective than GCBT for generalised anxiety and social phobia (Heimberg, Salzman, Holt & Blendell, 1993; Neron, Lacroix & Chaput, 1995), other research has reported equivalent outcomes for these approaches to these disorders (Gould et al, 1997; Shapiro, Sank, Shaffer & Donovan, 1982). While such conflicting findings and certain methodological weaknesses (e.g., a lack of control conditions, poor randomisation and small sample sizes) preclude conclusions been drawn from these studies, the knowledge base supporting the efficacy of GCBT for the various anxiety disorders appears encouraging.

Currently, authors are exploring GCBT treatments for anxiety that incorporate individuals with differing DSM-IV anxiety disorder diagnoses within the same treatment groups (Erickson, 2003). This approach derives from the hierarchical model of anxiety, which postulates that DSM-IV anxiety disorders are not distinct disorders, but represent multiple manifestations of the same negative affect pathology (Clark & Watson, 1991). In line with this theory, CBT is considered efficacious across all anxiety disorders as it is assumed to impact the core pathology underlying each of the diagnostic groups. Results of preliminary research for the efficacy of transdiagnostic treatments have been optimistic. For example, in an open trial of transdiagnostic anxiety treatment, Norton (2008) found dramatic reductions in anxiety at the conclusion of treatment. Importantly, these positive efficacy results have been replicated in several randomised controlled studies (Norton & Hope, 2005; Erickson, et al., 2002; McEvoy & Nathan, 2007) and a meta-analytic review of transdiagnostic anxiety treatments (Norton & Philipp, 2008). Of note, these results mostly derive from samples of patients in specialised mental health settings or are part of clinical research trials. Importantly, while these preliminary efficacy studies suffer from the common methodological problems often imposed by realities-lack of control groups, diagnostic uncertainties, inappropriate measures and confounding treatment variables-they consistently support the utility of GCBT in treating transdiagnostic groups.

In addition to the substantial empirical base that attests to the success of GCBT for anxiety, it is recognised that the group methods offer distinct advantages

over individual format. Certainly, the group format presents benefits from a clinical view point, such as potential time and cost savings per patient, opportunity to treat more people and reduce waiting lists (Morrison, 2001). Notably, the group setting also offers specific benefits to the patient. According to Yalom (1975), these relate to group cohesiveness, imitative behaviour, imparting of information, interpersonal learning and recognition of similarities in others. Indeed, similar themes have been found in several research studies (Jupe & Dudley, 1984; Powell, 1987; Campbell, Blake & Rankin, 1993). Finally, Morrison (2001) pointed out advantages that are specific to cognitive behavioural groups, including the opportunity to demonstrate the relationship between thoughts and feelings through the negative thoughts of group members and the opportunity for the clients to recognise the cognitive distortions of others, which then facilitates recognition and re-evaluation of their own cognitive style. Notably, although Morrison's assertions are not yet backed by research evidence, there is, nonetheless, some empirical support for the usefulness of group psychotherapy.

Importantly, there are also factors associated with group work that may be regarded as disadvantages. Hollon and Shaw (1979) have listed several of these, including the danger of one individual dominating the group, the risk of confrontation by group members, the development of subgroups, differential improvement rates dispiriting slower improvers, the susceptibility of the group to drift into 'small talk' and a difficulty arranging a time that suits all groups members, which may lead to a greater number of missed sessions. Additionally, Morrison (2001) noted that individuals may be reluctant to disclose disturbing cognitions in GCBT and subsequently fail to rigorously examine some of these more challenging cognitions. It is of note however, that the stated disadvantages are mainly anecdotal in nature (Hornsey, Dwyer & Oei, 2006) and the weight of empirical evidence is required before firm conclusions can be stated regarding these purported drawbacks.

The present study

A systematic survey of mental health in the Irish prison population revealed anxiety disorders are among the most common problems for sentenced prisoners (Kennedy, Monks, Curtin, Wright, Linehan, Duffy, Teljeur & Kelly, 2005). Prisoners are locked in confined spaces, separated from loved ones and surrounded by people

who are often unpredictable and violent (Islam-Zwart, Vik & Rawlins, 2007). Added to this is the trauma of the trial, sentencing and subsequent imprisonment (Islam-Zwart et al., 2007). All these factors have a deep impact on psychological layers resulting in high levels of anxiety and stress. The Irish Prison Service has responded to these mental health concerns by establishing a short-term group-based cognitive behavioural intervention to moderate prisoner anxiety. However, although four GCBT anxiety management programmes have been conducted in Irish prisons over a period of three years, no study has evaluated the overall effectiveness of these interventions.

Importantly, while transdiagnostic GCBT has demonstrated efficacy in clinical trials and specialised mental health settings, and group psychotherapy has been associated with a plethora of benefits, this may not reflect the results that would be obtained using equivalent methods in a forensic population. Indeed, the prison environment presents unique challenges to the delivery of effective GCBT. Elements of programmes such as content, activities, duration, location and number of participants may be limited by constraints of the prison environment and policies as well as the strong emphasis on prisoner security (Jeffries, Menghraj & Hairston, 2001). Thus, the empirical validation of the efficacy of transdiagnostic GCBT needs to be established in the prison setting. Furthermore, there is no information regarding what elements of the intervention are most effective and valuable to inform the continued development of these interventions.

The goals of this pilot study are twofold. The first goal is to evaluate the effectiveness of the four GCBT anxiety management programmes in reducing anxiety in Irish prisoners. Indeed, in this climate of evidence-based practice psychologists need to know that their interventions have research support. The second goal is to explore the participant's perspectives on the programme to inform future programme planning.

Methodology

Design

This was a two phased study comprising quantitative and qualitative techniques.

Phase 1: The first phase was a quantitative comparison of pre- and post-intervention measures of anxiety. Retrospective data from four previously implemented programmes was analysed. The independent variable was the data collection-point (pre-intervention and post-intervention) and the dependent variable was the difference between participants' pre- and post-measures of anxiety.

Phase 2: The second phase of the study involved a qualitative post-intervention evaluation of the programme. Semi-structured interviews were conducted face-to-face with participants who had completed the most recent CBT group. This technique was used to identify participants' views and experiences of the programme.

Study Population

Phase 1: The retrospective data was derived from the files of those prisoners who participated in the GCBT anxiety management programs conducted in Irish prisons between 2006 and 2008. While these individuals had presented with varying manifestations of anxiety, a specific anxiety disorder diagnosis had not been established (See Appendix 1 for details).

A total of 20 male prisoners agreed to their details being included in the study. The mean age of this group was 33.35 (SD: 9.76) and the age range was 23 to 71. 25% of participants were on medication (methadone) when completing the programme. In the case of five participants, medication details were not specified in the file. (See Appendix 2 for comprehensive profile description)

Phase 2: The eight prisoners who had completed the most recent GCBT anxiety management programme were invited to participate in the semi-structured interviews approximately one week after this programme had ended. This subgroup of participants ranged in age from 30 to 38, with a mean age of 34.5 (SD: 3.02). Two of the eight participants were on medication (methadone) when completing the programme. (See Appendix 3 for comprehensive profile description)

Materials

Phase 1: The data extracted from the prisoner database included age and crime. Medication details were obtained from medical files and pre-intervention and post-intervention anxiety scores, as assessed using the Beck Anxiety Inventory (BAI, Beck & Steer, 1990), were obtained from psychology files. (See Appendix 4 for copy of BAI)

Phase 2: A semi-structured interview guide was designed. The questions were based on the study objectives and previous related studies. (See Appendix 5 for interview schedule).

Procedure

At the outset, all methods and procedures were reviewed and approved by the Trinity Ethics Committee and Irish Prison Service Research Ethics Committee. (See Appendix 6 for Trinity Ethics Committee application form and approval letter and Appendix 7 for Irish Prison Service Research Application Form)

Phase 1: Psychology Department records of previous GCBT anxiety management programmes were reviewed. Prisoners who participated in the programmes were identified and sent an information sheet and consent form, which sought permission to use the individual's assessment scores and medication details in the research study. Those willing to participate signed the enclosed consent form and returned it to the Psychology Department for the attention of the researcher. 20 individuals permitted their details to be used and the necessary information was extracted from the relevant files. (See Appendix 8 for copy of information sheet and consent form)

Phase 2: The eight prisoners who participated in the most recent GCBT anxiety management programme were identified from the psychology files. Those individuals were sent an information sheet and consent form inviting them to participate in a face-to-face interview to discuss their experience of the programme. Interested parties were asked to sign the enclosed consent form and return it to the Psychology Department for the attention of the researcher. Those who consented to participate in the interviews were contacted within a week with a proposed date, time, and location for the interview. (See Appendix 9 for a copy of information sheet and consent form)

Data Analysis

Phase 1: Quantitative data was analyzed using the SPSS statistical package, Version 12 for Windows. The Wilcoxon-signed Ranked Test was used to examine differences in pre- and post-intervention measures of anxiety. This non-parametric test allowed for the small sample size and accommodated an irregular sampling distribution.

Phase 2: All interviews were tape-recorded. The researcher completed transcription of the interviews conducted. Transcribed data was analysed using thematic analysis. (See Appendix 10 for transcription)

GCBT Anxiety Management Programme

The GCBT anxiety management programs were facilitated in class-rooms in the Education Centre of the prisons. The programmes were delivered by clinical staff (Clinical and Counselling Psychologists and Psychologists in Clinical Training) in each prison. Participants attended one group orientation meeting and six to eight weekly 90-minute sessions.

The anxiety management programmes followed the 'Stress Control' treatment manual of White, (2000). 'Stress Control' advocates an hierarchical model of anxiety, where negative affectivity (NA) is conceptualised as an underlying factor common to all anxiety disorders. Thus 'Stress Control' targets this stable, common mechanism of NA and is deemed suitable to any individual with an identifiable anxiety disorder.

'Stress Control' is a didactic cognitive behavioural programme. The programme included psycho-education about anxiety, teaching behavioural exercises, challenging dysfunctional thinking and learning coping skills. Each session followed the pattern of agenda setting, reviewing the homework, addressing the week's topic and setting further homework.

Results

Phase 1: Quantitative analysis of retrospective data

The Wilcoxon-signed Ranked Test indicated that there was a significant difference between pre- and post-measures of prisoner anxiety ($z = -3.022$, $p > 0.05$, two tailed). Participant's anxiety scores had decreased post-intervention in 17 cases, had increased in only 2 cases and there was no change in one case.

Phase 2: Qualitative analysis

The following results are grouped and presented according to the interview questions asked. (See Appendix 11 for list of responses to the interview questions)

What were your expectations of the programme and were they met? Two participants indicated that they expected to develop an understanding of stress and to learn how to deal with it:

'To learn about stress and how to handle it basically like you know and how to cope with it' [3:196][1]

Indeed, the majority of participants reported that they anticipated learning how to cope with stress:

'To learn to deal with stressful situations' [6:464]

'The solution I suppose, I was looking for a solution and ah as you said to de-stress' [6:546]

Other similar expectations included learning 'to relax', learning 'how to deal with problems', learning 'how to put thoughts out of your mind', and to be 'stress-free'. One participant stated that he wanted to elucidate whether he was the only person affected by stress. Another participant focused on the teaching strategies used,

[1] This indicates that this quote is from interview with participant 3, line 196 on transcript

indicating that he had expected there to be 'more talking' about issues. He also reported that he anticipated 'doing questionnaires' and 'role-plays'.

The majority of participants emphasised that their expectations were met as they attained healthy stress management strategies. For example:

'Ya ya I would ya…because I get stressed out quite easily … so I didn't have any tools to effect that…and with the course it has improve that you know' [6:469-472]

The significance of understanding stress and its physiological and cognitive effects was also highlighted:

'ya well they were met…knowing that like your chest tightening…like you do like you are going to have a heart attack that there is something seriously going wrong... I remember saying to myself thank God he said that because now I know that it's not just me like it's a relief' [8:642-645]

'Ah they were in the second session…because I started thinking that I was probably reading into something I probably shouldn't be reading into' [5:387-389]

Finally, two participants delineated their appreciation of the material being presented in a manner that was uncomplicated and clear. For example:

'Ya…it was, one hundred percent…the way it was put across was straight forward like…it was real easy to understand' [3:199-103]

We discussed many aspects of stress during the programme, what aspects had most relevance for you? Many participants regarded learning practical and effective coping skills as the most relevant aspect of the programme:

'Am I think the talking and the coming up with ideas and stuff like that you would never imagine so much ideas about stress and the ways that you can actually cope with it' [4:280-281]

'The breathing exercises mainly because I get palpitations when I get … stressed…and the breathing techniques help that' [6:479-480]

One individual made reference to the significance of developing awareness of stress and its causes, highlighting it as a necessary step in learning how to manage symptoms effectively:

'what really caused stress like and ah … that's it's brought on by yourself maybe …and eh to, how to deal with it like you know maybe you know that you can deal with it quiet easily once you are aware of stress you know…' [2:118-120]

What techniques have you tried and what techniques will you continue to use on a long-term basis? Relaxation involving deep breathing and muscle relaxation were the most frequently practiced techniques to calm stress. Cognitive strategies were also attempted (i.e., distraction and cognitive restructuring), as were exercise, meditation, dietry recommendations, sleep hygiene behaviours and the body-check (scan), although these latter strategies were less frequently mentioned. The majority of participants intended to use breathing exercises and muscle relaxation on a long-term basis. Meditation, exercise, diet and sleep hygiene were also alluded to, albeit less frequently.

What aspects of the programme did you find most helpful? One factor participants particularly valued was the learning of information and techniques to support them in coping with stress:

'It made me more aware…it's nothing major that brings it on…you do it yourself…so I find it easier now to deal with stress because I am more aware of what causes it' [2:139-141]

'The relaxation…because it just clears your mind basically…stress does drop down when you're relaxed you know' [3:223-225]

Two participants referred to the value of learning sleep hygiene concepts and practices and one individual alluded to the benefits of assertiveness training. The 'group itself' was also offered as a helpful component of the programme as it demonstrated that there were people who were undoubtedly concerned about prisoners' feelings. Finally, feeling respected by the facilitators was also cited as a helpful factor.

What aspects of the programme did you find least helpful? Overall, participants could not think of any specifically unhelpful aspects of the programme. However, one individual commented that he was unable to grasp the imagery technique:

'Ah none really, just the imagery piece I just couldn't get it' [6:510]

How did you find being part of a group of people? Sharing information and ideas and the opportunity to learn from each other, were emphasised by the majority of participants as valuable aspects of the group experience:

'It was good you know, you can listen to some people tell of what their trouble then the idea help myself you know' [1:49]

'I found it good you know…it helped listening to each other and sharing with each other' [2:161-163]

Additionally, one individual alluded to the usefulness of other people asking the questions he wanted to have answered, but didn't want to broach himself.

What did you think was good about being in a group? The theme of learning from others had weight with a number of participants in the context of positive aspects of group work:

'Ya sharing other people's experiences about stress I suppose…it gives you insight about how to deal with your own stress' [6:515-517]

A number of other benefits to group work were mentioned, including the presence of a friendly environment, an opportunity to have fun with peers, an opportunity to make acquaintances, a confidential setting to discuss problems and a forum to facilitate the understanding that there are also others who suffer from stress.

Is there anything about being in a group that you felt didn't work well?

Lack of opportunity to discuss personal and private stresses was advocated as a disadvantage to being in a group situation:

'Sometimes you would like to talk …about something that is going on that's really causing you stress but you don't like to share it openly in front of everybody' [2:173-174]

Would you recommend a group intervention to other people? All participants affirmed that they would urge participation in this type of programme. Indeed, one individual pointed out that he had already done so:

'Ya even to younger friend I say you have to go to the and do something like that' [1:68]

How did you experience the time available to discuss, ask questions and to talk in the group? While three participants reported that they were satisfied with the time available to discuss, ask questions and talk in the group, the majority expressed a desire for more time:

'Well we were just kinda getting into the string of things when ah we would be called…more time, ya I think so an extra half an hour or something like that' [4:363-365]

'Maybe to have it twice a week' [4:357]

One individual suggested that there would be more available time in the mornings:

'The ideal might to have it in the morning, you would have more time' [5:448-449]

What would you change? While two individuals had no suggested changes, the remaining six participants recommended slight alterations or adjustments including, providing more time in the sessions, conducting the programme in the mornings rather than the evenings, incorporating drama into the programme and creating more comfortable surroundings, in particular, better heating. The provision of an opportunity to get a separate session to discuss personal issues was also put forward as a possible change.

Discussion

The current pilot study had two goals. The first was to evaluate the effectiveness of four GCBT anxiety management programs in reducing anxiety in Irish prisoners. Quantitative analysis revealed participant's levels of anxiety, as measured by the Beck Anxiety Inventory (BAI), decreased significantly from pre- to post-intervention. The second study objective was to explore participants' experiences of the programme. Qualitative results indicated education and coping skills acquisition were the most valued aspects of the programme, while behavioural strategies, including breathing and muscle relaxation were the most frequently applied coping techniques outside of sessions. Benefits of group participation included imparting of information, interpersonal learning and recognition of similarities in others. Lack of opportunity to discuss private issues and insufficient session time were the stated drawbacks. When asked how the group could be improved, suggestions included incorporating a drama component and improving features of the treatment setting.

Quantitative Phase

The results of the quantitative analysis are in line with past outcome findings on the effectiveness of CBT for transdiagnostic groups in routine clinical settings (Norton, et al., 2008; Erickson et al., 2002; McEvoy & Nathan, 2007; Norton & Philips, 2008). Thus, this study may offer support for the hierarchical model of anxiety and add to the literature supporting transdiagnostic group treatments for anxiety disorders. Yet, the diagnostic uncertainties within this sample render these assumptions tentative. Thus, future research needs to establish diagnoses in order to make a valid contribution to this literature on transdiagnostic conceptualisations. Ascertaining diagnoses would also enable future investigators explore differential improvements to ensure prisoners with differing manifestations of anxiety are yielding similar benefits. Notwithstanding the stated limitation, the positive results may suggest validation of transdiagnostic GCBT for anxiety can be extended to forensic populations, despite the barriers imposed by the prison setting (Jeffries et al., 2001).

Notably, a statistically significant reduction in anxiety symptoms does not guarantee clinically meaningful improvements in functioning (Jacobson & Traux, 1991). Thus, future studies should determine whether clinically meaningful change has been achieved, i.e., participants are no longer clinically impaired and distressed by anxiety at the end of treatment. Establishing clinical significance is important as failure to achieve a clinically significant reduction in symptom severity, alerts clinicians that a change in treatment approach or referral for further services may need to be considered (Follette & Callaghan, 1996).

The statistically significant results should also be interpreted in light of other research caveats. To begin with, administered medication (e.g., methadone) may have affected the results. It is noted however, that discontinuation of a prisoner's medication would be subject to ethical controversy. Secondly, data were obtained from open uncontrolled intervention trials without long-term follow up assessments. Thus, causal inferences concerning the effect of the programme cannot be assumed and assertions of maintenance of the changes cannot be made (Anderson & Rees, 2007). Thirdly, these results were obtained from a small sample of prisoners who actively sought treatment, which precludes generalisability to the prisoner population at large. Thus, while the current findings are encouraging, future studies must address these limitations before firm conclusions can be reached regarding the programme's efficacy in decreasing anxiety symptom severity. Of note, the current study also failed to attempt drop-out analysis, which should be included in future research in order to inform retention strategies.

Qualitative Phase

Qualitative analysis revealed that those aspects of the programme participants valued most, closely paralleled participant's expectations at the beginning of the programme. Thus, developing an understanding of stress and learning how to cope with stress, were named as most relevant and helpful for participants. Certainly, understanding its effects is recognised as a basic first step in conquering stress (Zeyfert & Becker, 2007). In relation to coping skills, the strategies used outside sessions were mainly behavioural in nature, for example, breathing and muscle relaxation and these were also the techniques that were intended for use on a long-term basis. Behavioural strategies for sleep were also highly valued. In contrast,

while reference was made to cognitive strategies (e.g., distraction and cognitive restructuring), they were mentioned less often. Overall, the fact that participants were practicing techniques outside the sessions is particularly significant as GCBT is a short-term programme that should enable participants employ techniques without the support of the group (Bottomley, 1999). This finding also reflects motivation in participants and positive changes in behaviour.

From the standpoint of these results, it remains unclear as to whether participants had a solid grasp of the cognitive component of CBT. Indeed, cognitive coping strategies were infrequently mentioned and when alluded to, were discussed in vague detail. Hence, participant's understanding of the cognitive component of CBT needs to be explored in future research. Indeed, this may be an important consideration in programme development as it may mean revising the cognitive material to a simpler level.

The advantages of group therapy as outlined previously (Yalom, 1975) were evident in the current study. Imparting of information, interpersonal learning and recognition of similarities in others were all outlined as positive aspects of the group. Indeed, the experience of universality was also mentioned, suggesting group work may be an influential way of normalising the anxious prisoner's experience. The many similarities between the stated benefits of the group experience for prisoners and participants in other reported studies, illustrates the universality of these process variables (Norton, 2008).

While the previously identified drawbacks of group work (Hollon & Shaw, 1979; Morrison, 2001) were not corroborated by the current findings, an additional potential disadvantage did surface, namely, the lack of opportunity for participants to discuss private issues. Notably, the current programme was modelled on the 'Stress Control' method, which is a purely didactic approach and actively prohibits personal disclosure. The rationale is that this helps control the problem of individuals dominating the proceedings and pushing their own agendas (White, 2000). Therefore, an arrangement had been established, whereby those who requested it, were referred to the waiting list for individual therapy. Indeed, restricting client self-disclosure

correctly reflects the realities of the psycho-educational format of many group psychotherapies.

A more generic difficulty mentioned with the programme was that there was insufficient session time available. Indeed, lack of time is an issue that has been cited by previous authors to be problematic in correctional facilities (Jeffries et al., 2001). Scheduled programme time is limited due to the availability of prison staff to escort prisoners to the site and to supervise (Jeffries et al., 2001). Another issue mentioned relating to timing concerned the particular period during the day where the group was scheduled. It was suggested that prisoners would be better served if the programme was scheduled in the morning as people would be more mentally sharp and alert. However, scheduling the programme in the morning would have excluded all working inmates and thus, possibly impacted recruitment for the program. Notably, past authors have noted that a drawback of group work is that it can be difficult to arrange a time that suits all group members (Hollon & Shaw, 1979). Finally, it is suggested that the finding that one individual found the imagery technique unhelpful does not necessarily cause concern as this participant attained and practiced other skills he found effective. Indeed, CBT offers individuals a choice of strategies with the expectation that they will pick out those that suit them best (Roth & Fonagy, 2005).

One recommended change to the programme was to incorporate a drama component. Certainly, providing opportunities to learn through active processing rather than passive absorption is recommended, as it keeps sessions interesting and helps participants learn (Zayfert & Becker, 2007). Improving features of the treatment setting, for example, providing extra heating was another suggested improvement. Indeed, the impact of the setting cannot be underestimated as past authors have found that setting features of the treatment facility, including comforts and conveniences, safety, attractiveness, size and privacy can have therapeutic effects (Grosenick & Hatmaker, 2000). Notably, while health professionals are currently endeavouring to establish improved treatment facilities in the prisons, the lack of space, coupled with the cement and steel austerity of the setting, renders it an ongoing challenge.

Whereas these qualitative findings provide some initial insights into prisoners' experiences of the programme, the limitations of this method of data collection and analysis should be noted. Firstly, the language used by the interviewer may have influenced the quantity and quality of information given by respondents (Symon & Cassell, 1998). Secondly, the researcher facilitated the group in which the qualitative work was conducted, which may have affected the results as participants may not have viewed the researcher as a neutral party (Reynolds & Hean Lim, 2007). Thirdly, the number of participants interviewed was too small to be representative of the population. Fourthly, as a pilot investigation this study used a very basic qualitative procedure that failed to comprehensively unpick and unravel all emerging patterns and themes. Finally, the current research did not take into account facilitators' views of the programme, precluding attainment of a more wide-ranging perspective. Thus, it is important to view the findings as preliminary and address these issues in future research.

Conclusions and Recommendations

This pilot study was the first to date to (a) evaluate the effectiveness of GCBT anxiety management programmes in reducing anxiety among Irish prisoners; and (b) examine prisoners' experiences of the programmes. While interpretation of the data must be considered tentative due to the methodological caveats mentioned, the data suggest that transdiagnostic GCBT anxiety management programmes may be beneficial in reducing anxiety in Irish prisoners.

Several issues for consideration in programme planning were also generated by this research. To begin with, it may be constructive to negotiate with prison officers around scheduling sessions of increased duration or incorporating extra sessions. It may also be of value to reconsider the positioning of the groups during the day. Perhaps consecutive programmes could be held at alternate times, in order to facilitate as many prisoners as possible. Future programmes may also encourage active learning through role-play and direct participation and facilitators may consider improving features of the treatment setting, such as the use of portable heaters, as this may provide enhanced therapeutic effects. Importantly, study findings need to be replicated before modifications are made.

References

Anderson, R.A. & Rees, C.S. (2007). Group Versus Individual Cognitive Behavioural Treatment for Obsessive Compulsive Disorder: A Controlled Trial. *Behaviour Research and Therapy, 45,* 123-137.

Beck, J.G., Coffey, S.F., Foy, D.W., Keana, T.M. & Blanchard, E.B. (2008). Group Cognitive Behaviour Therapy for Chronic Posttraumatic Stress Disorder. *Behaviour Therapy,* In Press.

Beck, A.T. & Steer, R.A. (1990). *Beck Anxiety Inventory Manual.* San Antonio, TX: Psychological Corporation.

Bottomley, A. (1999). Group Cognitive Behavioural Therapy with Cancer Patients: The Views of Women Participants on a Short-Term Intervention. *European Journal of Cancer Care, 7,* 23-30.

Butler, A.C., Chapman, J.E., Forman, E.M. & Beck, A.T. (2006). The Empirical Status of Cognitive Behavioural Therapy: A Review of Meta-Analyses. *Clinical Psychology Review, 26,* 17–31.

Campbell, T., Blake,N. & Rankin, H. (1993). Anxiety Management Courses in Clinical Practice: An Evaluation. *Clinical Psychology Forum, 59,* 18-22.

Clark, I. A. & Watson, D. (1991). Tripariate Model of Anxiety and Depression: Psychometric Evidence and Taxonomic Implications. *Journal of Abnormal Psychology, 100,* 316-336.

Craske, M.G. (2003). Anxiety Disorders. *Origins of Phobias and Anxiety Disorders,* 119-173.

Deacon, B. J. & Abramowitz, J. S. (2004). Cognitive and Behavioural Treatments for Anxiety Disorders: A Review of Meta-Analytic Findings. *Journal of Clinical Psychology, 60,* 429-441.

Erickson, D.H. (2003). Group Cognitive Behavioural Therapy for Heterogeneous Anxiety Disorders. *Cognitive Behaviour Therapy, 32,* 179-186.

Erickson, D.H., Janeck, A. & Tallman, K. (2002). A Cognitive Behavioural Group for Patients with Various Anxiety Disorders. *Psychiatric Services, 58,* 1205-1211.

Follette, W. C. & Callaghan, G. M. (1996). The Importance of the Principle of Clinical Significance-Defining Significant to Whom and for What Purpose: A Response to Tingey, Lambert, Burlingame and Hansen. *Psychotherapy Research, 6,* 133-143.

Gould**,** R.A., Otto**,** M.W**.** Pollack, M.H. & Yap, L. (1997). Cognitive Behavioural and Pharmacological Treatment of Generalised Anxiety Disorder: A Preliminary Meta-Analysis. *Behaviour Therapy, 28,* 285-305.

Grosenick, J.K. & Hatmaker, C.M. (2000). Perceptions of the Importance of Physical Setting in Substance Abuse Treatment. *Journal of Substance Abuse Treatment, 18*(1), 29-39.

Heimberg, R., Salzman, D., Holt, C & Blendell, K. (1993). Cognitive-Behavioural Group Treatment for Social Phobia: Effectiveness at Five Year Follow-Up. *Cognitive Therapy and Research, 17,* 325-339.

Hollon, S. D., & Shaw, B. F. (1979). Group cognitive therapy with depressed patients. In A. T. Beck, A. J. Rush, B. F. Shaw, & G. Emery (Eds.), Cognitive therapy of depression: A treatment manual (pp. 328-353). New York: Guilford Press.

Hornsey, M., Dwyer, L. & Oei, T.P.S. (2006). *The Role of Cohesion in Group Psychotherapy.* Manuscript Submitted for Publication.

Islam-Zwart, K., Vik, P. W., & Rawlins, K. (2007). Short-Term Psychological

Adjustment of Female Prison Inmates on a Minimum Security Unit. *Women's Health Issues, 17* (4), 237-243.

Jacobson, N.S. & Truax, P. (1991). Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychology, 59,* 12-19.

Jeffries, J.M., Menghraj, S. & Hairston, C.F. (2001). *Serving Incarcerated and Ex-Offender Fathers and Their Families: A Review of the Field.* Prepared for the Vera Institute of Justice.

Jupe, H. & Dudley, M. (1984). Group Cognitive/Anxiety Management. *Journal of Advanced Nursing, 9*, 573-580.

Kennedy, H.G., Monks, S., Curtin, K., Wright, B., Linehan, S., Duffy, D., Teljeur, C. & Kelly, A. (2005). *Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners.* Dublin: National Forensic Mental Health Service.

Lepine, J.P. (2002). The Epidemiology of Anxiety Disorders: Prevalence and Societal Costs. *Journal of Clinical Psychiatry***,** 63**,** 4-8.

McEvoy, P.M. & Nathan, P. (2007). Effectiveness of Cognitive Behavioural Therapy for Diagnostically Heterogeneous Groups: A Benchmarking Study. *Journal of Consulting and Clinical Psychology, 75*(2), 344-350.

Morrison, N. (2001). Group Cognitive Therapy: Treatment of Choice or Sub-Optimal Option? *Behavioural and Cognitive Psychotherapy, 29,* 311-332.

Nash, J. & Potokar, J. (2004). Anxiety Disorders. *Medicine, 32*(7), 17-21.

Neron, S., Lacroix, D. & Chaput, Y. (1995). Group Versus Individual Cognitive Behavioural Therapy in Panic Disorder: An Open Clinical Trial with a Six Month Follow-Up. *Canadian Journal of Behavioural Science, 27,* 379-392.

Norton, P.J. (2008). An Open Trial of a Transdiagnostic Cognitive-Behavioural Group Therapy for Anxiety Disorder. *Behavioural Therapy*, Article in Press

Norton, P.J. & Hope, D.A. (2005). The "Anxiety Treatment Protocol": A Transdiagnostic Group CBT for Anxiety Disorders. *Journal of Behaviour Therapy and Experimental Psychiatry, 36,* 79-97.

Norton, P.J. & Philips, L.M. (2008). Transdiagnostic Approaches to the Treatment of Anxiety Disorders: A Quantitative Review. *Psychotherapy: Theory/Research/Practice Training, 45*(2), 214-226.

Otto, M.W., Pollack, M.H., Gould, R.A., Worthington, J.J., McArdle, E.T. & Rosenbaum, J.F. (2000). A Comparison of the Efficacy of Clonazepam and Cognitive-Behavioural Group Therapy for the Treatment of Social Phobia. *Journal of Anxiety Disorders, 14*(4), 345-358.

Otto, M. W., Pollack, M. H., Penava, S. J., & Zucker, B. G. (1999). Group Cognitive-Behavior Therapy for Patients Failing to Respond to Pharmacotherapy for Panic Disorder: A Clinical Case Series. *Behaviour Research and Therapy, 37,* 763-770.

Peneva, S.J., Otto, M.W., Maki, K.M. & Pollack, M.H. (1998). Rate of Improvement During Cognitive-Behavioural Group Treatment for Panic Disorder. *Behavioural Research and Therapy, 36*, 665-673.

Petrocelli, J.V. (2002). Effectiveness of Group Cognitive Behavioural Therapy for General Symptomatology: A Meta-analysis. *Journal for Specialists in Group Work, 27*(1), 92–115.

Powell, T.J. (1987). Anxiety Management Groups in Clinical Practice: A Preliminary Report. *Behavioural Psychotherapy, 15*, 181-187.

Reynolds, F. & Hean Lim, K. (2007). Contribution of Visual Art-Making to the Subjective Well-Being of Women Living with Cancer: A Qualitative Study. *The Arts in Psychotherapy, 34*(1), 1-10.

Roth, A. & Fonagy, P. (2005). *What Works for Whom: A Critical Review of Psychotherapy Research.* Second Edition. The Guilford Press: London.

Shapiro, J. Sank, L.I., Shaffer, C.S., Donovan, D.C. (1982). Cost Effectiveness of Individual Versus Group Cognitive Behavior Therapy for Problems of Depression and Anxiety in an HMO Population. *Journal of Clinical Psychology, 38*(3), 674-677.

Stangier, U., Heidenreich, T., Peitz, M., Lauterbach, W. & Clark, D.M. (2003). Cognitive Therapy for Social Phobia: Individual Versus Group Treatment. *Behavioural Research and Therapy*, 41, 991–1007.

Stanley, M.A., Beck, J.G. & Glassco, J.D. (1996). Treatment of Generalized Anxiety in Older Adults: A Preliminary Comparison of Cognitive-Behavioral and Supportive Approaches. *Behavior Therapy*, *27*, 565-581.

Symon, G. & Cassell, C. (1998). Reflections on the Use of Qualitative Methods. In G. Symon & C. Cassell (Eds), *Qualitative Methods and Analysis in Organisational Research: A Practical Guide.* London: Sage pp 1-9.

White, J. (2000). *Treating Anxiety and Stress: A Group Psycho-Educational Approach Using Brief CBT.* New York: Guilford Press.

Yalom, I.D. (1975). *Theory and Practice of Group Psychotherapy.* New York: Basic Books.

Zeyfert, C. & Becker, C.B. (2007). *Cognitive Behavioural Therapy for PTSD: A Case Formulation Approach.* New York: Guilford Press.