Symposium

Using Groups in the Delivery of Healthcare
Using Groups in the Delivery of Healthcare

Conveners:
Mark Tarrant and Sammyh Khan

Speakers:
Aleksandra Borek, University of Exeter
Andrew Turner, Coventry University
Juliet Wakefield, University of Dundee
Sammyh Khan, University of Exeter
Using Groups in the Delivery of Healthcare

- Groups are a pervasive feature of our daily lives and structure health

- We work, rest and play in groups
  - Lifespan
    - Group socialisation

- Groups are increasingly used to deliver healthcare (interventions)
  - Community interventions (e.g., self-help groups for chronic illness, stroke singing groups)
  - Clinical interventions (e.g., CBT; weight loss)
Using Groups in the Delivery of Healthcare

- Some evidence that group treatments are at least as effective as individual ones

- But questions remain:
  - When don’t they work? Do they work for everyone? In all contexts?
    For all illnesses? How do they work? What are the critical ingredients? What’s the “dose” required?
  - Are they cost effective?

- This symposium explores some of these questions

- 4 talks: different conditions; different methodologies
Using Groups in the Delivery of Healthcare

1. Aleksandra Borek (University of Exeter)
   - Group-based diet and physical activity interventions for weight loss

2. Andy Turner (Coventry University)
   - The role of hope on group-based chronic disease self-management programmes

3. Juliet Wakefield (University of Dundee)
   - Support group identification and mental health among people with multiple sclerosis

4. Sammyh Khan (University of Exeter)
   - Patient experiences of a lifestyle intervention for managing obesity: Nurturing social identity, accessing resources

Discussant: Prof. Mark Conner (University of Leeds)
GROUP-BASED DIET AND PHYSICAL ACTIVITY INTERVENTIONS FOR WEIGHT LOSS.

PRELIMINARY FINDINGS

Aleksandra Borek
Charles Abraham, Colin Greaves & Mark Tarrant

University of Exeter Medical School
Psychology Applied to Health group

UKSBM, Nottingham, 3 December 2014
Small lifestyle changes can reduce risk of weight-related diseases

• Burden of weight-related diseases

• Lifestyle changes can reduce risk of type 2 diabetes
  • Weight loss of 5 - 10%
  • Healthy diet: high in fibre, low in fat & saturated fat
  • Engaging in moderate physical activity (≥ 30 mins/day)

NICE, 2012
Large variations in effectiveness of weight loss interventions

Diet + behaviour therapy + exercise vs control at 12 months

Avenell 2004 *Health Technol Assess*
Systematic review of reviews of intervention components associated with increased effectiveness in dietary and physical activity interventions

Colin J Greaves, Kate E Sheppard, Charles Abraham, Wendy Hardeman, Michael Roden, Philip H Evans, Peter Schwarz, The IMAGE Study Group

- Weight loss: 3-5kg at 12 mths, 2-3kg at 36 mths

- Intervention effectiveness increased by:
  - Engaging social support
  - Targeting both diet and physical activity
  - Using well-defined BCTs
  - Increased contact frequency
  - Using ‘self-regulatory’ BCTs (e.g., goal-setting, self-monitoring)

Greaves 2011 BMC Public Health
Many effective interventions are delivered in groups

- Self-management of T2DM\(^1\)
  - Decreased blood glucose, blood pressure & body weight, reduced need for medication

- Commercial weight loss programmes\(^2\)
  - Largest trial of Weight Watchers: 3.2% WL

- Community-based interventions to prevent T2D\(^3\)
  - Improvements in knowledge, adoption of regular PA

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Benefits of group setting for delivering health interventions

• Time- and cost- effective

• Group dynamics & social support

• Personal preference
Effectiveness of group vs individual interventions for weight loss at 12 mths

Avenell 2004 Health Technol Assess

Paul-Ebhoimhen 2009 Obesity Facts
Research Questions

• How are group-based diet and physical activity interventions designed and delivered?

• How effective are these interventions for weight loss?
Methods: search strategy

• 5 electronic databases searched: MEDLINE, EMBASE, Cochrane Library, PsycINFO, CINAHL

• Detailed search strategy based on PICOS model
  • Population
  • Intervention
  • Comparator
  • Outcomes
  • Study Design
  + Group setting
Selection Criteria

- **Population:** healthy overweight & obese adults
- **Intervention:** group-based, diet and/or PA, behavioural, educational or psychological
- **Comparator:** no intervention, minimal intervention, usual care, irrelevant intervention
- **Outcomes:** weight loss
- **Study Design:** RCTs
- **Other:** full text available in English, reports of intervention evaluations
Study selection

Records identified through database searching: 3,677

Records screened (Ti + Ab) 1,798

Full texts excluded: 239

Reasons for exclusion:
- Population: 105
- Intervention: 25
- Comparator: 58
- Outcomes: 4
- Study design: 28
- Other: 19

# included references: 37
# studies: 32
# group interventions: 38
Study characteristics \( (n=32) \)

- **Dates:**
  - 1992 – 2013

- **Study design:**
  - RCTs (27)
  - Cluster RCTs (5)

- **Countries:**
  - USA (20)
  - Canada (4)
  - Australia (4)
  - Japan, Portugal, Switzerland, UK (1)

- **Total participant pool:**
  - 7,600
  - Range: 34 to 2382
Study characteristics (n=32)

• Control groups:
  • No intervention (14)
  • Usual care (7)
  • Minimal intervention (6)
  • Irrelevant intervention (5)

• Primary aim:
  • weight loss (17)
  • prevention of T2D (9)
  • blood pressure & prevention of hypertension & CVD (3)
  • physical functioning (2)
  • eating behaviours (1)
Intervention characteristics (n=38)

- Delivery modes:
  - Mixed mode (21)
  - Groups only (17)

- Target behaviour:
  - Diet & PA (31)
  - Diet only (5)
  - PA only (2)

- Mixed mode delivery:
  - Self-delivered in print (15)
  - 1 to 1 consultations (6)
  - 1 to 1 online contact (6)
  - Telephone calls (5)
  - Self-delivered online/app/armband (3)
  - Video (1)

- Setting:
  - Community (9)
  - Primary care (2)
  - Hospital (2)
  - University (2)
  - Commercial (1)
  - Worksite (1)
  - Not reported (21)
Design

- **Source / development:**
  - Previous programmes (14)
    - DPP (7)
  - Formative research (5)
  - Not reported (20)

- **Theoretical background / change mechanisms:**
  - Social cognitive theory (8)
  - Self-efficacy (3)
  - Relapse prevention (2)
  - Transtheoretical model (2)
  - Not reported (23)

Contact time

- **Duration:**
  - 1.5 – 12 mths (M 5.25)
- **Total # group sessions:**
  - 5 – 90 (M 21.5)
- **Frequency:**
  - Weekly (19)
  - Decreasing frequency (7)
  - 2-4 x week (3)
  - Fortnightly (1)
  - Not reported (8)
- **Length:**
  - 30 - 180min (M 84) (n/r 12)
- **Total contact time by 12mths:**
  - 8 - 96hr (M 24.5) (n/r 13)
Participants

- Gender:
  - Women only (19), male only (2), mixed (17): 44% to 85% of women
- Tailored to specific groups (7):
  - Latino/Hispanic, Mexican American, African American
- Participants’ materials:
  - Manuals (18), s/m diaries (11), pedometers/accelerometers (8)
- Group size
  - 3 – 20, M = 8.5 (n/r 20)
- Attendance:
  - 57% - 84% sessions attended, M = 74% (n/r 28)
- Attrition:
  - 5.9% - 48.5% drop out, M = 18.6% (n/r 8)
Facilitators

• Background:
  • Multidisciplinary teams (7)
  • Dieticians (6)
  • Health workers (5)
  • Lay facilitators (3)
  • Grad students, GPs, nurses (2)
  • Community members (1)
  • Not reported (10)

• Number of facilitators:
  • Not reported (31)

• Facilitators’ training in intervention delivery:
  • Yes (16)

• Facilitators’ training in group facilitation:
  • Yes (3)
Behaviour change techniques

• CALO-RE (Michie et al., 2011):
  • Prompt self-monitoring of behaviour (21)
  • Goal setting (outcome) (13)
  • Barrier identification / problem solving (14)
  • Model / demonstrate the behaviour (8)
  • Relapse prevention / coping planning (6)

• Other ‘techniques’:
  • Hands-on group activities for skills development (6)
  • Sharing practical tips (5)
  • Tailoring the content to specific populations (5)
Mean weight loss [kg] at 3-6 months

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Intervention Mean</th>
<th>Intervention SD</th>
<th>Intervention Total</th>
<th>Control Mean</th>
<th>Control SD</th>
<th>Control Total</th>
<th>Mean Difference Mean Difference IV, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archer 2012 GLY+SWA</td>
<td>96.83</td>
<td>2.99</td>
<td>49</td>
<td>101.23</td>
<td>3.03</td>
<td>50</td>
<td>-4.40 [-5.59, -3.21]</td>
</tr>
<tr>
<td>Archer 2012 GWL</td>
<td>100.74</td>
<td>2.99</td>
<td>49</td>
<td>101.23</td>
<td>3.03</td>
<td>50</td>
<td>-0.49 [-1.68, 0.70]</td>
</tr>
<tr>
<td>Cousins 1992 Family</td>
<td>89.7</td>
<td>12.7</td>
<td>27</td>
<td>76.8</td>
<td>12</td>
<td>27</td>
<td>-7.10 [-13.69, -0.51]</td>
</tr>
<tr>
<td>Cousins 1992 Individual</td>
<td>74.8</td>
<td>13.9</td>
<td>32</td>
<td>76.8</td>
<td>12</td>
<td>27</td>
<td>3.3% [2.00, 4.61]</td>
</tr>
<tr>
<td>Folla 2009</td>
<td>87.7</td>
<td>19.6</td>
<td>55</td>
<td>85.9</td>
<td>13.9</td>
<td>30</td>
<td>2.8% [1.80, 3.83]</td>
</tr>
<tr>
<td>Gillett 1995 Education</td>
<td>63.5</td>
<td>11.6</td>
<td>52</td>
<td>67.2</td>
<td>11.1</td>
<td>23</td>
<td>4.3% [-3.70, 1.86]</td>
</tr>
<tr>
<td>Gillett 1995 Education+Exercise</td>
<td>63.3</td>
<td>10.4</td>
<td>53</td>
<td>67.2</td>
<td>11.1</td>
<td>23</td>
<td>4.7% [-3.90, 1.36]</td>
</tr>
<tr>
<td>Katula 2011</td>
<td>87.14</td>
<td>1.22</td>
<td>151</td>
<td>91.55</td>
<td>1.38</td>
<td>150</td>
<td>14.6% [-4.41, -7.70]</td>
</tr>
<tr>
<td>Lubans 2012</td>
<td>101.7</td>
<td>14.6</td>
<td>27</td>
<td>104.9</td>
<td>13.2</td>
<td>26</td>
<td>2.7% [-3.20, -0.40]</td>
</tr>
<tr>
<td>Moore 2011</td>
<td>78.11</td>
<td>14.98</td>
<td>180</td>
<td>81.2</td>
<td>17.39</td>
<td>72</td>
<td>5.6% [-3.09, -7.66]</td>
</tr>
<tr>
<td>Munsch 2003</td>
<td>93</td>
<td>17.6</td>
<td>32</td>
<td>85.5</td>
<td>6.8</td>
<td>7</td>
<td>2.5% [7.40, 15.31]</td>
</tr>
<tr>
<td>Nakata 2011</td>
<td>65.7</td>
<td>9.5</td>
<td>63</td>
<td>68.1</td>
<td>10.5</td>
<td>63</td>
<td>7.5% [2.40, 11.10]</td>
</tr>
<tr>
<td>Provencher 2009 HAES</td>
<td>77.4</td>
<td>8.4</td>
<td>44</td>
<td>80.3</td>
<td>9.1</td>
<td>38</td>
<td>6.9% [-0.90, 6.71]</td>
</tr>
<tr>
<td>Provencher 2009 Social Support</td>
<td>80.5</td>
<td>10</td>
<td>39</td>
<td>80.3</td>
<td>9.1</td>
<td>38</td>
<td>6.1% [0.20, 11.47]</td>
</tr>
<tr>
<td>Ross 2004</td>
<td>80.1</td>
<td>11.2</td>
<td>15</td>
<td>88.5</td>
<td>7.4</td>
<td>10</td>
<td>2.9% [-0.65, 15.79]</td>
</tr>
<tr>
<td>Schroder 2010</td>
<td>98</td>
<td>17.3</td>
<td>31</td>
<td>98</td>
<td>16.1</td>
<td>30</td>
<td>2.3% [0.00, 8.38]</td>
</tr>
<tr>
<td>Steffen 2001</td>
<td>85.4</td>
<td>17.1</td>
<td>45</td>
<td>94.7</td>
<td>17.9</td>
<td>22</td>
<td>2.0% [-9.00, 11.76]</td>
</tr>
<tr>
<td>Tanco 1998 Behavior Therapy</td>
<td>101.8</td>
<td>14.8</td>
<td>18</td>
<td>112.5</td>
<td>20.1</td>
<td>12</td>
<td>1.0% [-10.70, 12.57]</td>
</tr>
<tr>
<td>Tanco 1998 Cognitive Treatment</td>
<td>111.1</td>
<td>18.4</td>
<td>19</td>
<td>112.5</td>
<td>20.1</td>
<td>12</td>
<td>0.9% [-1.10, 12.80]</td>
</tr>
</tbody>
</table>

Total (95% CI) 987

Heterogeneity: Tau² = 0.32; Chi² = 62.09, df = 16 (P < 0.00001); I² = 71% 
Test for overall effect: Z = 4.11 (P < 0.00001)

Effect estimate: -2.88 [-4.25, -1.51]

19 studies
1,697 participants
Mean weight loss [kg] at 9-12 months

8 studies
1059 participants

Effect estimate: -4.70 [-6.88, -2.52]
Quality of reporting

Borek et al. Checklist to improve reporting of group-based behaviour-change interventions

4. Total # of group sessions
7. Duration of the intervention
21. F professional background
6. Frequency of group sessions
5. Length of group sessions
9. Change techniques
12. Participants’ materials
2. General setting
10. Session content
18. Group size
1. Intervention source/ development methods
23. F training in intervention delivery
8. Change mechanisms or theories
13. Activities during the sessions
26. Intended facilitation style
22. F personal characteristics
19. Number of facilitators
14. Methods for checking fidelity of delivery
20. Continuity of F group assignment
25. F materials
24. F training in group facilitation
11. Sequencing of sessions
17. Continuity of P group membership
16. Methods for group allocation
15. Group composition
3. Venue characteristics

Number of studies, N=32
Discussion

- Search & screening:
  - Identifying group-based interventions proved problematic
- Quality appraisal
  - Incomprehensive reporting
- Intervention design
  - Considerable variability in design
  - Unclear session content & BCTs
- Intervention delivery
  - Fidelity of intervention delivery
  - Low attendance & large attrition rates
- Effectiveness
Implications & Conclusions

• To what extent can we
  • compare the interventions?
  • generalise from the findings?

• What we can do:
  • Improve study designs
  • Build on formative research and previous studies
  • Improve process evaluation
  • Improve reporting
THANK YOU

Aleksandra Borek a.borek@exeter.ac.uk
Charles Abraham, Colin Greaves, Mark Tarrant

University of Exeter Medical School
Psychology Applied to Health group
The role of hope on group-based chronic disease self-management programmes

Andy Turner : PhD, HCPC Registered Health Psychologist, MBPsS
“I wanna tell you a story of…”

• Positive psychology

• Depression

• Peer support

• Why it’s better to be hopeful than optimistic!
HOPE Programmes
### Living Well and Ageing Well

<table>
<thead>
<tr>
<th>I was diagnosed early</th>
<th>I understand, so I make good decisions</th>
<th>I get the treatment and care which are best for my cancer, and my life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those around me are well supported</td>
<td>I am treated with dignity and respect</td>
<td>I know what I can do to help myself and who else can help me</td>
</tr>
<tr>
<td>I can enjoy life</td>
<td>I feel part of a community and I'm inspired to give something back</td>
<td>I want to die well</td>
</tr>
</tbody>
</table>

By 2014, all people living with dementia in England should be able to say:

1. I was diagnosed early
2. I understand, so I make good decisions and provide for future decision making
3. I get the treatment and support which are best for my dementia, and my life
4. Those around me and looking after me are well supported
5. I am treated with dignity and respect
6. I know what I can do to help myself and who else can help me
7. I can enjoy life
8. I feel part of a community and I'm inspired to give something back
9. I am confident my end of life wishes will be respected, I can expect a good death

- Quality of life outcomes for people living with and beyond cancer. What patients want. (Ciaran Devine, CE Macmillan Cancer Support, 10, August 2012)
- Quality outcomes for people with dementia: building on the work of the National Dementia Strategy
Preliminary work

Antecedent generation

Target selection

Strategy generation

Build pilot

Build final

Test Pilot

Measurement choice

Implement and monitor

If you build it, they will come


What is HOPE?

5 ways to wellbeing

- Take notice
- Connect
- Keep learning
- Be active
- Give

5 MH recovery concepts

- Hope
- Personal responsibility
- Self-advocacy
- Education
- Support

www.neweconomics.org/projects/entry/five-ways-to-well-being

www.mentalhealthrecovery.com

eHOPE

• Self-monitoring tools
• Quizzes
• Worksheets/diaries
• Audio & Video materials
• Interactive gratitude and goal setting walls
• Social networking via email and forums
• Moderated by peer coaches
HOPE Programme theory/process

• **Group curative factors**
  – Universality (“We’re all in the same boat”)
  – Altruism
  – Instilling hope

• **Positive psychology/positive emotions**
  – Hope theory
  – What’s right with you?

• **Social cognitive theory**
  – Doing precedes feeling (mastery)
Adult State Hope Scale

If I should find myself in a jam, I could think of many ways to get out of it
At the present time, I am energetically pursuing my goals
There are lots of ways around any problem that I am facing now
Right now, I see myself as being pretty successful
I can think of many ways to reach my current goals
At this time, I am meeting the goals that I have set for myself

“A cognitive set that is based on a reciprocally-derived sense of successful agency (goal-directed determination) and pathways (planning to meet goals)”. Snyder

“Optimism is the belief that things will get better. Hope is the belief, that if we work hard enough, we can make things. It needs no courage, only a certain naivety, to be an optimist. It needs a great deal of courage to have hope.” Rabbi Jonathan Sacks
# HOPE

## Cancer Survivors eHOPE

<table>
<thead>
<tr>
<th></th>
<th>Pre course Mean (SD)</th>
<th>Post-course Mean (SD)</th>
<th>P value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASHS Hope</strong></td>
<td>28.6 (9.4)</td>
<td>36.2 (7.6)</td>
<td>&lt;.001</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>MS HOPE</strong></td>
<td>27.7 (12.1)</td>
<td>34.7 (10.4)</td>
<td>0.03</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Parent Caregivers</strong></td>
<td>24.9 (10.0)</td>
<td>37.5 (5.3)</td>
<td>&lt;0.001</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Depression

“Over 30 years of self-management research. I am convinced that the underlying mechanism which prevents behavior change is depression. If we don’t deal with the depression and distress none of the other stuff we do is going to make any difference”

Professor Kate Lorig
## Depression

### Cancer Survivors eHOPE

<table>
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<th>P value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHQ 9 depression</strong> (0-27↓ = better)</td>
<td>8.8 (5.0)</td>
<td>5.9 (5.3)</td>
<td>&lt;.001</td>
<td>0.6</td>
</tr>
</tbody>
</table>

### MS HOPE

<table>
<thead>
<tr>
<th></th>
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<th>Post-course Mean (SD)</th>
<th>P value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HADS depression</strong> (0-21↓ = better)</td>
<td>5.6 (3.3)</td>
<td>3.3 (1.9)</td>
<td>.050</td>
<td>0.7</td>
</tr>
</tbody>
</table>

### Parent Caregivers HOPE

<table>
<thead>
<tr>
<th></th>
<th>Pre course Mean (SD)</th>
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<td><strong>HADS depression</strong> (0-21↓ = better)</td>
<td>9.4 (4.4)</td>
<td>5.2 (3.5)</td>
<td>&lt;.001</td>
<td>1.0</td>
</tr>
</tbody>
</table>
Courage to hope..

“Just purely being able to discuss issues with other group members gave me the courage.” Gave me the courage to go forward and do things. ” I have taken away from the programme what it says on the packet, ‘hope for the future”

“I have learned something from everyone, including how to be more positive and set goals to achieve more. We have enjoyed a lot of laughter and some sadness – to meet others with similar issues has been a good thing”
Hope, optimism and resilience and their relationship with workplace outcomes (Youseff and Luthans 2007)
Conclusion

• SM positive psychology course fosters hope and reduces depression
• Findings are consistent across delivery formats
• A wellness approach has the potential to address occupational and public health targets.
Thank you: Get social with us

www.hopeprogramme.co.uk

@HopeProgramme

HOPE Programme
Support Group Identification and Mental Health Among People with Multiple Sclerosis

Dr. Juliet R. H. Wakefield
Ms. Sarah Bickley
Prof. Fabio Sani
School of Psychology, University of Dundee, Scotland.

UKSBM, Nottingham, Dec 3rd 2014
Multiple Sclerosis (MS)

- Chronic neurological disease involving demyelination of nervous system.
- Affects 100,000 UK people.
- Fatigue, numbness, vision problems, bladder/bowel problems.
- Sub-types:
  - Relapsing–Remitting (periods of symptom remission & periods of relapse).
  - Primary Progressive (slow & continual worsening of symptoms).
  - Secondary Progressive (RR transitioning into steadier worsening of symptoms).
MS and psychological problems

• MS linked to range of psychological problems:
  > Depression
  > Anxiety

• Possible solution: support groups, but little evidence to support:
  > No improvements in depression in 8-week MS peer-support programme. (Uccelli et al., 2004)
  > CBT & antidepressants more effective than group therapy at reducing depression in MS. (Mohr et al., 2001)

• But: these studies fail to assess extent of support group identification.
Group Identification

- Social identity perspective (e.g., Turner et al., 1987).
  > Sense of belonging to group & commonality with members (Sani et al., 2014).

- Group identification linked with health via:
  > Social support.
  > Encouragement to behave healthily (Sani et al., 2014).
  > Sense of meaning & purpose.

- Supporting evidence (Sani et al., 2010/2012):
  > Highly-identifying prison guards report less psychiatric disturbance.
  > Lower depression in those identifying highly with family/army unit.

- **Hypothesis**: positive link between support group identification & mental health.
  > Does effect-size differ between MS sub-types?
Methods

• 152 people with MS (56 males, 96 females) recruited via UK MS support groups.

• Completed a questionnaire featuring measures of:
  > Support group identification (Doosje et al., 1995).
  > Anxiety (Zigmond & Snaith, 1983).
  > Depression (Zigmond & Snaith, 1983).
  > Satisfaction with Life (Diener et al., 1985).
  > Years of education & Age.

• Demographics:
  > 47.37% had depression.
  > 73.03% had anxiety.
  > Mean MS duration = 13.55 years.
  > Mean age at diagnosis = 38.37 years.
# Results: Correlations

<table>
<thead>
<tr>
<th></th>
<th>1. Support Group Identification (1-7)</th>
<th>2. Depression (0-21)</th>
<th>3. Anxiety (0-21)</th>
<th>4. Satisfaction with Life (1-7)</th>
<th>5. Education (years)</th>
<th>6. Age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support Group Identification (1-7)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Depression (0-21)</td>
<td>-31**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Anxiety (0-21)</td>
<td>-.27**</td>
<td>.54**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Satisfaction with Life (1-7)</td>
<td>.29**</td>
<td>.61**</td>
<td>.40**</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5. Education (years)</td>
<td>-.05</td>
<td>-.03</td>
<td>-.04</td>
<td>.00</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Age (years)</td>
<td>.10</td>
<td>-.13</td>
<td>-.19*</td>
<td>.10</td>
<td>-.14</td>
<td>-</td>
</tr>
</tbody>
</table>

(** p < .01; * p < .05.)
Results: Regressions

- 3 hierarchical multiple regressions: depression, anxiety, and SWL respectively.
- Predictor variable: support group identification
- Control variables: education & age.
- Support group identification was a significant predictor for all three outcomes:
  - **Depression** ($\beta = -.31, p < .01$).
  - **Anxiety** ($\beta = -.30, p < .01$).
  - **Satisfaction With Life** ($\beta = .30, p < .01$).
Results: Sub-Types of MS

Repeated the three regressions for each MS sub-type:

• Relapsing-Remitting MS: identification predicted all three health outcomes.

• Primary Progressive MS: identification predicted all three health outcomes.

• Secondary Progressive MS: identification not linked to any health outcome.
Discussion

- Key prediction confirmed for RRMS and PPMS.
  > Support group identification predicts mental health.

- Suggests identification is crucial factor in support group success.
  > Participation alone is not enough to improve mental health.

- No identification: no benefit, may even harm (Rook, 1984).

- Why no effect for Secondary Progressive MS?
  > Had MS longest = longer decline = more hopelessness?
  > Further research required.
Limitations/Implications

• **Limitation**: cross-sectional study: longitudinal would establish causality better.

• **Implications for clinicians**: encourage patients to identify with groups.  
  > e.g., collective agency over group-related decisions (Knight et al., 2010).

• Potential to help improve the mental health of people with MS.
Thanks for Listening!

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Patient Experiences of a Lifestyle Intervention for Managing Obesity: Nurturing Social Identity, Accessing Resources

Sammyh Khan, Mark Tarrant, Mark Daly Katarina Kos, Pooja Shah & Claire Farrow

This research is funded by a Research Project Grant awarded by the Leverhulme Trust (RPG-368)
Background

By 2025, 47% of men and 36% of women are predicted to have obesity in the UK (Foresight, 2007).

In England alone, bariatric weight loss procedures rose by almost 90% from just over 4,200 in 2008/09 to just over 8,000 in 2010/11.

Bariatric surgery:
- weight loss of 42-68% in one-year (O’Brien, McPhail, Chaston & Dixon, 2006)
- diabetes resolved amongst 78% of patients (Buchwald et al., 2004)
- improvement to quality of life (Karlsson, Taft, Rydén, Sjöström & Sullivan, 2007)
- cost-effective compared to non-surgical treatments (Picot et al., 2007)

Other factors that contribute to “success” after bariatric surgery, particularly in the long-term, include:
- preoperative weight loss (Livhits et al., 2012)
- psychological support (Ogden, Hollywood & Pring, 2014)
- social support (Orth et al., 2008)
Background

National Institute for Health and Care Excellence (NICE) guidelines:
“Surgery for obesity should be undertaken only by a multidisciplinary team that can provide: ...psychological support before and after surgery”

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – “Bariatric Surgery: Too Lean a Service”

“Bariatric surgery is a radical procedure with considerable risks, as well as benefits. It shouldn’t be undertaken without providing full information and support to patients. But, when we reviewed cases we found examples of inadequate processes from start to finish – even the basics, such as giving patients dietary advice and education before decisions to operate are taken, were sometimes lacking.”
In the Royal Devon and Exeter Hospital (RD&E), morbidly obese patients considered for bariatric surgery first undergo a 6-12 month weight-management group programme.

Eligibility:

a) 16 years of age or older;

b) BMI ≥ 40 Kg/m²; or

c) BMI ≥ 35 Kg/m² with co-morbidities

Patients attend 6 group sessions, consisting of 8-12 patients and the facilitators.

The group sessions are facilitated by Health Care Professionals (HCPs; dieticians and clinical psychologists) and focus primarily upon dietary behaviours.

Exploration of dynamics within the groups with a focus upon the role of social support and social identity processes and their consequences upon psychological and physical health outcomes.
The Project: Study 1

**Longitudinal Survey**: Approximately 60 patients surveyed before, during and after the programme.

- **Initial Consultation**
  - Weight
  - Psychological Outcomes
  - Eating Behaviour

- **Programme**
  - Social Identification
  - Social Support

- **Follow-Up Consultation**
  - Weight
  - Psychological Outcomes
  - Eating Behaviour

6-12 Months
The Project: Study 2

**Patient Experience Study:** Semi-structured in-depth interviews with 20 patients, focusing principally on the forms and functions of social support and social identification, and the benefits (or otherwise) of participating in the weight-management group programme.

20 semi-structured interviews (Mays & Pope, 1995; Guest, Bunce & Johnson, 2006)
- 12 Females
- 8 Males

Aged between 34 and 77 years (Mean = 52.3 years)

Participants had attended the weight management programme offered by EMOS for at least 6 months.

Thematic analysis (Braun & Clarke, 2006) - Six Step Process - NVivo.
Theme 1: Accessing Education

“I mean I suppose because you’ve got two professional people taking the group and they’ve got a lot of expertise between them. So I mean they come up with some very good ideas and strategies and so I think having the two professional people there rather than just having the group of patients is very useful so I think that helps.” (P20)

“I just think they explained things to me more, they had the time, they explained perhaps why that was happening to me, they explained that it was probably emotional, that I hadn’t even given a thought to, they were just, they were marvellous, absolutely marvellous.” (P16)
Patient Experience Study:  
The Group as a Resource Underpinning Individual Lifestyle Change

**Theme 2:**
Establishing Psychological Connections

“Yeah, it is nice to know that other people feel the same. That you’re not alone in how you feel. That is good. That is really good.” (P16)

“What other people have done, what they’ve tried, what they failed on, what they’re going to try. It’s, for me, always easier to take in rather than having like a diet sheet in front of you, if that makes sense.” (P4)
Patient Experience Study:  
The Group as a Resource Underpinning Individual Lifestyle Change

Theme 3: Supporting Individuals

“I didn’t realise that we were going to get weighed at the beginning of every meeting, so everybody sits in the waiting room and everybody goes off and comes back and says I’ve lost half a kilo or I’ve put on half a kilo or something and everybody else you know gives them encouragements and says if they’ve put on weight “oh never mind” you know or if they’ve lost weight they encourage them and say “oh that’s really good you’ve done a good job”. So I think pretty supportive of each other, which is nice.” (P18)
Patient Experience Study:  
The Group as a Resource Underpinning Individual Lifestyle Change

**Theme 4:**
Effecting Individual Lifestyle Change Through the Group

“Before you’re sort of thinking I’m a fat bastard what am I going to do about it. But now you’ve got everybody else is sort of thinking we need to change our lifestyle.” (P7)

“We’re all in the same sort of boat, and we’ve all had the same sort of problems and we’re all there for the same reason. And it just kind of gives you that whole group feeling, that whole belonging feeling, it’s the fact that you’re going through the same thing and you’re all wanting the same thing. It might differ slightly to how you get there but in the end you all want the same thing and that’s how I think, I think that’s why I feel part of the group. I think that’s how groups work.” (P12)
Patient Experience Study:
The Group as a Resource Underpinning Individual Lifestyle Change

Theme 4:
Effecting Individual Lifestyle Change Through the Group

“Like tonight I’m going to have a jacket potato with a few beans on it, that’s my tea, and if I get hungry I’ll have an orange. Where before I used to have a bar of chocolate or a pack of crisps, it’s a big change isn’t it” (P10)
Patient Experience Study: Summary

- **Accessing Education**
  - **Psychological Connections**
    - Commonality
    - Shared Experiences
  - **Social Support**
    - Advice/Consolation
    - Condition Specific
  - **Behaviour Change**
    - Collective Norms
    - Individual Goals
Need for belonging: “fundamental human need” (Baumeister & Leary, 1995).

Need for group belonging
- increasing evidence that groups can make important contribution to health (e.g., Cohen, 2004; Jetten, Haslam & Haslam, 2011; Smith & Christakis, 2008)
- health orientation (e.g., Oyserman, 2007; Tarrant et al., 2012)
- response to/coping with ill-health (Jones et al., 2012)

Psychological and social connections were an emergent property of the group and its activities.

BUT, a minority did not experience the group as empowering.

Facilitator intervention might be important to:
- identify and explore similarities which underpin psychological and social connections
- (thereby) maximise the potential of collective experience and identity in enabling behaviour change.
Patient Experience Study: Discussion and Implications

Increasing pressure on NHS to offer surgery
- NICE care pathway
- “Quick fix”?
  - weight gain in some patients
  - further complications/surgery

Requires fundamental lifestyle change
- Diet, attitudes, norms
- Pre- and post-surgery

Groups may be part of the solution!
THE END

Thank You For Listening!

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