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Exploring encounter groups: A research proposal on what works to improve the mental wellbeing of adults at risk of depression

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Abstract: The pervasive prevalence and burden of depressive disorders underscore the urgent need for action in prevention, recognition and treatment. Proactively addressing this condition among at-risk populations holds immense potential to positively impact individuals, their significant others, society, and the economy. Encounter groups (EGs) facilitate self-exploration, emotional expression and interpersonal learning in a psychologically safe and confidential space, enabling participants to express themselves without fear of judgement. This supportive environment encourages participants to explore and appreciate vulnerability, fostering openness and trust among group members. This study aims to investigate the efficacy of a novel approach to prevention, using EGs to enhance the mental wellbeing of adults vulnerable to depression. Additionally, it explores the feasibility of a co-production model, wherein lay individuals are trained to facilitate EGs. Employing a mixed methods approach with a randomised control trial, this proposed research aims to test both quantitative hypothesis and qualitative inquires. Statistical and thematic analyses would help generate a comprehensive understanding. It is hypothesised that EGs offer a promising, cost-effective strategy for promoting the mental wellbeing of at-risk adults. This has potential applicability across diverse resource settings, thereby broadening access to psychological and social support for managing depressive symptoms.

Keywords: Depression prevention; psychological interventions; encounter groups; adults; mixed methods.

Word count: 3,601

Introduction

Depression, a widespread and debilitating condition, afflicts approximately 280 million individuals worldwide (Global Health Data Exchange, 2023). Recognised by the WHO's Mental Health Gap Action Programme as a priority condition (The World Bank Group, 2016), depression is a significant global health concern. In England, one in six adults suffers from depressive symptoms (Office for National Statistics, 2022). The COVID-19 pandemic has further exacerbated the prevalence of major depressive disorder and anxiety disorders (Santomauro, et al. 2021). Often recurrent, chronic depression (Hollon et al., 2002) not only impacts physical and psychological health, but also extends its effects to families, society, and the economy. Moreover, accumulated evidence suggests that depression is '*avoidable*' (Herrman et al., 2021, p3), highlighting the necessity for preventive measures and interventions to mitigate its impact.

While considerable attention is given to detecting and treating depression, preventive strategies for non-specific, at-risk adult groups remain under-researched, especially in contrast to postnatal depression. Herrman et al. (2021, p6), in their Lancet-World Psychiatric Association Commission report, point out that depression is still a '*poorly recognised and understood health condition'*. At-risk individuals, experiencing depressive feelings not otherwise classified (Rodríguez et al., 2012; Baumeister & Morar, 2008), face significant challenges in daily functioning and quality of life. Despite the benefits of the Improved Access to Psychological Therapy (IAPT) in the UK (Binnie, 2015), access to treatment for depressed patients stays a challenge, with '*average waiting times for first treatment varied substantially across England, from 4 to 229 days*' (Baker & Kirk-Wade, 2023, p24).

One consequence of these waiting lists is that patients endure depressive conditions whilst awaiting real treatment. The suffering is '*mysteriously painful'* and '*nearly incomprehensive to those who have not experienced it in its extreme mode'* (Styron, 1990). The established mental health care system grapples with a substantial funding gap (Gilburt, 2015; Boer et al., 2005; World Bank Group, 2016), struggling to meet the rising need for depression care (Boer et al., 2005). Amid ongoing austerity measures (Iacobucci, 2016) that have had adverse effects on mental health services and contributed to an increase in depression and suicides in high income countries (Karanikolos et al., 2016), at-risk individuals are often not given priority. Nevertheless, '*prevention is essential to reducing the burden of depression'* (Herrman et al., 2021, p.6). Therefore, it is crucial to establish scientific evidence for cost-effective and sustainable strategies for preventing depression.

This study aims to investigate the efficacy of encounter groups (EGs) in enhancing mental well-being and reducing the risk of clinical onset of depression in nonspecific adult groups (e.g. postnatal depression). Building on Rogers' encounter groups (EGs) (1974), this intervention incorporates the concept of co-production (Realpe & Wallace, 2013), allowing clients to contribute to longer-term benefits. Co-production stems from Rogers' (1951) client-centred philosophy and has evolved as a new model of service delivery in health and social care services, creating an assets-based approach as opposed to the deficit model. The traditional deficit model emphasizing assessing service users' needs and diagnosing conditions, whereas the assets approach appreciates the skills, strengths and abilities of individuals or communities, and enables people to utilise their assets to improve self-care abilities or enhance their health and wellbeing.

Literature

Rationale for using EGs

Psychological interventions are more acceptable than antidepressants for many people with depression and research emphasises the need for interventions that demand less therapist expertise to enhance the access to prompt treatment (Jorm et al., 2008). The effect of paraprofessionals, as distinct from professionals with a psychotherapy training background in managing depression has been explored (Boer et al., 2005) and several randomised control trials (e.g. Bright, 1999; Bedi, 2000; Kelly, 1993) have compared the effects of treatments given by paraprofessionals with those by professionals. While there was insufficient evidence to draw conclusions about the comparable impact of paraprofessionals versus professionals, a significant positive effect for paraprofessionals

emerged. The term '*paraprofessionals*' refers to a wide range of personnel, such as general nurses, other allied health professions, and experienced patients, who have had relatively limited training in the types of clinical skills that can be expected of psychologists or psychiatrists (Grant, 1996; Moffic, 1984).

The basic aspects of EGs are small group size (8-18 members), with a relatively unstructured and non-directive, or '*leaderless*', approach (Rogers, 1974). Group members are able to freely express both real feelings and thoughts, positive and negative. With reduced defensiveness, they move toward greater acceptance of their total being, can hear each other, and can learn from each other. The facilitator's responsibility is primarily to develop a psychological climate of safety that allows for freedom of expression and the facilitator is themself a participant in the group, not in charge or manipulative, but interacting with others non-judgmentally and genuinely.

The foundational principles of EGs, encompassing therapist genuineness, empathy, and unconditional positive regard or '*acceptance*' (Arkowitz et al., 2008, p150) have been incorporated into the development of motivational interviewing (MI). MI is a client-centred, directive method designed to alleviate ambivalence about change and to enhance intrinsic motivation for change (Miller & Rollnick, 2002). While MI distinguishes itself from Rogers' (1951; 1959) client-centred therapy by emphasizing specific goals, such as increasing the client's motivation to change through eliciting change talk, it acknowledges that the principles of a non-judgemental attitude, empathy and unconditional positive regard are precursors to growth and change (Miller & Rollnick, 2002). Many studies have demonstrated the efficacy of these elements in the treatment of depression using the MI technique (e.g. Goldman, Greenberg & Angus, 2006; Elliot et al., 2004). Furthermore, empathy has been found to exert substantial effects in enhancing therapeutic outcomes in depression (Burns & Nolen-Hoeksma,1992).

In the literature these variables are commonly referred to as non-specific factors, e.g. empathic listening, encouragement, warmth, focusing on participants' problems and concerns. These factors are considered part of the basic interpersonal skill set of a therapist rather than specific psychological techniques (Cuijpers et al., 2012). These non-specific factors are easily recognisable in non-directive supportive therapies (NDST), commonly described as counselling, supportive therapy and non-specific therapy. Cuijpers et al. (2012) conducted a meta-analysis on the contribution of non-specific factors versus specific factors to the improvement of depressed patients, and their findings confirm that NDST is efficacious for mild to moderate adult depression. In addition, non-specific factors are found to have accounted for most of the effects, in contrast to the limited contribution by specific techniques.

Potential impact of EGs

The studies outlined suggest the therapeutic potentiality of EGs in mitigating the risk of developing major depression as a preventive strategy. This potential is attributed to the emphasis on empathetic understanding, genuineness, active listening, and the non-directive style of facilitation with EGs. Trust in the group's capacity to develop its own goal, and the acknowledgement of the incredible potential for mutual assistance among ordinary and untrained individuals, are key principles (Rogers, 1974).

The EG intervention is simple and can be implemented by health professionals from any discipline, including lay people, after brief training, in various settings. For example, EGs can be embedded into nursing practices in care homes, communities, primary care and acute settings. As a non-clinical intervention, it can also be offered in the form of social prescribing, typically delivered through primary care initiated either through a General Practitioner (GP) referral or self-referral. Furthermore, encounter group members can actively take part in implementing this intervention through a peer-to-peer approach. For instance, an appropriate client could be identified during the process of the EGs, empowered to assume the facilitator's role, and allowing for the contribution of EG sessions over a longer period to generate enduring effects. This transformation turns EGs into a more sustainable strategy for promoting well-being, wherein individuals leverage their own skills and strengths to improve self-care abilities and provide support within community. Hollon et al. (2002) suggest that learning outcomes from psychosocial interventions such as emotional regulation or

improved social relationships have specific potential for producing enduring effects. These outcomes were observed both during the process of EGs and afterwards (see Rogers, 1974).

Research proposal and methods

Bearing these factors in mind, this study sets out the following research proposal:

Objectives
Primary aims:

- To assess the effectiveness of encounter groups in enhancing the mental well-being of individuals at risk of depression.
- To examine the impact of encounter groups on individuals with suspected depression from their perspectives.

Secondary aims:

- To explore the feasibility of a co-productive, asset-based approach and volunteers' experiences of undertaking the EG facilitator role.

Hypothesis
Participants in encounter groups will demonstrate improved mental wellbeing scores compared to those in control groups.

Qualitative questions

- What are participants' experiences of engaging in encounter groups?
- What are the experiences of participants who facilitate or lead encounter groups?
- Is the co-productive approach feasible for facilitating encounter groups?

To achieve this, the following research methodology is proposed:

Participants
The participants would include adults (age ≥ 18) who have had any of the following symptoms for at least two weeks or more, which are below the ICD-10 threshold criteria:

1) feeling down
2) not being able to enjoy the things they usually enjoy
3) avoiding people, even those close to them
4) low energy or fatigue.

Those with any of the following would be excluded from participating: Diagnosed depression; Suicidal thoughts or acts; Non-English speakers; Multiple chronic physical health problems.

Sample size calculations will be conducted for the randomised control trial, aiming to recruit an equal sample size for both the encounter and control groups.

Design
The study aims to employ a mixed-methods randomised control trial approach to provide a comprehensive understanding of variations between encounter groups and the control group, along with identifying common themes generated from participants' experiences in encounter groups. The randomised controlled trial design allows for the evaluation of the efficacy of encounter groups for suspected depression and its magnitude. Semi-structured interviews with a purposeful sampling would be conducted with several participants from each group to assess wellbeing outcomes. The rationale behind purposeful sampling is to identify and select information-rich cases, optimising the effective use of limited resources (Patton, 2002). Selection criteria include participants' availability, willingness to participate, and their ability to articulate experiences and opinions in a reflective manner (Bernard, 2002).

Measurements
The validated and widely used Warwick-Edinburgh Mental Well-being Scale (WEMWBS) and the Patient Health Questionnaire-9 (PHQ-9) (Spitzer et al., 1999) would be used. WEMWBS is

developed to measure subjective wellbeing, from feelings to psychological functioning, and can be used to measure the effectiveness of a particular programme for improving mental health and wellbeing (Stewart-Brown & Janmohamed, 2008). The scale has 14 items with five response categories, which are summed to generate a single score within the range of 14-70. The PHQ-9 is also a reliable and valid measure of both detecting depression and assessing depression severity (Kroenke et al. 2001). In addition, both self-assessment instruments are simple, brief and easy for participants to use.

Procedure

Phase One: Eligible participants would be randomly allocated to either group, ensuring an equal sample size for each group if recruitment allows. The researcher, with nursing background but not specialised in mental health, to lead the encounter groups. To manage the groups effectively, the encounter group to be divided into smaller groups of no more than 10 individuals; each group to participate in the EG session once a week for 12 weeks. Both the encounter and control groups to undergo baseline measurements using WEMWBS and PHQ-9, and these measures will be reassessed at weeks 3, 6, 9, and 12. At the conclusion of the 12 weeks, the researcher to conduct semi-structured interviews with selected participants from encounter groups.

Phase Two: During the EG process, appropriate participants to be identified and selected to undertake the facilitator's role. To prepare them for this new activity, the researcher will reflect on the EG experience with the participants and provide brief training. The EG sessions to continue weekly for 6 weeks; the rationale for 6 weeks rather than 12 being that the shortened duration might be more acceptable for the participant acting as the facilitator for the first time. The WEMWBS and PHQ-9 measurements would be repeated in the third and sixth weeks or, in fact, weeks 15 and 18. Follow-up measurement to be taken in 6 months and 12 months, respectively. A semi-structured interview would be conducted with the participant facilitators at the conclusion of week 6.

Data Analysis

First, quantitative and qualitative data will be analysed sequentially. The Independent Samples t-Test to be used to compare both the mean WEMWBS scores and the mean PHQ-9 scores of the encounter groups and the control group. The effect size to be determined by calculating the mean differences between the two groups, and then dividing the result by the standard deviation. The results of the first 12 sessions by the researcher will be compared with those of the last 6 sessions by the lay person, an EG group member. For qualitative data, thematic analysis to be conducted to identify common themes generated from the experiences of EG members. Second, the integration of mixed methods to be conducted to uncover enriched findings that would not be attainable through either method alone.

Ethical Considerations

Prior to the study, ethical approval to be sought from an appropriate Research Ethics Committee.

Conclusions

The introduction of the EG intervention holds promise for reaching a wider population of adults who experience depressive symptoms below the diagnostic threshold. This approach presents a cost-effective strategy with potential for long-term social and economic benefits. By targeting at-risk populations, it has the potential to alleviate the demand for formal mental health services, positively affecting both individuals and their significant others. The affordability and potential cost-effectiveness of EGs underscores the necessity for studies explicitly assessing their efficacy as a preventive measure for depression.

The proposed study aims to examine the effect of EGs on reducing the risk of depression among adults, thus contributing to the body of evidence on depression prevention, investigating EGs as a novel approach. The relatively low resource requirements for implementing EGs suggest their feasibility in various settings.

Quantitative results may reveal improvements in WEMWBS and PHQ-9 scores among EG participants compared to control groups across various assessment points. Additionally, qualitative interview findings may illuminate participants' positive experiences with regular group meetings, providing valuable insights into the potential benefits of this intervention. Interviews with EG facilitators could also shed light on the feasibility of a co-production approach to depression prevention and mental health promotion.

Even if quantitative results do not show significant differences between the encounter and control groups, qualitative findings can offer valuable insights into factors influencing individuals' engagement with EG sessions and questionnaire responses. Such insights, along with other findings from the study, could inform and refine future research designs for prevention strategies.

In conclusion, exploring the efficacy of EGs in depression prevention aligns with the urgent global priority of addressing one of the global disease burdens–depression. As Herrman et al. (2022) emphasise, prevention, along with early detection and treatment, is paramount in addressing this pressing issue. Therefore, investigating the EG intervention represents a worthwhile endeavour with the potential to positively impact public health and wellbeing.

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