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Article

Increasing Social Connection through the SURE Group: The Development of a Social Identity Group Intervention for People with Enduring Mental Health Difficulties

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Abstract: Many people with enduring mental health difficulties (EMHD) have reduced social connections and subsequent experiences of isolation and loneliness. This paper outlines the development and trial of a manualised social-identity-based group therapy intervention to increase social connection and develop social skills to build connections outside of healthcare settings. This intervention was developed in line with the quality intervention development (6SQuID) methodology. The paper describes initial data from a feasibility study (which was ceased prematurely due to COVID-19 restrictions). Semi-structured outcome interviews were conducted with the participants and analysed using thematic analysis. Uptake, retention and acceptability of participants was high. Four primary themes were identified across the dataset: Therapeutic Process, Social Identity, Generic Components of Group Therapy and Impact of COVID-19. Participants experienced positive changes in their social behaviour, mood and avoidance. Some were unsure of the concept of social identity while reporting positive changes. A theoretically coherent manualised treatment was developed and tested on a small scale. This study supports social identity-based CBT groups as a potentially effective way of increasing social connection in those with EMHD. Social identity theory supported participants to positively integrate an area of potential social threat into their self-concept and may offer a positive addition to current psychological interventions

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1. Introduction

Enduring Mental Health Disorders (EMHD) can often impair people's social networks, leading to increased loneliness - a discrepancy between one's desired and perceived quality of social connection [1,2]. While psychological interventions for EMHD often focus on symptom reduction and relapse prevention, few target social and quality-of-life needs. This paper outlines the development of a novel group-based intervention which facilitated attendees to reflect on their own personal social identity, supporting them to acquire skills to connect with community groups that may have a positive effect on their mental health. This treatment was developed in a secondary-care mental health service using the six steps in the quality intervention development framework (6SQuID) [3]. The 6 SQuID phases were created to amplify the likely effectiveness of interventions by ensuring a practical and evidence-based approach to intervention development. These steps involve: (1) defining and understanding the problem and its causes; (2) identifying which causal or contextual factors are modifiable; (a) which have the greatest scope for change and (b) who would benefit most; (3) deciding on the mechanisms of change; (4) clarifying how these will be delivered; (5) testing and adapting the intervention and (6) collecting sufficient evidence of effectiveness to proceed to a rigorous evaluation.

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Step 1: Define and understand the problem and its causes

Research has recognised that loneliness can lead to adverse physical and mental health outcomes, but healthcare practitioners are often unable to address it [4,5]. Effective approaches to treating loneliness in working-age adults are an urgent issue of wider public health concern [6]. Adults with EMHD have fewer social connections and are more likely to rely on healthcare workers for companionship [7]. EMHD typically have their onset in early adulthood, a period of identity development which can lead to someone internalising mental health difficulties into their self-concept [8]. EMHD can disrupt people's involvement with community groups, and their involvement can be disrupted due to inpatient stays or anxiety around reconnecting afterwards.

Step 2: Clarify which contextual factors are malleable and have greatest scope for change

Social connection, in general, can positively impact psychological wellbeing [9]. Within the context of people with EMHDs, social identification with natural community groups facilitates the maintenance of positive mental health and reduces the likelihood of mental health relapse [10]. The possible benefits of increased social connection happen through four processes [11]:

- Social identification allows pro-social behaviours such as receiving and providing social support to occur [12].
- Social identification is related to fundamental psychological needs, initially identified by Maslow [13], such as belonging and self-esteem [14].
- Social identification can reduce negative attributional styles that are associated with depression [15]
- Social identification can provide broader viewpoints and an increased sense of meaning [16]

Step 3: Identify the mechanism of change

A scoping review of loneliness interventions for people with mental health difficulties described four types of intervention: (i) changing cognitions; (ii) social skills training and psychoeducation; (iii) supported socialisation or having a 'socially-focused supporter'; (iv) and 'wider community approaches', concluding that none of these had developed a robust evidence base [6]. Approaches that presented attendees with an opportunity for prescribed friendships through peer-mentoring, befriending or supported socialisation were ineffective in reducing loneliness [1,17].

Meta-analyses have highlighted the importance of targeting maladaptive cognitions, improving social skills, enhancing social support and increasing opportunities for social contact [6,18]. There is a need for theory-driven group interventions for non-elderly people of similar experience. Existing loneliness interventions lack a theoretical foundation, with only 17 of 68 existing studies in a review based on attachment, social learning or group development theory [19]. The greatest effect has been found in targeted groups of people with similar issues, where attendees and facilitators work collaboratively on issues of social isolation and interventions using cognitive-behavioural therapy [20,21].

Step 4: Identify how to deliver change

The SURE Group was developed for adults with EMHD to facilitate reconnection with naturalistic community groups. The program was developed by a research steering group with Public and Patient Involvement (PPI) and a range of multi-disciplinary team members. This steering group collaboratively refined the target of the intervention and agreed on outcome measures and the theoretical underpinning of the intervention. An initial six-session pilot intervention was run based on a "Groups4HealthTM" model for people with EMHDs attending an outpatient department [22]. Participant feedback was gathered on the intervention's goal, focus and nature. Participants highlighted their need for a longer intervention, a greater skills focus, and a greater focus on addressing negative thoughts and emotions. This feedback was brought to the steering committee, and an 18-session manual was designed for the SURE group. This intervention drew on Social Identification Theory and focused on improving social networks through cognitive-behavioural

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experiential learning methods, using within-group social interactions, between-session social exposure and a focus on developing positive beliefs about self, others, and social identity [22–24]. The 5-phase, 18-session intervention manual was as follows:

- Phase 1 looked at the importance of groups and anxieties around re/joining groups. This phase sought to normalise social anxiety, awkwardness, and worry. The intervention hoped to create a supportive, pro-social and pro-socialising group atmosphere. The atmosphere was facilitated through long periods of interaction between participants, separate from the facilitators.
- Phase 2 asked attendees to create a visual representation of their social groups, called a social identity map [25]. This process identified existing connections and encouraged reflection on areas where social connection could be increased.
- Phase 3 looked at ways to reconnect to old and new groups. The sessions looked at what barriers might be in the way of connecting and reconnecting. Each person developed a personalised action plan to identify on which new groups or social connections they could work. The group looked at techniques for reducing social anxiety [24].
- Phase 4 built up the skills needed to get the most out of groups. The sessions looked at building self-confidence [24], learning skills of interpersonal effectiveness and challenging the social anxiety that occurs when joining new groups [27].
- Phase 5 forecasted how to stay connected over time. The sessions anticipated issues or difficulties that might occur in the future.

Step 5: Test and refine on a small scale

A feasibility study was registered with the Open Science Foundation. This research was a non-blinded, pragmatic feasibility study of the social and emotional outcomes following a group psychological intervention to increase community connections and relationships. The Regional Ethical Committee reviewed the intervention, and seed funding was granted for the feasibility study. The group and study were stopped after 9 sessions due to the COVID-19 crisis. Telephone support was offered to group members. A video teleconference version of the group was proposed, but participants reported that they did not have the technological resources to access this. The initial feasibility study of the intervention examining uptake, retention and acceptability was stopped due to COVID-19. At the time of the cessation of the study, the study protocol was adapted to examine qualitative experiences of the intervention.

2. Materials and Methods

This section details step 6, relating to the collection of sufficient evidence to justify rigorous evaluation. An adapted "Change Interview" was used to gather qualitative data [28], providing a structured interview to explore therapeutic outcomes and a range of prompts to gather greater information. Data were analysed using inductive thematic analysis [29].

Participants

Participants (n=6) (self-identified female=2; self-identified male=4; age range 30-64) were outpatients of an adult secondary mental health service in Ireland recruited through clinicians working in the service.

Procedure and data collection

All attendees provided informed consent to their data being used for research. Ethical approval was granted by the St John of God Research Ethics Committee (reference ID721). The first author collected data through audio-recorded remote phone interviews lasting between 12 and 30 minutes (M = 23:40).

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Table 1. Interview Topics and Questions.

Interview Topics	Questions
Wellbeing	How are you now in general?
Changes	Have you noticed any changes in yourself since the group started? Were you surprised by these changes? How important were these changes to you?
Positives/Negatives	What was helpful about the group? What was unhelpful about the group?
Attributions	What can you attribute these changes to?
Suggestions	Have you any suggestions as to how the group could be made any better?
Impact of COVID-19	How has COVID-19 impacted you? How has COVID-19 impacted any changes from the group?

Data analysis

Interviews were transcribed verbatim before being checked and identifiable information removed by the first author. QSR International's NVivo V.11 (qualitative data analysis software) was used to store and analyse the data. Thematic analysis by the first author assumed an essentialist interpretation and inductive approach [29]. The concept of change was inherent in the interview schedule, which placed a deductive element to what was reported in interviews. For quality assurance, both authors reviewed the transcripts and codes and refined the final themes.

3. Results

Four primary themes were identified: "Therapeutic process", "Social identity and interactions", "Generic components of group therapy", and "Impact of COVID-19". Themes were of variable length and supported by participant quotations with gender-matched pseudonyms used throughout.

3.1. Therapeutic process

Participants highlighted the impact of the group on their levels of social activity and social confidence and, subsequently, on their wellbeing. However, they noted the discomfort of being in a group therapy situation. They recognised a reduction in avoidance of social situations and a growing social confidence:

"It was easier to do the things that I previously would have refused to do or try to figure out an excuse to not to. […] I often consider myself a bit of a hermit, so I'd often wouldn't partake in those sort of social interactions. But when I was doing the course, I found it easier to try and confront those demons, if you like, tried to take part in social engagements of that otherwise I wouldn't have." (Charlie)

Mary recognised as sessions progressed, she was "coming out of myself a bit more" and "less cautious around others in the canteen … that feeling of people looking at me kind of went away" in addition to being "less hyper" around others and needing less movement breaks to regulate. Sarah found she could "speak more freely" when out with friends and that she was empowered to help others:

"I could not only contribute but I could help other people … [I was] opening up and kind of trying to help other people as opposed to just think[ing] about it yourself all the time."(Sarah)

John was disappointed that the pandemic had halted his plans to join a night class:

"I'm nearly sure I definitely would have pursued, at that time, more as the group went on, you know. Maybe not after the month or two, but after three or four months maybe, I would have looked to doing a night class or something like that." (John)

Charlie's growth in confidence was also important to his family:

"It's probably more important to those that I'm closest to because, I mean, me not going somewhere would often mean that they couldn't go either." (Charlie)

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The group provided stability. John described it as an "anchor which stopped me from deteriorating" while it helped Sarah to "[maintain a] good level playing field". Peter recognised that as the group progressed "I was getting better" but that this was effortful:

"Telling your body to do something you don't really want to do, and your body is telling you to get out of there, and you've just got to try and conquer it." (Peter)

Others cited discomfort both with the group process itself, or with increased exposure.

"I found all of it difficult to be honest with [the facilitators]." (Sarah)

"being not very extroverted or able to talk about myself made it difficult to interact." (Charlie)

Charlie arrived exactly on time to minimise time spent socialising. John found it difficult to "recalibrate a new person in" to the rolling group. He found that this social discomfort lessened with time and that this was empowering:

"I established I could be in a room with others for an hour – the practicalities of that." (John)

3.2. Social identity

There was a divergence among participants in how much they took the concept of social identity on board. When asked if their social identity had altered across the therapy, one said:

"If you asked me when you mean by that I wouldn't be able to tell you." (Charlie)

When reminded of the concept he agreed that the group's content was beneficial:

"It reminded me of the fact that I am involved in social circles and that I might be an important constituent of them. It helped me to engage in activities I wouldn't otherwise have […] and I think those activities improve my mood in general." (Charlie)

John recognised how exercises helped him to understand and interact in social situations:

"It was practically a better way for me to feel better about myself - you know? And how to manage the situations outside of the hospital better. and I felt safe in that group, with the other people, I think the way it was kind of a laid back yet serious way of doing it like. It worked very well … content of the group sessions, you know, helped me understand, you know, the processes that are going on in social situations." (John)

Exercises also helped Charlie to "challenge beliefs and thoughts I had and to try to address them". Peter remembered an example of this through a thought-logging exercise:

"I remember John was saying that he didn't help his parents, but then he looked back on it and then he did actually, he did help his parents … I think he was saying that you have an idea in your head but when you flesh it out its actually not as true, or as black or white as you think."

Mary benefited from a worry time of twenty minutes at the end of her day, and to think of the people in their life in terms of groups. Participating in the group setting offered a place to practice new learned social skills which provided a "grounding of confidence in dealing with other people" (John). Others recognised themselves using skills learned at group to help them deal with anxiety before attending the weekly session. Some of the group found the psychoeducation component helpful "hearing from the professionals what you should do" (Charlie). Peter recognised much of the mindfulness and evolutionary content from sessions as repetitious of other group therapies: "a lot of the content was stuff I had done before" (Peter). However, Peter benefited from how "fight or flight" responses can cause us to feel anxious and that "it's just natural and that I've to try and cope with it".

3.3. Generic components of group therapy

In general, participants found the group process helpful.

"It brought a connection in with people who understand what it's like with mental illness … I was letting my barriers down quite a bit, even in giving, and what other people were going through … I was surprised by how much I could offer to the group in terms of coming out of myself with other people." (John)

There was a mixture of views concerning the practical structure of the sessions. Participants reported that having a break in the middle of the group offered an opportunity for people to bond, to practice their skills and to expose themselves to open social scenarios. Some asked for a longer group session or an "afternoon workshop" (John) but Peter was worried about his hand shaking during longer sessions, which he described as a side effect of medication. Facilitators were spoken of

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favourably, and presentations were seen as beneficial. The size of the group was considered appropriate as it allowed for all to contribute.

3.4. Impact of COVID-19

COVID-19 was seen as a significant stressor and negatively impacted the individuals' wellbeing. Participants described coping through exercise, routine and connecting with family members. Mary discussed how the closing of gyms had challenged her identity as a gym attendee: "No gym for three months was kind of a nightmare" (Mary). They discussed disruption to mental health services and preference for face-to-face appointments:

"I also view the issues that I have as unable to be helped by conversations over the phone." (Charlie)

"I am a bit apprehensive about coming to the hospital and to hospitals in general." (Peter)

In terms of mood, some struggled in social isolation while others found positivity in the isolation as they were not challenged to face their social anxiety, while recognising how this was not positive for them in the long term:

"the hermit side of me privately finds that great, but I realise that's not healthy, a healthy way to be." (Charlie)

Table 2. Themes, Subthemes, and Illustrative Quotes.

Themes	Subthemes	Illustrative Quotes
Therapeutic process	Social activity and growing social confidence	*"it was easier to do the things that I previously would have refused to do or try to figure as an excuse to not to"*
	Mental health and wellbeing	*"An Anchor which stopped me from deteriorating"*
	Discomfort	*"[it was] difficult to interact"*
Social identity and interactions	Differences in the understanding of the concept	*"if you were to ask me that I wouldn't know what you mean"*
	Exercises and developing confidence	*''manage a simple friendship better''*
	Psychoeducation and theoretical understanding	*[anxiety]: ''it's just natural and that I've to try and cope with it''*
Generic components of group therapy	Positive group dynamics	*"I was finding that I was letting my barriers down quite a bit, even in giving, and what other people were going through. It was very helpful"*
	Differences in the helpfulness of the group structure	*"it was difficult. All of it was difficult to be honest with you. I just find it difficult in general if you know what I mean"*
Impact of COVID-19	Coping with social isolation	*"I got a lot of cabin fever, but I was able to walk and that helped"*
	Disruption of social activities and therapy	*"the hermit side of me privately finds that great, but I realize that's not healthy, a healthy way to be"'*
	Stability of mood	*"Mentally, I don't do that well when I'm isolated because I go off into a tangent of [laughs] this that and the other"*
		[mood] "I think it kind of went the other way with me, I quite enjoyed it [laugh]. I think some people enjoyed it."

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4. Discussion

This paper discussed the development of a novel social identity and skills group for people with enduring mental health difficulties, utilising the 6Squid methodology and a qualitative analysis of participant experiences. The SURE Group offered practical skills for people to use in social situations, a space for them to reflect on groups they were an important part of, and to consider other groups they might connect with in the future. The group provided a combination of shared-experience, group-learning, social opportunity and psychoeducation to aid in establishing new relationships with people outside of mental health settings. This group protocol was developed through PPI involvement while integrating findings of meta-analyses of loneliness interventions and a social-identity theoretical framework [6,16,18].

Thematic analysis indicated positive social and personal changes for those who attended. While the group led to these positive reflections on group identity, it was not apparent that participants attending fully internalised the concept of social identity. Equally, it was not clear that this theoretical concept was necessary for people to practice their social skills, recognise that they were valued members of families and clubs, or increase their exposure to social situations.

There are several limitations to the study. The COVID-19 pandemic prematurely halted the project. This interfered with the full completion of the intervention, further recruitment and small-scale quantitative analysis. The initial feasibility study was not able to be implemented. Further research is necessary to assess any feasibility and effectiveness. A larger-scale comparison using a social anxiety group as a control condition would be beneficial in assessing the utility of the SURE group. The assessment was not blinded, and there are issues of how representative the sample is of people with EMHDs.

Conclusion

Given the limitations, the SURE group offered a novel approach to healthcare which could have beneficial applications for outpatients following discharge from inpatient services.

The current study protocol appeared effective for those experiencing enduring mental illness. The authors feel that the social identity focus supported participants to positively integrate an area of potential threat (i.e., social situations) into their self-concept, which may offer a positive addition to current interventions.

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Institutional Review Board Statement: The study was conducted under governance of St John of God Hospitaller Group and approved by their Ethics Committee (ID721) on 16/07/2020.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study. No participants are identifiable in this paper.

Data Availability Statement: Data available on request due to restrictions of privacy. The data presented in this study are available on request from the corresponding author.

Conflicts of Interest: The authors declare no conflict of interest.

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