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Article

All in for mental health: a pilot study of group therapy for people experiencing anxiety and/or depression and a significant other of their choice

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ABSTRACT

Background A need to provide treatment for people with anxiety and/or depression, and to provide preventive strategies for individuals who love them has been identified. In response, an innovative group therapy programme for people with anxiety and/or depression and a significant other of their choice was developed and implemented.

Methods Mixed methods were employed. Five 'significant other' groups were held between May 2005 and June 2006. All group participants were requested to complete the Depression Anxiety Stress Scale (DASS), World Health Organization Quality of Life Assessment (WHOQol) and Connor–Davidson Resilience Scale (CD-RISC), pre- and post-therapy, and three months after their last therapy session. In addition, participants who attended groups between July and September 2005 were invited to provide feedback about the group therapy in an individual semi-structured interview.

Results Pilot results indicate positive responses from clients, related to facilitation of knowledge and understanding and skills development. For people referred to the group significant improvements were found in the DASS scores, resilience, psychological health and living environment.

Limitations Due to the small sample size, and lack of follow-up data and control group, the findings need to be considered with caution and indicate the necessity to collect further data to provide conclusive findings.

Conclusions Overall, the outcome of the 'significant other' pilot programme was useful, in that it facilitated a number of positive outcomes for participants. Areas for further research have been identified including strategies to improve social relationships, the de-identification with the sick/supporter role, and testing this model with diverse populations and clinical groups.

Keywords: anxiety and/or depression, family, group therapy

Introduction

It is generally accepted that mental health problems are a major health issue, with the World Health Organization predicting that by 2020 mental health problems will account for 15% of the disease burden worldwide.[1] In Australia, 20% of people over the age of 18 years meet the criteria for mental health problem or disorder, with anxiety and depression being the most prevalent disorders.[2,3] More than half (62%) of these people do not seek professional assistance for their mental health problems, but most who do, consult a general practitioner (GP) in the first instance.[2,3]

The 'Better Outcomes in Mental Health Care' (BOMHC) initiative was announced by the Department of Health and Ageing, Australian Government in 2001.[4] It aims to improve the community's access to primary mental health services by providing better education and training for GPs, and more support for them from allied health professionals and psychiatrists. A key component of the BOMHC is the 'Access to Allied Psychological Services' programme, which enables GPs registered with the initiative to access focused psychological strategies from specified allied health professionals, to support their patients with mental health problems through time-limited interventions. It is being implemented through divisions of general practice.

The Adelaide North East Division of General Practice (ANEDGP) is currently running group therapy sessions, which were evaluated by the Department of General Practice, University of Adelaide. Therapy groups offered currently are 'Coping with depression', 'Anxiety', 'Panic', 'Chronic pain' and 'Managing the stress of motherhood (postnatal depression)'. They include six, two-hour sessions and comprise psychoeducation, skills-based training, and discussions involving all group members as well as time spent working through appropriate computer programs individually – an innovative component of the group programme. The model of group therapy employed is described in detail elsewhere.[5]

The outcomes of the evaluation were positive showing that the service improves depression and anxiety symptoms for individuals, and is well received by participants and their referring GP.[6] During a focus group session, participants suggested including significant others in group sessions to assist them with ongoing care, as an alternative to follow-up sessions to help solidify their new skills.

Research indicates that group and individual therapy are comparable in effectiveness and both superior to no treatment for depression and anxiety.[7,8] Previous therapies have involved parents, families or spouses to increase the efficacy of interventions. Many of these have been used in clinical populations such as those suffering from pain, chronic illness, depression, agoraphobia, schizophrenia, eating disorders and obsessive compulsive disorders.[9–11] However, as noted by Beaucom *et al*, there are many interventions used for individual disorders that involve families or spouses, and considerable variation in both the strategies used and the targets of the intervention.[9] They suggest they can be classified into three basic groups. Firstly, family or partners are like coaches or surrogate therapists assisting the client with assignments out of therapy. Secondly, therapy focuses on how couples or families interact or deal with situations related to the individual's disorder. Thirdly, couple or family therapy is used, which focuses on alleviating marital or family distress as it is viewed as having the potential to precipitate or exacerbate a variety of individual disorders. There do not appear to be any interventions that focus on mutual support, providing focused psychological strategies to both clients and carers together.

It could be suggested that providing therapy that focuses on mutual support could assist with normalising or de-stigmatising the illness, taking the client out of the 'sick' role. It could also provide primary prevention or protective psychological strategies for significant others at the same time as providing treatment interventions for those experiencing anxiety and/or depression.

The negative effects on carers' and/or families' well-being have been well documented in many clinical populations. In particular, some of the effects include increased stress, anxiety and depression.[11–15] Interventions to reduce these effects have been undertaken and have shifted the focus from supporting the person with the condition to reducing the effects on the carer or family, thus separating the focus.

Clearly there is a need to provide treatments for people with anxiety and depression, but also to provide primary prevention or bolster protective factors for their loved ones.

In response to the suggestion by ANEDGP, group participants and the literature, an innovative group therapy programme for people with depression and/or anxiety *and* a significant support person of their choice (e.g. a partner, parent, sibling, or friend) is being piloted. The aim is to provide *all* participants – clients and significant others – with knowledge and skills to assist them to address anxiety and/or depression. The focus is that participants support *each other* rather than focusing on the significant other being there to support their loved one who is experiencing anxiety and/or depression.

This paper reports quantitative and qualitative findings from the pilot.

Methods

Five 'significant other' groups were held between May 2005 and June 2006 at the ANEDGP. All groups were facilitated by a psychologist and co-facilitated by a trainee psychologist. The group programme used was similar to that used for groups with individuals attending alone which is described by Mitchell *et al*,[5] with an additional component focusing on the effects of loving someone with depression/anxiety. Essentially the group includes psychoeducation, cognitive behavioural therapy (CBT), assertive communication, relaxation training and narrative therapy. It was emphasised that the role of the significant other was not as the support person for the client or coach or co-therapist, but rather to give and receive mutual support. This emphasis was to highlight that everyone can benefit from learning new skills and strategies to deal with everyday life, whether they are experiencing depression and/or anxiety or not, to normalise mental illness, foster interdependence rather than dependence, and enhance generalisability of skills. The intention of this approach is to provide treatment and prevention for mental health issues simultaneously.

The University of Adelaide, South Australia, ethics committee granted ethics approval to conduct this study.

Participants were provided with an information sheet and consent form to participate in the evaluation of the study. All participants provided consent and were requested to complete the Depression Anxiety Stress Scale (DASS),[16] World Health Organization Quality of Life Assessment (WHOQol),[17] and Connor–Davidson Resilience Scale (CD-RISC),[18] pre- and post-therapy, and three months after their last therapy session. In addition, participants who attended groups between July and September 2005 were invited to provide feedback about the group therapy in an individual semi-structured interview. The interviewer was independent of the group therapy; however, she had completed a Masters of Clinical Psychology placement at the ANEDGP prior to the commencement of the significant other groups and was therefore familiar with the group therapy and processes utilised. Interviews were conducted by telephone within two weeks of completing therapy, and each took about 30 minutes to complete.

An inductive approach to data generation and analysis was used. The use of these qualitative techniques to generate and analyse participant self-reported data was expected to enhance the depth and validity of the information attained.[19]

The researcher recorded handwritten notes during the collection of interview data, which were later transcribed into a Microsoft Word file. Immersion strategies were used to enhance reliability of data. For example, the researcher personally transcribed the data generated during each interview, and the qualitative data analysis was carried out by hand. These processes facilitated the identification of key ideas and patterns in the data.[20]

Thematic analysis was used for analysing interview data.[21] Following identification of a thematic framework, codes were developed and systematically applied to all of the data. Subsequently, the data were organised under each identified theme, and charts were created for each theme. The charts contained the essence of participants' views and experiences, and were useful for making sense of the nature and range of data generation.[20]

Two-tailed paired-samples t tests were used to analyse pre and post quantitative data using SPSS 13.0 for Windows. Insufficient three-month follow-up data were returned by participants, although reply-paid, self-addressed envelopes were provided and were followed up with a reminder telephone call.

Results

Quantitative data

There were 25 people who attended a 'significant other' group between May 2005 and June 2006 – 13 females and 12 males. Just one male and one female (partners) only attended one session. The number of sessions attended by all other participants varied from four to six, with the majority (52.4%) of them attending the full course of six sessions. Three people attended more than one group and provided pre and post group data for each group, but only the first complete set of data provided has been included in the analysis.

DASS (see Table 1)

The anxiety, depression and stress levels, self-reported by participants referred to the programme, significantly reduced after group therapy sessions. Applying mean scores to the DASS severity-rating index shows a reduction in all three subscales, severe to mild for depression; extremely severe to moderate for anxiety; and severe to mild for stress. There were no changes found in the significant other group, with all scores being in the normal range.

Table 1 Paired *t* test: pre and post DASS total subscale scores

DASS subscales	Mean (standard deviation)	95% confidence interval[a]	*P* (two-tailed)[b]
Total depression			
Person referred (*n* = 9)			
Pre	24.1 (11.0)	6.5–18.9	0.002
Post	11.4 (8.6)		
Significant other (*n* = 11)			
Pre	8.0 (9.3)	–2.7–5.4	0.472
Post	6.6 (7.6)		
Total anxiety			
Person referred (*n* = 9)			
Pre	20.1 (13.7)	4.5–11.9	0.001
Post	11.9 (12.3)		
Significant other (*n* = 11)			
Pre	5.8 (8.3)	–6.1–3.8	0.605
Post	7.0 (9.0)		
Total stress			
Person referred (*n* = 9)			
Pre	25.6 (10.2)	6.7–14.9	0.000
Post	14.8 (10.6)		
Significant other (*n* = 11)			
Pre	10.2 (7.0)	–8.3–6.0	0.717
Post	11.4 (10.2)		

[a] 95% confident that the true value of the difference between pre- and post-therapy results lies between the values
[b] *P* represents the probability that the pre- and post-therapy difference happens by chance if there is truly no difference – two-tailed implies we are looking for a difference in either direction

Table 2 Paired *t* test: pre and post CD-RISC total scores

CD-RISC total	Mean (standard deviation)	95% confidence interval[a]	*P* (two-tailed)[b]
Person referred (*n* = 9)			
Pre	39.0 (12.2)	–24.0– –5.8	0.005
Post	53.9 (10.9)		
Significant other (*n* = 11)			
Pre	62.8 (11.7)	–11.4–7.4	0.646
Post	64.8 (10.9)		

[a] 95% confident that the true value of the difference between pre- and post-therapy results lies between the values
[b] *P* represents the probability that the pre- and post-therapy difference happens by chance if there is truly no difference – two-tailed implies we are looking for a difference in either direction

CD-RISC (see Table 2)

Resilience improved significantly for those referred to the group, but not for significant others although there was a small increase in the mean score for them overall.

WHOQoL (see Table 3)

Pre and post WHOQoL assessments were provided by the same 20 participants who provided pre and post DASS and CD-RISC assessments. Two people had too many missing values in their pre-therapy WHOQoL assessment to allow domain scale calculations; therefore they were excluded from the analysis.

For participants referred by their GP, psychological health and the living environment significantly improved after group therapy sessions; however, social relationships and physical health did not change significantly although there is a trend towards improvement for these domains too.

Although there were no changes found in the significant other group, the mean WHOQoL scores increased for physical health, psychological health and the living environment, but not for social relationships.

Qualitative data

There were 18 participants who attended the groups between July and September 2005, with eight being the most in any one group. In all but one case, the person attending as a significant other was the partner or spouse of the client. The exception was a female friend who attended with one of the clients.

Table 3 Paired *t* test: pre and post WHOQoL total subscale scores

WHOQoL subscales	Mean (standard deviation)	95% confidence interval[a]	*P* (two-tailed)[b]
Physical health			
Person referred (*n* = 8)			
Pre	45.5 (16.6)	–27.9–0.2	0.053
Post	59.4 (14.3)		
Significant other (*n* = 10)			
Pre	59.3 (23.6)	–14.6 –1.7	0.108
Post	65.7 (20.2)		
Psychological			
Person referred (*n* = 9)			
Pre	37.1 (14.2)	–28.1 – –5.2	0.011
Post	53.7 (15.0)		
Significant other (*n* = 11)			
Pre	59.2 (12.1)	–11.1–1.9	0.146
Post	63.8 (12.1)		
Social relationships			
Person referred (*n* = 9)			
Pre	51.0 (25.1)	–36.8–9.7	0.211
Post	64.6 (11.6)		
Significant other (*n* = 11)			
Pre	65.8 (16.4)	–14.4–17.8	0.820
Post	64.2 (17.1)		
Environment			
Person referred (*n* = 9)			
Pre	53.9 (10.5)	–23.4 – –6.3	0.005
Post	68.8 (11.6)		
Significant other (*n* = 11)			
Pre	60.9 (13.1)	–11.7–9.2	0.793
Post	62.2 (16.2)		

[a] 95% confident that the true value of the difference between pre- and post-therapy results lies between the values
[b] *P* represents the probability that the pre- and post-therapy difference happens by chance if there is truly no difference – two-tailed implies we are looking for a difference in either direction

Three participants attended two of the three groups offered. The woman who had attended with a friend attended a further group with her husband – she was interviewed twice as she attended with different people. Another couple attended a second group as they were only able to attend four of the six sessions in the first group they attended – they were interviewed once after the first group therapy they completed. There were 16 people interviewed, eight women and eight men.

Findings from semi-structured interviews are presented thematically. They include raw data in the form of participant quotes to illustrate and provide evidence for identified themes, and to add credibility to the analysis.[22] While participants from three separate 'significant other' groups were interviewed, several major, recurrent themes were located across all three groups of transcripts.

Five clients reported having previously participated in group therapy, although none had previously attended a group with a significant other. One client stated that she attended a social anxiety support group affiliated with an anxiety disorders association six years previously. Another reported having attended a general adolescent services group for two years, nine years previously. Three other clients reported having attended a therapeutic group for either depression or anxiety, at the ANEDGP earlier in the same year.

Repeated themes to emerge from participants' responses included: participation in the group facilitated participants' knowledge and understanding about the client, significant other and their relationship to the problem (i.e. anxiety/depression); participation in the group facilitated development of skills by both the client and significant other to help manage the problem; participation in the group facilitated development of self-care skills (e.g. relaxation, stress management) for both the client and significant other.

All of the participants in the study reported that they found it useful to attend the group with someone close to them rather than attending alone. The reason most frequently reported for this by both the clients and significant others was the increased understanding that the significant other was able to gain about their partner and their partner's mental health concerns by attending. Both clients and significant others reported that attending the group increased their personal understanding of mental health issues. One participant suggested that couples may benefit from attending the group together, stating that 'it's a really good learning process for two people to go through together'. This view was elaborated on by another participant who described her experience of attending the group with her husband by stating, 'we were able to feed off each other's questions and help each other understand'. The same participant also stated that attending with her husband raised her awareness of the ways in which the depression she has been experiencing has been affecting her relationship with her husband.

The shared involvement of clients and significant others in the group activities was mentioned by participants as a particularly helpful aspect of the group. For example, participation by significant others was reported to enhance group discussions through the inclusion of a greater diversity of perspectives and ideas. This was illustrated by one participant's comment: 'I found that we were able to have more rounded discussions by having significant others present. We were able to get more perspectives'. Participants also reported gaining a better understanding of both the clients' and significant others' problems. One client observed, '[my husband] realised that he can also get stressed sometimes'. She explained that through his participation in the group he gained greater insight into himself, and more awareness about how he responds to stress, as well as learning strategies for dealing with stress.

Participants also reported using the information they learnt in the group between weekly sessions with their partner. Several participants reported that having a significant other attend the group facilitated their transfer of skills learnt in the group to real-life situations. It also facilitated the shared or joint application of strategies learnt in the group in real-life situations. One participant explained, 'we could learn the stuff together and practise it when we got home'. The frequency of using the information learnt varied between participants, with several stating that they were able to remind each other to use some of the skills in stressful situations they encountered. Others commented that they applied the knowledge and skills learnt in the group to their shared parenting.

The significant others who were interviewed reported having benefited personally from participating in the group. They mentioned gaining knowledge and learning skills for their own benefit. One significant other stated, 'as the support person I got a lot out of it myself ... we all have day-to-day issues and problems we need to work through'. Another explained, 'it was helpful for me to learn how to cope with [my partner's depression]'. Another stated, 'I learnt that people with anxiety are normal people with problems'. One of the clients explained how her significant other who attended the group benefited from the sessions, when she stated, 'he was able to learn a few things for himself ... he learnt how to stay calm and not let things get to him as much'.

Another theme to emerge from the transcripts of significant others was that attending with a partner facilitated their self-disclosure in the group, as one

significant other stated, 'it made it easier to share'. Significant others reported that participating in the group helped them to develop a support network among the other significant others attending, and to take part in social interaction that they may otherwise not have access to. Significant others also reported that they appreciated the opportunity to speak up and contribute to the group processes from their perspective, which helped them to feel valued as a significant other.

Two of the significant others stated that they would not have attended a therapeutic group had the significant other format not been available. One significant other explained, 'being a support person, I wouldn't have gone by myself. It was more useful attending the group with my wife rather than attending a group for support persons alone'.

When asked what they thought could have been done differently in the group, one of the most frequent suggestions made by participants was to extend the group over a longer period of time, such as over eight to 12 weeks instead of six. Alternatively, follow-up group sessions were also suggested as a means of providing extended support to participants. Only one participant reported a disadvantage to having a significant other attending group therapy. His comment related to the discussion of sensitive relationship issues in a group context, which he sometimes found problematic, as he felt it challenged the confidentiality of his relationship with his partner. For example, a client may mention something during a group discussion that the significant other may not want revealed about themselves to the group.

A recurrent theme that emerged from the interviews was that attending the group with a spouse or partner enhanced relationship functioning. Comments to this effect included, 'I am far better as a support for my wife and our marriage is far better after attending the sessions'. Another participant made the following comment about attending the group with her husband, 'It has brought us a lot closer, and we talk more now'. One client explained that the shared experience of attending the group with her husband facilitated her discussion of sensitive topics with him. She explained, 'I was able to tell my husband things I wasn't able to before, such as things that had happened in the past'. One participant made the observation that it is preferable, in the interests of communication and relationship dynamics, for both members of a couple to learn and experience change as a result of attending the group together, rather than only one partner learning something new and making changes.

Discussion

For people referred to the groups by their GP, significant improvements were found in all DASS domains, resilience and psychological health and the living environment. No significant improvements were found for the significant others, although means in some domains were improved. Owing to the small sample size and the aberrant scores of one significant other, this finding needs to be considered with caution and indicates the necessity to collect more data to provide conclusive findings.

Interestingly, no significant improvements were found for social relationships. However, participants self-reported that they found it was useful to attend with a significant other, as it assisted them to gain a common understanding about anxiety and depression and insight into the impact it had on each other.

Compared to findings of this group format but with people attending alone,[6] the results are similar for DASS scorers and psychological health outcomes using the WHOQoL. For those attending alone, significant improvements in their physical health were detected.[6] This was not the case for those attending a group with a significant other. Conversely, significant improvements in living environment were seen for those attending with a significant other in the present pilot programme, but not for those attending alone.[6] Although it would require further exploration, possible explanations may be differences in marital and/or living arrangements between groups.

All participants were very positive about the group and found it helpful both for themselves and to support their loved one. In particular, they noted it fostered greater understanding and communication between them and provided strategies and skills they both could use and support each other to do so. This indicates that providing treatment and prevention strategies simultaneously is acceptable and advantageous to all participants.

Some clients suggested extending the group over a longer period of time, such as over eight to 12 weeks instead of six. Unfortunately, resources currently restrict the programme to six weeks. Results from the qualitative data give an indication of the improvements gained in six weeks, and therefore the adequacy of this time period.

Participants also suggested providing follow-up group sessions to provide extended support to participants. Again, programme restrictions allow clients to attend up to two group therapy programmes within a 12-month period.

One participant reported that a disadvantage to having a significant other attending group therapy was that confidentiality within their relationship could be compromised. It may be prudent in future groups to address this issue when establishing group guidelines at the outset, and to suggest partners discuss this topic privately between group sessions.

It is interesting that some participants used the term 'support person', despite it being emphasised from the outset of the group that the role of the significant other was not as the support person for the client or coach or co-therapist, but rather the aim was that each person should give and receive mutual support. The use of the 'support person' term was particularly evident in the way that significant others spoke about their experience in the group and their role in the relationship. This indicates that the group process was not entirely successful in addressing the issue of the sick/supporter roles. Additional strategies need to be devised for future groups to address this shortfall.

Future research needs to compare the effectiveness of this group therapy format with a control group or group therapy where clients and significant others attend alone, to continue to explore the nature of any benefits experienced by significant others attending these groups. Another area to explore is whether an additional focus on interpersonal skills and relationships within the groups would be of benefit. It would also be interesting to develop and test this model of group therapy in other mental health disorders.

Conclusion

Overall, although this is a pilot study and thus has limitations, the outcome was useful, in that it indicates an acceptable format for both clients and their loved ones, and it facilitated a number of positive outcomes for participants. Improvements in client well-being and functioning, and decrease in symptomatology were observed and reported, through both self-report measures and semi-structured interviews. It is recommended that future groups include strategies to improve social relationships and to address participants' identification with the sick/supporter role. Further groups of this nature and structure could also be developed, implemented and tested in diverse populations and clinical groups. For example, 'significant other' groups may be conducted to address other mental health disorders such eating disorders, psychosis and postnatal depression.

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CONFLICTS OF INTEREST

None.

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