COMMUNITY-ORIENTED MENTAL HEALTH: REFLECTIONS ON THE IMPLEMENTATION AND EFFECTIVENESS OF A PSYCHOEDUCATIONAL GROUP PROGRAMME IN GENERALIZED ANXIETY DISORDER (GAD)

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Abstract: Mental health problems are creating increasing demand in primary healthcare services. The objective of this paper is to assess the effectiveness of a nurse-led psychoeducational group programme for Generalized Anxiety Disorder (GAD) in a rural community in Catalonia. It is a quasi-experimental pre-post intervention study, in which we worked with a sample of 32 patients diagnosed with GAD in a rural Basic Health Area in different years.

Keywords: Primary health care, Generalized anxiety disorder, Community nurses, Psychoeducational groups.

Salud mental orientada a la comunidad. Reflexiones acerca de la implementación y efectividad de un programa de intervención psicoeducativa en el transtorno de la ansiedad generalizada (TAG)

Resumen: Los problemas de salud mental generan una demanda creciente en Atención Primaria de Salud. El objetivo de este trabajo es evaluar la implementación de grupos psicoeducativos dirigidos por personal de enfermería a personas con Trastorno de Ansiedad Generalizada. Se trata de un estudio experimental pre-post intervención, en el que trabajamos con

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una muestra de 32 pacientes diagnosticados de TAG captados en distintos años en un Área Básica de Salud Rural.

Palabras clave: Atención primaria, Trastorno de ansiedad generalizada, Enfermería comunitaria, Grupos psicoeducativos.

Introduction

Mental health problems are creating increasing demand in primary healthcare services (ESCA, 2015)[1]. According to Gili, Roca, Basu, *et. al.* (2013) much of the increase in the *psychological disorders* treated in primary healthcare —mainly anxiety (19.7%), dysthymia (25.1%), depression (47.5%) and alcohol dependence (2.7%)— is related to the economic crisis. These authors, who compared data from 2006 and 2010 in Primary Healthcare Centres in 17 Spanish regions, found that generalized anxiety disorder (GAD) had increased by 8.4%, major depression by 19.4%, dysthymia by 10.8% and alcohol dependence by 4.6%. In this paper, the authors highlight the risk factors that determine the increase in the prevalence of mental disorders in primary healthcare services, including unemployment (one's own or that of a family member), eviction and financial hardship.

According to data published by the Ministry of Health, Social Services and Equality (2013), the annual prevalence and lifetime prevalence for anxiety disorders is 10.6% and 16.6% respectively. However, studies that have been carried out among users attending primary healthcare centres raise this prevalence by between 20 and 40%[2]. According to the Spanish Medicinal and Health Products Agency[3] (AEMPS), the consumption of anxiolytics and hypnotics in Spain increased from 56.7 DHD in 2000 to

1 Enquesta de Salut de Catalunya (ESCA), 2015; 99 páginas. Available in URL: <http://salutweb.gencat.cat/web/.content/home/el_departament/estadistiques_sanitaries/enquestes/esca_2015.pdf>.

2 The variability of the epidemiological data presented is related to factors such as the inclusion criteria, the country studied, the sample size and diagnostic instruments used. Clinical Practice Guidelines for the management of anxiety in the AP, 2009. Available at URL: <http://ics.gencat.cat/web/.content/documents/assistencia/protocols/Protocol_Intervencio_Grupal_Psicoeducativa.pdf>.

3 Memoria de Actividades de la Agencia Española de Medicamentos y Productos Sanitarios. 2012. Agencia Española de Medicamentos y Productos Sanitarios (AEMPS). Avail-

89.3 in 2012 – an increase of 57.4%. One of the most widely used drugs is Diazepam. While the number of people taking Diazepam in 2008 was less than 6 per 1,000 inhabitants, by 2012 this figure had increased to 8 people per 1,000 inhabitants. Another drug that has seen an increase is Lorazepam, which has gone from being prescribed to 11 per 1,000 people in 2000 to 22 per 1,000 in 2016. It is also noteworthy that Spain leads the consumption of Orfidal, Lexatin and Valium in Europe (Novak, Hakanson, Martínez *et. al.*, 2016).

The Spanish Society for the Study of Anxiety and Stress[4] (SSAS) notes that 15.5% of the Spanish population regularly takes anxiolytics (6). This figure is three points higher than the European average, and double the average consumption in countries such as Germany (5.9%) and the Netherlands (7.4%), and is only surpassed by France (19.2%) (SSAS, 2013).

It is therefore interesting to consider the variations in spending on psychotropic drugs in Spain over the last decade (2003-2013): The expenditure on antidepressants has increased most, as it has risen by 38.7%, ahead of antipsychotics (32.6%), hypnotics (28.4%) and anxiolytics (7.8%). It is also important to note that in Spain, the bulk of prescriptions for antidepressants and anxiolytics are provided in primary healthcare, and in fact, only 30% of these drugs are prescribed by a specialist. The studies are varied and show that the start of the economic crisis was a turning point. The Spanish Neuropsychiatry Association[5] (SNA) warns of the consequences that may result from excessive and widespread prescription of medication, and we should remember that the consumption of anxiolytics provides a temporary relief of symptoms, which indirectly and directly contributes to medicating and medicalizing these patients' suffering while failing to address the underlying problem that leads them to develop the disorder.

As an example of community nursing, our study presents the effectiveness of psychoeducational intervention for Generalized Anxiety Disorder. While we are aware of the macro-structural factors affecting people's mental health, our proposal uses a psychoeducational group

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able at URL: <http://www.aemps.gob.es/informa/notasInformativas/laAEMPS/2012/NI-AEMPS_02-2012.htm>.

4 Sociedad Española para el Estudio de la Ansiedad y el Estrés (2013) Boletín SEAS núm. 39. Octubre. Available at URL: <http://www.ansiedadyestres.org/boletin-39-oct-2013>.

5 Observatorio de Salud Mental de la Asociación Española de Neuropsiquiatría (SNA). Available at URL: <http://www.observatorio-aen.es/generador-de-estadisticas/>.

intervention to provide people, who have been diagnosed with GAD in a Basic Health Area located in a rural environment with around 10,000 inhabitants, with the tools they need to be able to manage their discomfort, improve their quality of life and indirectly reduce the consumption of psychotropic drugs for the relief of symptoms of anxiety.

In this context, we propose psychoeducational groups for patients with GAD led by primary healthcare nursing staff. The content covered in each session is established by the group's psychoeducational intervention protocol for patients with anxiety symptoms, published by the Catalan Health Institute[6] (ICS) and divided into four areas: training and information on signs and strategies for symptom control, practical workshops on relaxation and deep breathing, group dynamics involving work on expressing emotions and coping strategies for crisis situations, and lastly, a final stage covering behavioural change and adopting healthy lifestyles.

Some studies provide evidence for the effectiveness of psychoeducational groups in primary care. Casañas, Raya, Ibáñez *et alii* (2008) discuss improvements in scores in the Goldberg test and the Anxiety and Depression Scale (HADS) before and immediately after the group intervention in 87 patients with anxious-depressive symptoms. The number of visits to the primary healthcare centre fell by 45% over the course of the sessions. This detail is interesting for a cost/benefit analysis of the psychoeducational group, and can also be used to incorporate two new dimensions into our study. The first is related to including the EuroQol-5D test to objectify health-related quality of life, which is added to the Goldberg test and the HADS test pre-and post-intervention. The second is related to leaving a period of three months after the end of the group sessions before the assessment of the three tests, in order to prevent bias when the data are collected immediately after the intervention.

The research is a quasi-experimental pre-post intervention study. We worked with a sample of 32 patients diagnosed with GAD in a rural Basic Health Area. These patients were referred to the nursing centre by either the family doctor/nurse or they were recruited by the Demand Management programme in the Basic Health Area.

6 Available at URL: <http://ics.gencat.cat/web/.content/documents/assistencia/protocols/Protocol_ Intervencio_Grupal_ Psicoeducativa.pdf>.

Methods

We performed a quasi-experimental pre-post intervention study with patients diagnosed with Generalized Anxiety Disorder[7] (GAD) in a rural Basic Health Area (BHA) between 2009 and 2012. These patients were referred to the nursing centre, either by the family doctor/nurse or they were recruited by the Basic Health Area's Demand Management programme. The psychoeducational intervention programme consisted of ten sessions, and involved one session per week lasting approximately ninety minutes. Each group consisted of a maximum of 12 participants and was led by a nurse. In addition to the solidarity and reciprocity intrinsic to the dynamics of the group (Canals, 2002), in each session the group worked on contents related to educational information on signs, mechanisms for controlling symptoms, and coping strategies in crisis situations.

We excluded patients who could not be evaluated using the Goldberg test, HADS and EuroQol-5D after the intervention. Participants who missed more than 50% of the sessions were also excluded.

We used the following data collection instruments:

The Goldberg Anxiety and Depression Scale

This test was developed by Goldberg in 1988, based on a modified version of the *Psychiatric Assessment Schedule*, in order to produce an easily administered test that could be used by healthcare workers, not necessarily medical staff, as a screening tool. The Spanish version was validated by Montón C. *et alii* (1993), due to its simplicity, sensitivity, specificity and ability to discriminate between anxiety and depression. It is designed to detect «probable cases,» not to diagnose them. Its ability to discriminate helps guide the diagnosis. Symptoms with a duration of less than two

7 Generalized Anxiety Disorder was included in the psychiatric nosology in 1980. In the DSM-IV (2002), GAD is listed as an Anxiety Disorder and its diagnosis requires the presence of 4 of the 22 symptoms which are listed in Appendix 1 (DSM-IV, 2002: 534). However, in the DSM-5 (2013), Anxiety Disorder is included in Section II for the first time, and in contrast to the DSM-IV. Although GAD is listed as a diagnosis in its own right, post-traumatic stress disorder and obsessive compulsive disorder are removed from the anxiety disorders, and panic disorder, selective mutism and separation anxiety disorder are added to Anxiety Disorders.

weeks and/or are mild in intensity do not score on the scale. It consists of two separate scales, one for anxiety and one for depression, with 9 items each and a dichotomous answer (yes/no). Only the affirmative answers obtain a point.

HADS

This scale was designed by Zigmond and Snaith in 1983. The Spanish translation and adaptation was performed by Snaith in collaboration with A. Bulbena and G. Berrios. It was validated in 1986 by Tejero *et. al.* The HADS test is a 14-item self-administered questionnaire consisting of two 7-item subscales, one for anxiety (odd-numbered items) and one for depression (even-numbered items). The intensity of the symptom is assessed using a Likert-type scale. Although the questions are formulated in the present, the timeframe refers to the previous week. For each item, the individual has to select the response alternative that best reflects their situation. The score for each subscale is obtained by totalling the values of the selected statements (0-3) for the respective items (even-numbered items for depression, odd-numbered items for anxiety). The score range is 0-21 for each subscale, and 0-42 for the total score.

EuroQol-5D

This is a questionnaire on quality of life related to health and consists in two sections: a descriptive system and the Visual Analogue Scale (VAS). The descriptive system consists of five sections that evaluate five dimensions: mobility, self-care, everyday activities, pain/discomfort and anxiety/depression. Each question has three response options, ranging from 1: «I have no problems» to 3: «I have a lot of problems». In the VAS, the patients have to rate their health on a scale ranging from 0 (the worst health imaginable) to 10 (the best health imaginable).

Semi-structured (SE) interviews

The SE interviews are divided into two parts. The first part includes sociodemographic and health variables related to Anxiety Disorder symptoms. In the second part, the patients are asked about their life story and the factors they consider have triggered the mental health problem.

Results: Sociodemographic data

Thirty-two patients with a diagnosis of Generalized Anxiety Disorder between 2009 and 2012 were selected in the BHA studied. All the patients joined the psychoeducational groups voluntarily. Among all the group participants, the gender ratio was 93.7% women (mean age 36.6 years old, ranging between 25 and 56 years old), and 6.25% men (mean age 32 years old). This factor should be taken into account when qualitative research is carried out on this topic.

The drop-out rate for the group was 18.75%. In terms of medication, 40.6% were taking psychotropic drugs in different proportions, while 28% were not taking anything, or taking valerian infusions/tablets if necessary.

Regarding the participants' employment status, 37.5% were not working and/or unemployed when the data were collected. The qualitative data show that workplace stress and financial difficulties in making ends meet are among the main reasons that our informants developed their disorder (55%).

> «Workplace stress, poor working environment. I have a position of responsibility, and either I've been unable or the company's management has been unable to give me enough authority to assert myself.» JCM, 31 years old. Woman. Works in an optometry practice.

> «The household economy: my husband and I don't have jobs.» MMF, 38 years old. Unemployed. Trained as an administrative assistant.

> «My father's death, my sister's illness, problems with my oldest daughter, with my brother who has come to live with us and my brother-in-law has also come to live with us.» ZBT, 56 years old. Not working. No educational training.

> «Mainly because of work. I have one or two problems as a result of the crisis and I want to sort things out myself without having to ask for help. I often feel alone.» TFS, 41 years old. Self-employed. Primary education.

> «Physical problems – breathlessness, headache, wanting to cry, I get upset very quickly; I suppose it has to do with the amount of work, especially at home and the little time I have because of my working hours.» JCC, 49 years old. Accountant. University education.

> «I often think that something bad will happen to my husband, or my children, we're not going to make it out of our current financial situation.» MMF, 37 years old. Waitress. Vocational training as a clerical worker.

Regarding their family situation, 53% were married when the data were collected, 25% were single, 12.5% were separated or divorced and 9.37% lived with a partner. A total of 68.75% had children (ranging between 1 and 5 children).

The qualitative data showed that 45% said «family factors» were the trigger for their disorder:

> «A lot of fear, I'm scared that something bad will happen to me or my family, a strong desire to be with people who love me.»
>
> «Everything around me: work, home, my child…» EDC, 38 years old. Shop assistant. Primary education.
>
> «Personal disappointment with my partner and stress at work.» JPM, 25 years old. Shop assistant. Higher secondary education.
>
> «Keeping my family going. My separation.» MAA, 33 years old. Unemployed. Primary education.
>
> «I have a 2½-year-old daughter and nobody to turn to. Having a health problem is a luxury for me, I have to cope with her and my job.» SFM, 30 years old. Not working. Vocational training in Electronics.

Pre-and post-intervention test results (Goldberg Scale, HADS and EuroQol)

The Goldberg scales of anxiety and depression, the HADS Hospital Anxiety and Depression Scale (instruments measuring the level of anxiety and depression symptoms) and the EuroQol-5D Health Questionnaire, administered in 15 patients before and after the group intervention, were used to evaluate the intervention.

The Wilcoxon test for paired data was performed to check the variation in the scales using SPSS.

The Goldberg scale results obtained after the corresponding test was applied are shown in the figure. The study showed statistically significant differences in the results of the scale at the start. The significance level was 0.033, which is less than 0.05, and as such there are differences in the level of anxiety and depression in the participants before and after attending the psychoeducational group.

The results of the EuroQol questionnaire on health-related quality of life obtained after the Wilcoxon test was applied are shown in Figure 1. The level of significance was found to be 0.027 ($p = 0.027$). As this score is

lower than 0.05, there are differences in the perceived quality of life before and after attending the psychoeducational group.

The results of the HADS hospital anxiety and depression test obtained after applying the Wilcoxon test are shown in Figure 1. The level of significance was found to be 0.111, which is more than 0.05, and as such there are no differences in the participants' level of anxiety and depression before and after attending the psychoeducational group.

Given that the values of the critical level on the Goldberg scale (0.033) and in the EuroQol questionnaire (0.027) are less than 0.05, we can conclude that the variables compared (test pre-and post-intervention) differ significantly.

Discussion

The study highlights the effectiveness of applying psychoeducational groups for people with Generalized Anxiety Disorder symptoms, as the groups improve their knowledge about the mental health problem and they show an improvement in symptoms only three months after they complete the intervention. The results demonstrate the potential of primary healthcare nurses in dealing with GAD, which is a field in which interventions have traditionally been limited to follow-up and adherence to medical prescriptions.

The improvements in mean Goldberg test scores show the potential of nurse-led psychoeducational groups as a focus and activity for promoting health. This would increase the population's health assets and increase awareness, leading to an improvement in symptoms. This is an important point, as we are convinced that the implementation of psychoeducational groups can help to alleviate the nature of Anxiety Disorders and may also contribute to a decline in the consumption of psychotropic drugs, and thus decrease pharmaceutical expenditure. The results of the EuroQol scale administered before and three months after the intervention enable us to numerically objectify the positive perception of the control of anxiety symptoms and the improvement in the patients' health-related quality of life. Specifically, although the data compared using the Wilcoxon test were not as we anticipated, we believe it is necessary to give special consideration to applying the HADS test in studies arising from this work in order to determine trends related to changes in how symptoms of anxiety are expressed.

Another point we would have liked to cover, and which we are considering as a line of research based on this study, concerns the need for multicentre experimental studies, which as well as evaluating the efficiency in terms of cost-benefit, also evaluate the effectiveness of the groups: a decreased use of psychotropic drugs and a reduced number of visits to primary healthcare centres three months after the end of the intervention. We also believe that as well as performing quantitative studies that evaluate the effectiveness and efficiency of the groups, it is necessary to implement a qualitative methodology using semi-structured interviews and participant observation in groups. This would enable us to analyse some of the factors mentioned in depth, such as the «situations» that contribute to developing the disorder in the context of the patient's life story; the structural factors contributing to the unequal distribution of the disorder according to the gender variable; the factors determining non-adherence to the group, and the significance and meanings that patients attach to psychotropic drugs. We are thus convinced that we will be able to provide a more complex reading and propose broader measures that will gradually be implemented in the community nursing practice.

Figure 1. Median results before and after the psychoeducational intervention according to Goldberg, HADS and EuroQol Tests.

	Before the Intervention (Median)	**After the Intervention (Median)**	**P**
Goldberg	12	8	0.033
HADS	23.8	18.3	0.11
EuroQol	4.5	6.4	0.027

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