Working together
www.rcis.ro

Revista de Cercetare si Interventie sociala

ISSN: 1583-3410 (print), ISSN: 1584-5397 (electronic)

DEPRESSION AND DEFICIENCIES OF INTIMACY AND COMMUNITY INTEGRATION IN OLDER PATIENTS

Maria Raluca RADU, Roxana CHIRITA, Cozmin MIHAI, Lucian Constantin PAZIUC

Revista de cercetare și intervenție socială, 2018, vol. 61, pp. 32-43

The online version of this article can be found at:
www.rcis.ro, *www.doaj.org* and *www.scopus.com*

Published by:
Expert Projects Publishing House

expert projects
publishing

On behalf of:
„Alexandru Ioan Cuza" University,
Department of Sociology and Social Work
and
HoltIS Association
REVISTA DE CERCETARE SI INTERVENTIE SOCIALA
is indexed by Clarivate Analytics (Web of Science)
Social Sciences Citation Index
(Sociology and Social Work Domains)

Depression and Deficiencies of Intimacy and Community Integration in Older Patients

Maria Raluca RADU[1], Roxana CHIRITA[2], Cozmin MIHAI[3],
Lucian Constantin PAZIUC[4]

Abstract

Patients with depressive disorder may exhibit similar clinical symptoms, but their personal descriptors can be sometimes quite different in terms of existential expectations, basic needs, and motivational structure. And while it is true that medication can be widely used to treat same therapeutic class in order to restore neurotransmitter homeostasis, psychotherapy approach must take into account all the symptoms which are unique for each individual. In this regard, our expertise has emphasized two major needs to point out a patient with depressive disorder's response to therapy: the need for community integration, and the need for intimacy. We aim to demonstrate the finding that introverts (defined by a greater need for intimacy) tend to react better to individual therapy as opposed to extroverts (defined by a greater need for community integration) who tend to prefer group therapy.

Keywords: depression, intimacy, community, individual psychotherapy, group psychotherapy.

[1] University of Medicine and Pharmacy „Gr. T. Popa", Iasi, ROMANIA. E-mail: raluca_m2003@yahoo.com
[2] University of Medicine and Pharmacy „Gr. T. Popa", Iasi, ROMANIA. E-mail: d.stigma@gmail.com
[3] University of Medicine and Pharmacy „Gr. T. Popa", Iasi, ROMANIA. E-mail: dr.cozminmihai@gmail.com (corresponding author)
[4] University of Medicine and Pharmacy „Gr. T. Popa", ROMANIA. E-mail: paziuc.lucian@yahoo.com

Introduction

As long as we perceive the individual as a complex bio-psycho-social being, there will always be present a constant need for attachment, namely a constant need to be in a relationship. Relationships, connecting to self and to the others, represent a biological imperative throughout life (Erskine, Moursund & Trautmann, 1999). An individual's social network is a source of vitality and stimuli, which are essential for the management of all the challenges and frustrations of social cohabitation (Erskine, Moursund & Trautmann, 1999; Baumeister & Leary, 1995).

If we assume that mental health requires harmony, and the ability to fluidly go through all the stages of a relationship while being able to share elements of oneself, and also being able to receive and integrate feedback, depression begins to look like a failure of harmonization, a false note breaking the symphony of expression and comprehension, generating as a result an unfortunate detachment from the real world (Andre, 2012). In his book "Feelings and Moods", Christophe Andre explores depression from this particular perspective of social isolation pointing out that not only our connection with other people is altered in this way, but the very connection with our own self is affected, a depressed person tending to indulge himself/ herself in helplessness, loneliness and social fracture, while having to deal with a benevolent pressure or misunderstanding from his/ hers close ones. In this context, extending one's social support network is definitely an important asset for the management of mental health in general, and the management of depression in particular (Andre, 2012; Kessler 2003). Although many studies have analyzed all the descriptors for such a social network, with a special stress on its quantitative aspects, qualitative aspects should also not be neglected. Relationships involving deep emotional support with one person or a small group of persons can be an experience as valuable and resourceful as relating to a larger social structure (Yalom & Leszcz, 2005; O'Reilly Knapp, 2001). Widening social support network from a qualitative point of view represents an approach centered on the need for intimacy, while a quantitative approach is mostly centered on the need for community integration.

The need for community integration and the need for intimacy, although not entirely antagonistic, stand each for two different aspects of any emotional balance which can find some level of harmony on a higher or on a lower plane depending on the individual's personal descriptors. The need to be oneself again is the first step toward intimacy. A definition of intimacy could be: close, genuine and deep relationship with someone, which can be one and the same person in a first stage or can be some other person. Once the number of people who participate in a relationship grows, the intimacy degree decreases as the shared feelings and the depths of the relationship itself tend to dissipate.

The need for intimacy is a profound human need, and a specific human trait, a psycho-emotional act that connects human being, regarded as a rational being, to

his/ hers deep emotional structure. This particular need resonates very well with the ability of self–analysis and self-expression (O'Reilly Knapp, 2001; Erskine, 2009, Derlega & Chaikin, 1975). More than that, alexithymia as part of depression, namely the inability of understanding of oneself, is often correlated with a slower response to therapy. The need for intimacy is also linked with a certain ability to shed more light on the inner self, so the individual be able to deal with his/ hers own feelings, and to map this inner world just to know at all times where he/ she is and what it is happening to him/ her. Intimacy with others is a good way of mirroring oneself. Since intimacy requires an assessment made by yourself or by another person, it also involves trust because when you allow yourself to be analyzed you suddenly become a vulnerable person (Derlega & Berg, 2013).

Without intimacy, human beings are as lonely as someone living inside a crystal ball, and there is no unhappiness and lack of fulfillment stronger than total isolation and loneliness, since we are all beings conceived to be happy, and able to express and to share our feelings. Our humanity depends on us being able to communicate closely with ourselves and with the others, and when this ability disappears (we are no longer able to send some form of feedback to our own self and to the others) we become alienated from ourselves and the others. Community has a regulatory role, and at the same time a limiting role (Andre, 2012). Human beings demonstrate an inherent need to belong to a group of persons with whom to be able to share their ideas, their visions, and with whom one can feel understood, one can find himself/ herself, one can be able to participate, to be useful, and to be validated as a normal human being.

The need for community integration mirrors, and responds to other primordial needs, and depths of the human psyche such as: the need for validation, the need for expressing emotions, the need for contact, the need for initiative. The need for community integration urges the individual to make and accept compromises in order to be compatible with other human beings. Up to a certain limit, these compromises are appropriate, and can be related to an individual's sense of adaptability and the ability to integrate and function as a social being, but beyond these limits, these sort of compromises can weaken the need for intimacy, thus generating a direct conflict with the individual's own set of values, and getting to intrapsychic tensions and conflicts (Frank, Swartz, & Kupfer, 2000).

The undeniable benefits are that the need for community integration provide a stronger basis for a solid psychological support, adding personal coping mechanisms to those of the community itself. Medical science supports the fact that people integrated within a solid social network are accomplished human beings, and are able to better manage their own frustrating experiences (for those subjects involved with social supported, spiritual and ideological communities the actual duration of depressive episodes, traumatic stress and suicide rates are far lower) (Larson & Larson, 2003; Miller & Thoresen, 2003). The practical applications for the study of these needs can be better reflected in a depressive patient's approach to psychotherapy. Certain personality types correlate better with certain needs which

are largely expressed, and these needs dictate the type of psychotherapy approach to which the patient will be most responsive (Mihai *et al.*, 2017).

For example, introverts demonstrate a particular need for intimacy, due to their inner structure leading toward introspection and self dialogue, while extroverts crave mostly for community integration, being oriented to communication, socialization and approval. Our expertize in working with depressed patients has led us to formulate a series of hypotheses concerning the manner in which certain psychotherapeutic approaches can accommodate better to the unique configuration of all the patients who are looking for such medical services. Given the strong associations backed up by the medical literature between introversion / extroversion, and orientation toward intimacy – introspection, namely social adherence, furthermore we will separate inside our experiments the introverts, and their need for intimacy, from the extroverts, and their need for community integration. To clearly formulate our working hypotheses, we defined concordant therapy as the type of psychotherapy adjusted to a patient's personality structure, and we defined nonconcordant therapy as a standard therapeutic approach, not taking into account the particular need for community integration or a patient's need for intimacy.

Results

Patients responded better to concordant therapy, thus suggesting that adapting therapy to their individual needs is a simple and important step to achieve the full extent of all therapeutic benefits.

Working Hypotheses

H1: Introverts tend to benefit more from concordant therapy (individual, coaching type, that satisfies the need for intimacy) rather than nonconcordant therapy.

H2: Extroverts will benefit more from a concordant therapy (group therapy that satisfies the need for community integration) rather than nonconcordant therapy.

H3: Extroverts tend to respond better than introverts to both concordant therapy and nonconcordant therapy.

H4: For both types of personality, adjusting therapy to the individual needs (concordant therapy) will give superior results as compared to standard therapy (nonconcordant).

Material and Methods

To assess the working hypotheses we recruited a total of 200 patients, assigned after performing personality profile test (Eysenck Personality Questionnaire) (Eysenck & Eysenck, 1975) into two equal groups – introverts and extroverts. These groups were each divided randomly into two other groups, depending on the psychotherapy approach, as follows:

Table 1. Experimental design

		Therapy approach	
		Concordant	Nonconcordant
Personality type	Extroverts	Group 1 - 50 patients	Group 2 - 50 patients
	Introverts	Group 3 - 50 patients	Group 4 - 50 patients

The following criteria were used for including patients into our study: (1) the patient understands, undergoes, and consents to participate to the study; (2) the patient is diagnosed with some form of depressive syndrome, and is still under treatment; (3) the patient is not diagnosed with another chronic psychiatric pathology or other psychotic disorders, like dementia or mental retardation; (4) the patient accepts and remains under therapy for the whole period of the study.

After performing personality profile tests, and after forming each group, patients were administered at the beginning and at the end of the study the following tests, the final scores being centralized into a single overall score, initial and final, according to which we assessed the evolution of patients, and therapy efficiency. The Rosenberg Scale is a self-report measure of global self-esteem. It consists of 10 statements related to overall feelings of self-worth or self-acceptance. The items are answered on a four-point scale ranging from strongly agree (1 point) to strongly disagree (4 points). Overall scores range from 10 to 40; a lower score indicate low self-esteem (Goldsmith, 1986). Hamilton Rating Scale for Depression also called the Hamilton Depression Rating Scale (HDRS) is the so called “golden standard” for depression, and includes a multiple item questionnaire used to provide an indication of depression, and as a guide to evaluate recovery. It is one of the most used tools for evaluating the severity of depression, and patient’s evolution under treatment, and it also can be used as a standard for other psychiatric tools. Hamilton refers to it as a tool for evaluating patients diagnosed with depression, and not as a tool for diagnosing depression. We used a version which includes 21 items, with scores between 0 (no depressive symptoms) and 62 (extreme depression) (Hamilton,1960).

The SAS-SR scale also known as Social Adjustment Scale - Self-Report provides you with an understanding of an individual's level of satisfaction with his or her social situation. It is often used to evaluate the efficacy of treatment by revealing the effect treatment is having on the respondent. The SAS–SR is used by psychiatrists, psychologists, social workers, and other mental health professionals in clinical or research settings. We used the short version, which includes 21 de items evaluating 6 different social roles, from two perspectives – instrumental (activity itself) and expressive (relational). These roles are: work, leisure and social activities, extended family relationships, partner role inside a married couple, parental role and role within the family including perception of economic environment. This particular version of SAS–SR scale that we have used is usually recommended when contact time with the respondent is limited, and can be used as a tool for monitoring a patient's evolution under treatment (Bosc, Dubini & Polin, 1997).

The Visual Stigma Scale is designed by the authors of the present medical study, which provides the patient with a self-assessment tool to measure the stigma of his mental illness by using 5 different scores ranging from 0 (absence of stigma) to 4 (extremely stigmatized). All the data we obtained following the tests were statistically analyzed using SPSS 10 standards.

Therapeutic intervention: Each of the patients from the 4 groups was included in one of the following therapeutic interventions.

Group Psychotherapy Program (concordant to the extroverted group)

Random therapy groups formed from 8-10 introverts were administered weekly sessions of 120 minutes each, for a duration of 6 months. Therapy groups were approached thematically in connection with universalization, validating and legitimizing the patient's sufferance, stimulating therapeutic relationship, and strengthening relationships within the group by consolidating group cohesion and exercising positive group pressure, communication and feedback, building premises for the therapeutic change, giving and receiving support within the group, socializing, creating and fostering trust (Yalom *et al.*, 1967; Erskine, 2009; Mountain *et al.*, 2008).

Individual Psychotherapy Program (concordant to the introverted group)

Patients were administered with weekly individual therapy sessions of 50 minutes each, for 6 months. Although psychotherapeutic style varied according to the psychotherapeutic orientation of each psychotherapist part of the intervention team, the topics were the same, focusing on creating and developing coaching therapeutic relationship, fostering trust and psycho-emotional intimacy, strengthening and affirming of inner self, developing internal control factors, self-acceptance, personal development, validation and self-validation, development of communication with hygiene communication items and giving/ receiving

constructive feedback, adaptation of reality testing, adapting personal requirements and expectations, gratification and self-reward (Michel, 2002).

Standard Psychotherapy Program (nonconcordant psychotherapy)

Patients completed a standard therapy program less flexible, and adapted to each personality profile, consisting of two group therapy sessions and two individual therapy sessions pe luna, for a duration of 6 months, going through all the aspects as illustrated within the therapy programs listed above. The program was addressed to both introverts and extroverts (Yalom & Leszcz, 2005; Malat *et al.*, 2008).

Results and discussions

In order to assess the first working hypothesis, we analyzed the scores obtained by extroverts when applying concordant therapy or nonconcordant therapy, and then we used the T-test for independent subjects.

The score for extrovert subjects with concordant therapy = 84.34

The score for extrovert subjects with nonconcordant therapy = 87.34

$F = 0.30$, $p = 0{,}585$; $t(98) = -2.14$, $p = 0.035$

There are significant differences for extrovert subjects depending on the type of therapy, meaning that results obtained by subjects in concordant group therapy are significantly better than those obtained by subjects in nonconcordant group therapy.

Concerning the second working hypothesis, we analyzed the scores obtained by the introvert subjects when applying concordant therapy or nonconcordant therapy, and then we used the T-test for independent subjects.

The score for introvert subjects with concordant therapy = 87.20

The score for introvert subjects with nonconcordant therapy = 108.74

$F = 2.84$, $p = 0.095$; $t(98) = -19.77$, $p < 0.001$.

There are significant differences for introvert subjects depending on the type of therapy meaning that results obtained by subjects in concordant group therapy are significantly better than those obtained by subjects in nonconcordant group therapy.

Although both of our hypotheses were confirmed, one can notice the difference with greater statistical significance for introverts ($p<0{,}001$ compared to $p<0{,}035$), which is explained by the fact that introverts respond less to nonconcordant therapy as opposed to extroverts, who are more open and spontaneous, and who seem able to adjust easier to different therapy styles.

In this regard, we took under analysis the difference between the scores obtained by extroverts and introverts when applying nonconcordant therapy, and then we used the T-test for independent subjects.

The score for introvert subjects with concordant therapy = 108.74

The score for extrovert subjects with nonconcordant therapy = 87.34

$F = 6.82$, $p = 0{,}010$; $t(98) = 19.63$, $p < 0.05$

There are significant differences between the scores obtained by introverts and extroverts when applying nonconcordant therapy, meaning that extroverts achieved significantly better final scores.

Concerning the third hypothesis, we analyzed the differences between the final scores obtained by introverts and extroverts (regardless if they benefited from concordant or nonconcordant therapy). Then we used the T-test for independent subjects.

The score for introverts = 97.97

The score for extroverts = 85.94

$F = 80$, $p < 0{,}001$; $t(198) = 8.70$, $p < 0.01$

There are significant differences between the scores obtained by introverts and extroverts, meaning that extroverts achieved better results (regardless if they benefited from concordant or nonconcordant therapy).

In order to assess the fourth hypothesis, we analyzed the differences between the final scores obtained by subjects in concordant therapy group compared with those obtained by subjects in nonconcordant therapy group (regardless if they were introverts or introverts).

Then we applied the T-test for independent subjects.

The score for subjects with concordant therapy = 85.87

The score for subjects with nonconcordant therapy = 98.04

$F = 79.67$, $p < 0{,}001$; $t(198) = -8.85$, $p < 0.01$

There are significant differences between the scores obtained by subjects in concordant therapy group and those obtained by subjects in nonconcordant therapy group, meaning that subjects who received concordant therapy showed significantly better scores. In other words, adjusting therapy to patient's needs will give superior results as opposed to standard therapy (unadjusted). The study confirms the fact that adapting the type of intervention to the specific needs of a personality profile provides certain benefits, from improving integrative abilities and self esteem to reducing stigma and depressive symptoms. These findings are consistent with other data from the scientific literature (Evans, Chisholm & Walshe, 2001; Blumenthal *et al.*, 1982).

Patients with elevated scores on extroversion at the STAI scale are characterized by openness to communication, abilities for public expression and better adapted social skills, but they also have more vivid social needs (Beutler, Moos, & Lane,

2003). Therefore, the impact of a group is more evident in these patients. The group also comforts the depressive's need of compassion and provides the context of developing coping strategies and good treatment adherence (Pompili *et al.*, 2009; Neff, Rude & Kirkpatrick, 2007). In this context, it is expectable that extroverts to fully function in an environment that satisfies their needs of integration, belonging and social acceptance. Our results confirm that extroverts progressed in group therapy. Other studies also validated different group approaches to depression, some taking into consideration personality specificities (Schafer *et al.*, 2005; Kim & Kang, 2013; Bumpus, 2009). On the other hand, extroverts developed comparable progress in standard therapy programs. This result suggests that both forms of therapy are effective for the extrovert. Regarding the introverts, they seem to react selectively and tend to benefit more from individual therapy that comforts their intimacy need. Data concerning therapy approaches for other age ranges is consistent with our findings (Strader-Garcia, 2012; Ghasemian, D'Souza& Ebrahimi, 2012; De Fruyt *et al.*, 2006; Detweiler-Bedell & Whisman, 2005). As opposed to extroverts, introverts don't seem to benefit as much from the standard therapy, probably due to their less developed sociability and other psychosocial variables such as alexithymia. (Zinbarg, Uliaszek, & Adler, 2008; Rana, 2016; Chen *et al.*, 2011) Contemplative, with a limited degree of expansiveness and low tolerant to self inadequacy, the introvert patient feels better when participating to individual therapy sessions where one can easily develop intimacy and safer self exposure.

Conclusions

Our findings support the idea that adjusting the type of psychotherapy to a depressed patient's needs represents a useful step, more likely to increase the value of therapeutic act, and to improve wellbeing, and adapting to the social environment, and to increase self-esteem and perception of stigma. Both introverts and extroverts reacted better to adjusted therapy, with the exception those extroverts overall scores were better than those obtained by the introverts, meaning that the need for intimacy takes more time to be fulfilled and it is deeper than the need for community integration, because it probably requires more time for achieving maximum results.

References

Andre, C. (2012) *Feelings and moods*. Cambridge: Polity Press.

Baumeister, R.F., & Leary, M.R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, *117*(3), 497.

Beutler, L.E., Moos, R.H., & Lane, G. (2003). Coping, treatment planning, and treatment outcome: discussion. *Journal of Clinical Psychology*, *59*(10), 1151-1167.

Blumenthal, J.A., Williams, S.R., Wallace, A.G., Williams Jr, R.B., & Needles, T.L. (1982). Physiological and psychological variables predict compliance to prescribed exercise therapy in patients recovering from myocardial infarction. *Psychosomatic Medicine*, *44*(6), 519-527.

Bosc, M., Dubini, A., & Polin, V. (1997). Development and validation of a social functioning scale, the Social Adaptation Self-evaluation Scale. *European Neuropsychopharmacology*, *7*(1), S57-S70.

Bumpus, K. M. (2009). *Experience group therapy: A model to work with and inspire at-risk youth* (Doctoral dissertation, Prescott College).

Chen, J., Xu, T., Jing, J., & Chan, R. C. (2011). Alexithymia and emotional regulation: A cluster analytical approach. *BMC Psychiatry*, *11*(1), 33.

De Fruyt, F., Van Leeuwen, K., Bagby, R. M., Rolland, J. P., & Rouillon, F. (2006). Assessing and interpreting personality change and continuity in patients treated for major depression. *Psychological assessment*, *18*(1), 71-80.

Derlaga, V.J., & Berg, J.H. (Eds.). (2013). *Self-disclosure: Theory, research, and therapy*. Heidelberg: Springer Science & Business Media.

Derlega, V.J., & Chaikin, A.L. (1975). *Sharing intimacy: What we reveal to others and why*. New Jersey: Prentice-Hall.

Detweiler-Bedell, J. B., & Whisman, M. A. (2005). A lesson in assigning homework: Therapist, client, and task characteristics in cognitive therapy for depression. *Professional Psychology: Research and Practice*, *36*(2), 219-223.

Erskine, R.G. (2009). Life scripts and attachment patterns: Theoretical integration and therapeutic involvement. *Transactional Analysis Journal*, *39*, 207-218.

Erskine, R.G., Moursund, J. P. & Trautmann, R. L. (1999). *Beyond empathy: A therapy of contact-in-relationship*. Philadelphia: Brunner/Mazel.

Evans, S., Chisholm, P., & Walshe, J. (2001). A dynamic psychotherapy group for the elderly. *Group Analysis*, *34*(2), 287-298.

Eysenck, H.J., & Eysenck, S.B.G. (1975). *Manual of the Eysenck Personality Questionnaire: Junior and Adult*. Hodder and Stoughton.

Frank, E., Swartz, H.A., & Kupfer, D.J. (2000). Interpersonal and social rhythm therapy: managing the chaos of bipolar disorder. *Biological Psychiatry*, *48*(6), 593-604.

Ghasemian, D., D'Souza, L., & Ebrahimi, S. (2012). Effectiveness of Rational Emotive Behaviour Therapy on Shyness: Influence of Age. *Journal of Psychosocial Research*, *7*(2), 313

Goldsmith, R.E. (1986). Dimensionality of the Rosenberg self-esteem scale. *Journal of Social Behavior and Personality*, *1*(2), 253.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery & Psychitry*, *23*(1), 56-62.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R., ... & Wang, P.S. (2003). The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA*, *289*(23), 3095-3105.

Kim, M. K., & Kang, S. D. (2013). Effects of art therapy using color on purpose in life in patients with stroke and their caregivers. *Yonsei Medical Journal*, *54*(1), 15-20.

Larson, D.B., & Larson, S.S. (2003). Spirituality's potential relevance to physical and emotional health: a brief review of quantitative research. *Journal of Psychology and Theology, 31*(1), 37-51

Malat, J., Leszcz, M., Negrete, J. C., Turner, N., Collins, J., Liu, E., & Toneatto, T. (2008). Interpersonal group psychotherapy for comorbid alcohol dependence and non-psychotic psychiatric disorders. *The American Journal on Addictions*, *17*(5), 402-407.

Michel, D.M. (2002). Psychological assessment as a therapeutic intervention in patients hospitalized with eating disorders. *Professional Psychology: Research and Practice*, *33*(5), 470.

Mihai, C., Chirita, R. , Robu, V., Untu, I., & Szalontay, A.S.(2017). Predicting Suicide Risk Among Male Offenders: The role of severe personality disorders. *Revista de Cercetare si Interventie Sociala*, *57*, 28-50.

Miller, W.R., & Thoresen, C.E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist*, *58*(1), 24.

Mountain, G., Mozley, C., Craig, C., & Ball, L. (2008). Occupational therapy led health promotion for older people: feasibility of the Lifestyle Matters programme. *British Journal of Occupational Therapy*, *71*(10), 406-413.

Neff, K.D., Rude, S.S., & Kirkpatrick, K.L. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality*, *41*(4), 908-916

O'Reilly-Knapp, M. (2001). Between two worlds: The encapsulated self. *Transactional Analysis Journal*, *31*(1), 44-54.

Pompili, M., Serafini, G., Del Casale, A., Rigucci, S., Innamorati, M., Girardi, P., ... & Lester, D. (2009). Improving adherence in mood disorders: the struggle against relapse, recurrence and suicide risk. *Expert Review of Neurotherapeutics*, *9*(7), 985-1004.

Rana, M. (2016). Psychosocial Correlates and Treatment Compliance in Depressive Disorder: A Hospital Based Study. *Journal of Institute of Medicine*, *39*(1), 16-24.

Schafer, A., Meyer, F., Matzat, J., Knickenberg, R. J., Bleichner, F., Merkle, W., ... & Beutel, M. E. (2005). Utilization of and experience with self-help groups among patients with mental disorders in Germany. *International Journal of Self-Help & Self-Care*, *4*(1-2).

Strader-Garcia, S. S. (2012). *The impact of an expressive arts group therapy process on anxiety and self-esteem for highly sensitive adolescents*. Institute of Transpersonal Psychology. Michigan: ProQuest Dissertations Publishing

Yalom, I.D., & Leszcz, M. (2005). *Theory and practice of group psychotherapy*. New York: Basic Books.

Yalom, I.D., Houts, P.S., Newell, G., & Rand, K.H. (1967). Preparation of patients for group therapy: A controlled study. *Archives of General Psychiatry*, *17*(4), 416-427.

Zinbarg, R. E., Uliaszek, A. A., & Adler, J. M. (2008). The role of personality in psychotherapy for anxiety and depression. *Journal of Personality*, *76*(6), 1649-1688.