Empowering Adults in Recovery from Depression: A Community-Based Self-Management Group Program

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ABSTRACT

This paper reports on the development and evaluation of the Depression Self-Management Workshop (DSMW) that aims to empower participants to implement self-management behaviours in their daily lives in order to improve their mental health and prevent relapse. The 10-session intervention was delivered to 46 adults with depression who completed pre-, post- and follow-up structured interviews and questionnaires. Depressive symptoms were significantly reduced at the end of the intervention and at follow-up. Improvements in participants' knowledge about depression, self-management behaviours and self-efficacy were also observed. These results were corroborated by the participants' strong convictions regarding the DSMW's usefulness.

Keywords: self-management, depression, empowerment, community-based research

RÉSUMÉ

Cet article porte sur le développement et l'évaluation de l'Atelier d'Autogestion de la Dépression (AAD) qui vise à habiliter les participants à adopter des comportements d'autogestion dans leur vie quotidienne, afin d'améliorer leur santé mentale et prévenir les rechutes. Au total, 46 adultes souffrant de dépression ont participé à l'atelier de 10 séances et ont complété des questionnaires et des entrevues pré, post et suivi. Les résultats indiquent que les symptômes dépressifs ont significativement diminués suite à l'intervention, ainsi que lors du suivi. Des améliorations concernant les connaissances de la dépression, les comportements d'autogestion et l'auto-efficacité ont également été observées. Ces résultats ont été corroborés par la conviction des participants en ce qui concerne l'utilité de l'ADD.

Mots-clés : Autogestion, dépression, empowerment, recherche communautaire

Major depression is the most widespread mental disorder in North America: more than one in ten persons will suffer from this disorder during their lives (Kessler & Bromet, 2013). It is a complex and recurring disorder (Hardeveld, Spijker, De Graaf, Nolen, & Beekman, 2010) for which the available treatments have proven to be of limited efficacy (Trivedi, Hollander, Nutt, & Blier, 2008). In addition, access to psychotherapy—the preferred form of treatment, compared to the use of antidepressants, for most persons with depression (Houle, Villaggi, Beaulieu, Lespérance, Rondeau, & Lambert, 2013; van Schaik, Klijin, & van Hout, 2004)—remains limited due to high cost (Vassiliadis, Tempier, Lesage, & Kates, 2009).

Given the limitations of the usual treatments for major depression as well as the high level of recurrence, it is important to develop alternative approaches to support recovery from this disorder. According to persons with depression, recovery cannot be defined solely in terms of reduced symptoms (Johnson, Gunn,

& Kokanovic, 2009; Zimmerman et al., 2006). Rather, they report that recovery requires acquiring a greater sense of balance, control and self-confidence, as well as new attitudes and abilities, in order to re-establish a sense of well-being in daily life and work toward achieving personal goals. Such individuals believe that the recovery process must be directed by the person in a depressive episode rather than by professionals or experts, who are perceived as tools that they can use in their personal processes (van Grieken, Kirkenier, Koeter, Nabitz, & Schene, 2013).

Self-management support is well aligned with this vision of recovery. While usually employed in the management of chronic physical diseases like diabetes and cardiovascular diseases, the reported objective measurements of the processes or outcomes of care, and employed acceptable experimental or quasi-experimental study designs as defined by the Cochrane Effective Practice and Organization of Care Group.

Results: Two reviewers evaluated 16,917 titles and identified 102 studies that met the inclusion criteria. Identified studies represented 11 chronic conditions: depression, diabetes, rheumatoid arthritis, chronic pain, coronary artery disease, asthma, heart failure, back pain, chronic obstructive pulmonary disease, hypertension, and hyperlipidemia. Disease management programs for patients with depression had the highest percentage of comparisons (48% [41/86]); the self-management approach consists of equipping the person to "manage the symptoms, treatment, physical and psychological consequences and life style changes inherent in living with a chronic condition." (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002). The self-management approach recognizes the central role that the individual plays in managing his or her health. While the traditional programs have been prescriptive and normative, focused on patient compliance with the recommendations of professionals (Anderson & Funnell, 2010), empowerment-based approaches are focused on the person and his or her preferences, needs and health objectives. This means that professionals are there to provide support as the individual identifies health concerns and acquires the knowledge and skills needed to attain his or her objectives. It has been shown that these empowerment-based self-management interventions are effective in persons with chronic metabolic diseases (Kuo, Lin, & Tsai, 2014), but they have not yet been assessed with respect to persons suffering from mental health problems such as depression.

A systematic review found that self-management support interventions reduces symptoms of depression and improves feelings of self-efficacy, self-management behaviours, and the individual's overall ability to function (Houle, Gascon-Depatie, Bélanger-Dumontier, & Cardinal, 2013). However, there are only six published studies of the subject, and the interventions they assessed were primarily focused on patient compliance with their professionals' recommendations. In contrast, the newly developed Depression Self-Management Workshop (DSMW), described below, seeks to empower adults with major depression to freely choose and implement self-management behaviours in their daily lives, taking into account their preferences and personal circumstances, in order to improve their mental health and prevent relapse. This article describes our efforts to create and test a pilot version of the DSMW among a group of adults with major depressive disorder.

METHOD

DSMW development

The DSMW was developed through a partnership between a community psychologist and a non-profit organization that helps people suffering from anxiety, depression, and bipolar disorders. Our study was based on a community-based participatory research orientation (Minkler & Wallerstein, 2010) that promotes equal relationships and mutual learning among researchers, community workers, health professionals, and people in recovery from a depressive disorder (peer specialists). This approach made it possible to combine the scientific knowledge of researchers, the professional knowledge of community caregivers, and the experiential knowledge of people in recovery. The study was approved by the Ethics Board.

From the outset, our team agreed on certain basic principles. First, we wanted to take a group approach, since it has often been shown that it is beneficial for people recovering from mental disorders to receive support from persons who have had similar experiences (Johnson et al., 2014). Second, we wanted to avoid being prescriptive. Instead, we aimed to emphasize personal empowerment. We repeatedly reinforced our belief that participants were the experts in their own recovery: that they knew better than we did what would prove useful to them. Lastly, we advocated an approach based on each individual's strengths, with the facilitators taking the time each week to recognize participants' good ideas, and encourage them to be easy on themselves.

An initial version of the DSMW was developed based on a review of the scientific literature on recovery from depression. This version was given to a group of 12 participants. Two independent observers attended each session in order to assess the way in which the intervention was provided. Following the 10 DSMW sessions, the participants were interviewed individually to give their opinions on the strengths and weaknesses of the intervention. The observations and interview results were used to develop a second version of the DSMW. This second version was implemented, observed, and evaluated by its participants. It was also submitted to a committee of experts consisting of researchers who were not involved in the program development process, health professionals (psychologist, psychiatrist, social worker and nurse), persons in recovery from depression, and their friends and family. A third and final version of the DSMW was refined by the comments made by members of the expert committee and participants. This article reports on the evaluation of this third and final version of the DSMW.

Description of the DSMW

The DSMW is an intervention consisting of ten 2-and-a-half-hour sessions (see Table 1) given once a week and led by two mental health facilitators. The facilitators were trained through a highly detailed guide to ensure that the program content would be delivered in a standardized fashion. Ten booklets were also developed for the participants. Each week, the participants received a different booklet with information on the theme of the week and containing exercises to be performed within the group setting or at home. This staged delivery of the content was intended to prevent participants from becoming discouraged by the amount of material to be covered.

The co-facilitators used three strategies: (1) knowledge transfer, which always began by seeking participants' ideas and then adding the information in the facilitator's guide and the pamphlets, as required; (2) group discussions, to foster modeling and social support; and (3) practical exercises, to help the participants acquire specific skills. Participants were also given an assignment to complete before the next session. The assignments were designed to expand on an aspect of the content of the workshops or to have participants

Table 1

Content of the Sessions of the Depression Self-Management Workshop

Session 1. Understanding Depression to Mount a Better Response
Recognize the warning signs of your episodes of depression.
Identify strategies to use when you see warning signs.

Session 2. Finding and Choosing Allies
Understand the role played by the members of your care team.
Develop self-observation skills.
Know how to prepare for an appointment with your doctor.

Session 3. Getting Back on Your Feet
Become aware of self-criticism and its effects.
Gradually replace self-criticism by being easier on yourself and building self-worth.
Work toward better management of your emotions through emotion regulation.

Session 4. Getting Support from Friends and Family
Understand the difference between sources of positive and negative support.
Learn how to communicate your needs to friends and family appropriately.
Become more aware of the reality of your friends and family.

Session 5. Finding Anchors
Identify and reactivate activities that feel good and your sources of comfort.
Identify your reasons to live.

Session 6. Reviewing Lifestyle Choices
Understand the effects of good lifestyle choices on mood.
Take stock of your lifestyle choices and target potential improvements.
Develop skills for building an action plan.

Session 7. Seeing Things Differently
Recognize perceptual filters and their impacts on mood.

Session 8. Learning to Ease the Tension
Better understand stress and its effects on health.
Identify your sources of stress.
Acquire strategies for managing and preventing stress.

Session 9. Being Comfortable in the Workplace
Recognize depression protection and risk factors in the workplace.
Develop strategies for improving your well-being at work.

Session 10. Consolidating Your Toolbox
Recognize the progress you have made since the program began.
Consolidate your personal toolbox.

trying out a new skill introduced during the session. The theoretical rationale for the intervention predicts that increased knowledge about depression, self-efficacy and self-management behaviours could help reduce depressive symptoms in persons recovering from depression.

DSMW evaluation

To examine the acceptability of the DSMW and explore preliminary outcomes, we used a mixed-method quantitative and qualitative within-group longitudinal design, taking measures at three points over a six-month period. Participants were assessed prior to beginning the intervention, at the end of the intervention, and at four months post-intervention. We tested four hypotheses regarding changes in participants over time:

1. Depressive symptoms would decrease following the intervention;
2. Changes in depressive symptoms would be maintained four months after the end of intervention;
3. Knowledge about depression, self-efficacy, and self-management behaviours would increase following the intervention; and
4. The change in depressive symptoms would be explained by participants' increased knowledge about depression, self-efficacy, and self-management behaviours.

Participants

Participants were recruited through advertisements in newspapers and by referrals from professionals working for four community partners: two health and social services centers (HSSCs) and two community organizations. The inclusion criteria for this study were (a) being 18 years old or older; (b) speaking French; (c) meeting the criteria for a major depression in the past two years, as assessed by the *Structured Clinical Interview for DSM-IV Axis I Disorders* (SCID-I; First, Spitzer, Gibbon, & Williams, 1996); and (d) having a score ≥ 6 on the *Clinician-rated Quick Inventory of Depressive Symptomatology* (QIDS-C_{16}; Rush et al., 2003) and a score ≥ 8 on the *Hamilton Rating Scale for Depression* ($HRSD_{17}$; Hamilton, 1960), which corresponds to the minimum severity for a diagnosis of mild depression (American Psychiatric Association, 2000). The exclusion criteria included (a) meeting the criteria for a bipolar or psychotic disorder as assessed by the SCID (First et al., 1996); (b) having suicidal ideations that require urgent treatment; or (c) being pregnant or having given birth in the past six months. A total of 46 participants, distributed in four groups, took part in the study following the screening of 108 persons (29 did not meet the inclusion criteria and 33 refused to participate).

Participants' characteristics are presented in Table 2. A majority (78%) of participants reported more than one depressive episode, and comorbidity with anxiety disorder was high (72%). Before participating in the DSMW, almost half (43%) of the sample reported severe to very severe depressive symptoms (assessed with the $HRSD_{17}$), despite the fact that the large majority were either being treated currently with antidepressants (83%) or had received psychotherapy during the previous year (70%).

Table 2

Characteristics of the Sample before Participation in the DSMW (n = 46)

Characteristic	Frequency (%)
Female	30 (65%)
Born in Canada	41 (89%)
Heterosexual orientation	43 (94%)
Level of education level	
High school diploma	4 (9%)
College degree	17 (37%)
University degree	25 (54%)
Below the poverty line	9 (20%)
Currently receiving antidepressant treatment	38 (83%)
Psychotherapy consultation in the last year	32 (70%)
Having experienced at least one previous depressive episode	36 (78%)
Number of depressive episodes	3 (min. 1, max. 12)
Comorbid anxiety disorder	33 (72%)
Comorbid substance use disorder	9 (20%)
Severity of depressive symptoms at baseline ($HRSD_{17}$)	
Mild (8–13)	4 (9%)
Moderate (14–18)	22 (48%)
Severe (19–22)	14 (30%)
Very severe (≥ 23)	6 (13%)

Measures

Severity of depressive symptoms was assessed using the *Hamilton Rating Scale for Depression* ($HRSD_{17}$; Hamilton, 1960) and the *Quick Inventory of Depressive Symptomatology* (QIDS-C_{16}; Rush et al., 2003). The $HRSD_{17}$ is the most widely used instrument in clinical trials for depression treatment (Uher, Perlis, & Placentino, 2012) and gives a continuous score of depression severity on a scale of 0 to 50. The QIDS-C_{16} provides a continuous score of depression severity on a scale of 0 to 27 and demonstrates a good capacity to detect changes in depressive symptoms, as well as good internal consistency and adequate concurrent validity (Trivedi et al., 2004; Rush et al., 2003).

Knowledge about depression was evaluated using a self-administered questionnaire developed by Ludman et al. (2003). Using a Likert scale ranging from 1, "strongly disagree," to 5, "strongly agree," participants were asked to rate agreement with six statements evaluating their knowledge about depression treatment. A mean score was calculated. The internal consistency of the scale is adequate in our sample ($\alpha = 0.72$).

Self-efficacy was measured using a 6-item scale (Bush et al., 2001) that asked participants to rate, on a scale from 0, "not at all," to 10, "extremely," their confidence in their ability to manage and prevent depression. Previous psychometric analyses indicate that the scale is internally consistent ($\alpha = 0.79$) and that a single factor explained 50% of the variance (Bush et al., 2001). The internal consistency of the scale is adequate in our sample ($\alpha = 0.74$).

Inspired by a method used by Ludman et al. (2003), six self-management behaviours were evaluated: (1) participating in pleasant activities; (2) distracting themselves from their thoughts or talking to themselves in a positive way; (3) preventing problems by planning ahead for stressful situations; (4) keeping track of depressive symptoms; (5) looking out for early warning signs of depression; and (6) following a written plan to manage their depression. For behaviours 1 to 3, participants were asked to report how often they engaged in each behaviour during the past month, using a Likert scale from 1, "daily," to 5, "not at all." A score of 1 was attributed if the participants reported performing the behaviour once a week or more during the past month. For behaviours 4 to 6, participants were asked if they performed the behaviour in the past month, and they could answer "yes" (score of 1) or "no" (score of 0). Total score was computed by summing the six items, with the potential score ranging from 0 to 6.

Procedure

All participants signed a consent form. The inclusion and exclusion criteria as well as baseline knowledge of depression, self-efficacy, and self-management behaviours were assessed during a face-to-face meeting with a co-investigator not involved in the intervention. Depressive symptoms were evaluated through a structured phone interview made by two independently trained clinicians, who were blinded to the treatment. Participants were not compensated for their time, but the DSMW was free of charge. After the workshop's sessions were finished, open-ended questions were asked in an individual interview in order to explore participants' experience of the intervention. The facilitators participated in a group interview to explore their perceptions of the DSMW's acceptability and efficacy.

Statistical analyses

Linear mixed models (LMM) were used to analyze relationships between depressive symptoms and time, knowledge about depression, self-efficacy, and self-management while controlling for demographics and clinical data. A restricted maximum likelihood approach was used to estimate the coefficients. Interactions between independent variables and time were tested. The examination of residuals did not reveal any problems associated with non-linearity, non-normality, or outliers. All statistical analyses were performed using SPSS, version 21.0, SPSS Inc., Chicago, USA. The level of significance was set at 0.05 for all two-tailed tests.

Qualitative analyses

The qualitative portions of the post-test interviews with participants, as well as the group interview with the facilitators, were digitally recorded, transcribed, and checked for accuracy. Two co-investigators used NVivo v.10 software to code the data. This analysis was based on the principles of thematic analysis (Braun & Clarke, 2006), which is appropriate for qualitative studies with a preliminary theoretical model

(Crabtree & Miller, 1992). The two co-investigators developed a coding table for each dimension under study. The initial coding table was not fixed; rather, it was subject to change as the analysis progressed. Team members were required to reach a consensus concerning each new coding category and each change made to a category. This approach is frequently used in qualitative research and reduces the bias associated with data analysis (Edwards, Dattilio, & Bromley, 2004).

RESULTS

Acceptability of the DSMW

Out of the 46 persons who participated in the workshop, eight dropped out of the program before the end (for a retention rate of 83%). On average, the participants attended 8.2 out of 10 sessions (9.1 out of 10 sessions among completers). No statistically significant difference was observed, in the demographic and clinical variables, between the persons who dropped out of the program and those who completed it.

In terms of strengths of the program, both participants and facilitators greatly appreciated the structure of the workshop, with its phases cycling through knowledge transfer, group discussions, and practical exercises. Brief recaps of the theme addressed in the previous session were also identified as a strength.

The participants also appreciated the 10 booklets (one per session) that they received and could keep and consult again after the workshop. The tools and the proposed self-management behaviours were valued.

> I'll keep consulting the booklets from the 10 sessions. I plan on rereading it all, from the first booklet to the last. It's part of a regular follow-up that I plan on doing. It isn't over as far as I'm concerned. (Participant 1-04)

> The hints they give are excellent. Personally, it took me five years to find all these hints that they share in 10 weeks. (Participant 3-13)

The facilitators, as well as almost every participant, mentioned the beneficial effect of the mutual help given in the group as one of the most appreciated components of the DSMW. Besides allowing participants to feel less alone, it allowed them to discuss their feelings without being judged and share personal tools with others. They were also encouraged by seeing the positive impact that the program was having on the other participants.

> We're all living with depression, we all know how it hurts, and I could see how people wanted to help me, and I wanted to help, too. After many years of depression, I was pleased to share what I had learned, the things that worked for me. (Participant 3-12)

Almost all the participants, of their own accord, remarked that the facilitators were one of the aspects of the workshop that they appreciated the most. Their listening skills, their empathy and their open-mindedness put participants at ease and created a light, warm atmosphere, despite the seriousness of some of the subjects discussed. The participants appreciated the clear explanations of the program's content and their ability to give a recap of the relevant points in each discussion and make sense of what had been said.

> How we were received by the two facilitators proved extremely useful and important, since I trusted them right from the start, and I opened up. (Participant 1-07)

> The summaries that the facilitators made after our discussions—I just drank it up. They really understood what we were trying to say. Even if things came out badly, sometimes, they saw through it. (Participant 2-02)

The co-facilitation was also highly appreciated by both the facilitators and the participants. The facilitators were able to give each other feedback and continually improve, and it helped in the management of any problems that arose (e.g., when a participant needed to be taken aside). Lastly, good chemistry between the two facilitators made a positive contribution to the general mood in the group.

Some improvements were suggested by the participants and the facilitators. Many participants would have liked to receive a personal follow-up during the workshop, and others complained that the sessions ended too abruptly, saying that they would have liked to see the group again after the DSMW had ended. The participants in one group took the initiative, on their own, to organize more informal meetings after the sessions had ended.

> During the 10 sessions we experienced all kinds of things; we really spilled our guts, and then all of a sudden it was over. We just couldn't take it. So on our own, we decided to meet somewhere, quite regularly, without the facilitators. (Participant 2-11)

Efficacy of the DSMW

Quantitative results: Table 3 provides descriptive statistics for all the quantitative outcome variables. The LMM analyses (see Table 4) found a significant decrease in depressive symptoms following the intervention for both measures ($HDRS_{17}$ and $QIDS\text{-}C_{16}$), supporting Hypothesis 1. The negative linear effects ($p < 0.001$) were decelerated by positive quadratic effects ($p < 0.001$) at follow-up, meaning that the rate of decrease in depressive symptoms declined over time. However, these results support Hypothesis 2, since they show that the change in depressive symptoms was maintained four months after the end of the intervention. The demographic and clinical data, as well as the number of sessions attended by the participant, were not associated with the decrease in depressive symptoms.

Table 3

Means (Standard Deviations) for All Outcome Measures at Each Time Point

Scale	Pre-test	Post-test	Follow-up	Variable range
HRSD-17	19.52 (5.44)	11.51 (6.89)	9.29 (6.57)	0-50
$QIDS\text{-}C_{16}$	13.76 (4.20)	8.71 (5.08)	6.57 (4.58)	0-27
Knowledge about depression	3.75 (0.65)	4.12 (0.52)		1-5
Self-efficacy	5.54 (1.67)	6.79 (1.26)		1-10
Self-management behaviours	3.76 (1.64)	4.55 (1.15)		0-6

Table 4

Estimated Fixed Effects from Linear Mixed Models

	HRSD-17	QIDS-C16	Knowledge about depression	Self-efficacy	Self-management behaviours
	B ± SE(B) p-value	B ± SE(B) p-value	B ± SE(B) p-value	B ± SE(B) p-value	B ± SE(B) p-value
Intercept	19.5 ± 0.92 0.000	13.8 ± 0.69 0.000	3.75 ± 0.09 0.000	5.53 ± 0.21 0.000	9.09 ± 0.45 0.000
Linear time	-4.20 ± 0.52 0.000	-2.54 ± 0.40 0.000	0.15 ± 0.04 0.000	0.50 ± 0.09 0.000	0.54 ± 0.22 0.020
Quadratic time	0.41 ± 0.07 0.000	0.23 ± 0.06 0.000	NA	NA	NA

NA = None applicable

As shown in Table 4, knowledge about depression, self-efficacy and self-management behaviours increased linearly over time ($p<0.020$), supporting Hypothesis 3. However, contrary to Hypothesis 4, they were not associated with the decrease in depressive symptoms.

Qualitative results: The results from the qualitative post-test interviews with participants and facilitators are convergent with the quantitative results. Several participants attributed the improvement in their mood to their experiences in the workshop. Their mood had improved, they had more energy, and were happier after the program. They also felt better equipped and were more confident in their ability to deal with their next episode of depression. This converges with their improved sense of self-efficacy observed in the quantitative results.

> I feel able to identify behaviour that can lead to depression. I feel that I'll be able to take what I've learned and apply it in my life. (Participant 4-04)

Many participants mentioned that they had adopted new self-management behaviours following their participation in the workshop, such as taking part in more enjoyable activities, using better health practices, changing their self-talk (self-criticism, rumination), looking for more social contacts, acknowledging and monitoring for the warning signs of a relapse.

> Taking some time for the things that please me. Yeah, I was doing it less often, particularly these last few years; it just got harder to do it. Being in the group gave me a chance to shed some light on the problem and give myself some time to take care of myself. (Participant 4-03)

Several participants noted that the workshop had increased their knowledge about depression.

In addition, participants reported some unexpected effects of the workshop, including the fact that it helped them accept their disease, be less ashamed of suffering from depression, and be easier on themselves and more accepting of their disease.

> It's accepting that depression is a disease, and a cure is possible. There's no need to be ashamed about saying that you're in a depressive episode. Taking part in the workshop and reading the literature greatly helped me accept the situation. (Participant 2-04)

DISCUSSION

The present paper has described the development, implementation and evaluation of a community-based group program for self-management, designed to empower persons suffering from depression. The Depression Self-Management Workshop was developed through a collaborative process involving community workers, peer experts, clinicians and researchers. While costly in terms of time and energy, this approach was nevertheless crucial in order for the program to have specific qualities: a non-hierarchical relationship between the participants and the facilitators, an emphasis on mutual help, and respect for each individual's speed and preferences. By providing relevant information, encouraging discussions among the participants and applying different techniques and strategies, the DSMW allows individuals suffering from depression to develop a personal plan for self-management of their mental health, one that is based on their particular life circumstances and personal preferences. The DSMW applies an approach founded on participants' strengths, on reciprocity (the individual not only receives assistance but also helps others) and on capacity building to allow persons suffering from depression to regain a sense of confidence and take concrete action to recover. The facilitators do not present themselves as experts who are there to impart their knowledge and tell "ignorant" people what to do; rather, their role is to support, motivate, value, and foster social cohesion among the participants, who are seen as the real experts in their recovery. The non-professional approach taken by the DSMW proved successful, since participants identified the quality of the facilitation and the beneficial effect of being in the group as two of the program's greatest strengths.

The preliminary outcomes of the DSMW are promising. The results show that depressive symptoms decreased significantly between pre- and post-test, and this reduction is maintained four months later. Our study converges with others and suggests that depression self-management support could be a valuable addition to traditional treatment approaches (Houle, Gascon-Depatie, Bélanger-Dumontier, & Cardinal, 2013). The significant reduction in symptoms (41% at post-test and 52% at follow-up on the HRSD) is even more encouraging given the fact that it occurred in a cohort of participants most of whom (78%) were not experiencing their first episode of depression and the great majority of whom (83%) were being treated with antidepressants when the study began. Our sample therefore appears to have consisted of individuals who were unable to attain remission of symptoms, despite having obtained treatment. As a complement to treatment, the DSMW appears to have had a beneficial impact on mood for people suffering from depression, in addition to improving their knowledge of depression, their level of confidence in their ability to manage the illness and their use of self-management behaviours. However, these changes must be interpreted with caution due to the absence of a control group, since it is impossible to state with certainty that the improvements witnessed among the participants was due to their participation in the DSMW. The passage of time, treatments received during the same period, or their participation in the research process may have played

a role in their recovery. However, the scale of the reduction in depressive symptoms observed in our study was much greater than that reported in a meta-analysis of persons on waiting lists (10% to 15% over a period of 20 weeks; Posternak & Miller, 2001). Further, the results from the qualitative discussions showed that participants tended to attribute the improvement in their mental health to the DSMW. A randomized clinical trial would nevertheless be necessary in order to be able to reach a more definitive conclusion on the DSMW's effectiveness.

Our study's results cannot provide an empirical explanation of how the DSMW may have reduced depression symptoms. The three mechanisms that we postulated (increased knowledge, feelings of self-efficacy, and self-management behaviours) do not appear to be related to the change in depressive symptomatology. These results may be attributable to the small size of our sample or to the fact that the measures had not been rigorously validated. However, the program may also have had an impact through variables that were not assessed, such as social isolation or self-stigma. Participants mentioned that the DSMW helped them feel less isolated and be less ashamed of their illness. Future studies should be conducted to examine these issues.

The beneficial impact of the group was particularly salient in the qualitative comments received from participants. Consequently, it is unlikely that the same content, delivered in an individual support format, would have the same impact. Group approaches are not for everyone, since some people are uncomfortable in this type of situation, so it is extremely important to pay particular attention to this issue when selecting participants. In this study, all the participants were open to a demanding process that verified their eligibility, and this helps explain our high participation rate and the high attendance rate throughout the DSMW: only 17% attrition, compared to an average of 24% for psychotherapy (de Maat, Dekker, Schoevers, & de Jonghe, 2007). In a more natural setting, it would be well-advised to implement a participant evaluation and selection mechanism to ensure that the Workshop's objectives match participants' needs and that they are interested in investing considerable effort in such a demanding group process.

In conclusion, the sharing of scientific, professional and experiential knowledge by peer specialists made it possible to develop, through a collaborative process anchored in the community, an innovative program to support self-management of depression to empower people suffering from depression. This study suggests that such group interventions are appreciated by the target group, and could become a good complement to the traditional treatment for depression, particularly among persons at risk for recurrence.

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