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BRIEF REPORT

Development and pilot testing of a social intervention for depressed women of Pakistani family origin in the UK

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Abstract

Background: Depressive disorders are common in women of Pakistani origin living in the UK. In a pilot study we developed and tested a culturally sensitive social group intervention for persistently depressed Pakistani women.

Methods: A total of 55 persistently depressed women were identified in a population-based study. The first consecutive 18 who agreed to participate were enrolled into the study. Out of these, eight women dropped out before the start of the intervention, one woman attended the first session only and nine women attended 10 weekly sessions of the group. Outcome measures at baseline and at the end of the intervention were the 20 item Self Reporting Questionnaire (SRQ) and the Schedule for Clinical Assessment in Neuropsychiatry (SCAN).

Results: All 9 women attended at least six of the 10 sessions. Mean SRQ score at baseline was 15.0 (SD = 3.08) and 11.7 (SD = 5.95) at the end of the intervention ($p = 0.039$). Three women reported reduction in suicidal ideas.

Conclusions: A culturally appropriate social intervention successfully brought together a group of isolated chronically depressed Pakistani women, enabling them to form informal networks and forming the basis of an RCT to treat the depression.

Keywords: *Mental health, depression, social intervention, Pakistani women, ethnic minority, United Kingdom*

Background

Depression is one of the leading causes of disability in adults across the world (Murray & Lopez, 1997). Ethnic minority women of South Asian origin in the UK have a high prevalence of depression (Gater et al., 2009; Weich et al., 2004) and higher rates of suicide and attempted suicide (Bhugra, 2002; Cooper et al., 2006; Raleigh, 1996). The EMPIRIC study of common mental disorders in ethnic minorities across the UK, reported depressive disorders to be highest in the women of Pakistani family origin as compared to other ethnic minorities and whites (Weich et al., 2004).

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A high prevalence of depression may result from high incidence or lack of restitution. Our previous studies suggest that the latter contributes greatly to the high prevalence of depression among Pakistani women in the UK. In 45% of white Europeans attending primary care depression was persistent over six months (Ronalds et al., 1997). However in another primary care study of people of Pakistani family origin persistence of depression over one year was 97% (Husain et al., 1997). Depressed Pakistani women reported particularly severe and persistent social difficulties in the realms of marriage, housing, health and finances and they lacked supportive relationships (Husain et al., 1997).

Some of these difficulties are similar to those found in white Europeans but many family factors are unique to this population. These may only become clear when Pakistani women seek professional care in crisis (Chew-Graham et al., 2002).

In spite of this high prevalence and chronic course of depression in ethnic minorities particularly women, there is only one reported intervention testing the effect of an educational pamphlet on depressed immigrant Indian women in the UK (Jacob et al., 2002).

Considering that there is little evidence of any psychosocial interventions in ethnic minorities in the UK we decided to develop and test, in a pilot study, a culturally sensitive social intervention in Pakistani women by establishing a social group at the local Pakistani Community Centre in Manchester.

Method

Development and process of intervention delivery

A group of mental health professionals of Pakistani family origin in consultation with the local voluntary groups developed a basic framework about the content, facilitation skills and logistics of this 10-session social group intervention. The aim was to facilitate the development of informal networks that will engage these women in social contacts and if needed will later link them with appropriate mental health services. We provided free pick and drop taxi service accompanied by female Urdu speaking transport facilitators. This was done to ensure that the family and community did not object to women going out alone with a taxi driver. The venue was culturally acceptable as this was the local Pakistani community centre where social events are arranged regularly. We provided refreshments at the end of each session and this gave the women a good opportunity to mix with each other and the facilitators to get one-to-one informal feedback. In order to maintain good attendance the facilitators made telephone reminders to all participants on the evening before the morning session. Those who did not attend a session were later contacted to find the reasons for non participation. All participants were helped to resolve any possible barriers and were encouraged to attend subsequent sessions.

Content of the sessions

We had an introductory session addressing issues like confidentiality which was of immense importance as we wanted to give the women a sense of security that whatever they said during the group session would be kept within the group. This was the only way they could openly describe their problems and provide support to each other. A list of activities was drawn up at this session with the help of members of Pakistani Community Centre and the women themselves. A 10-item list of preferred group activities was made; this included a session on psycho education, three sessions were dedicated to activities (personal grooming,

exercise, and yoga) while four outdoor sessions were planned for visits to Manchester museum, science museum and local shopping malls. We planned the final session as a farewell session. All these details regarding form and content of sessions were documented in a manual for future use.

Recruitment

Women with a primary ICD 10 diagnosis of depressive disorder based on the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (World Health Organization [WHO], 1994) were recruited from an ongoing population-based study of depression in people of Pakistani family origin. Participants had to be persistently depressed both at baseline and at six months follow up to be included in the study. We had already gathered detailed information on the demographics and also social difficulties assessed by Life events and difficulties schedule (LEDS) (Brown & Harris, 1978). Participants were included after obtaining written Informed consent. Women with a learning disability, history of psychotic symptoms, alcohol dependence and dementia were excluded from the sample. The study had ethical permission from Central Manchester Ethical committee (CEN/00/122).

Out of 89 depressed women at baseline we identified 55 women who were persistently depressed at 6 months follow. The researchers contacted these women by phone and invited them to take part in the intervention study. The first consecutive 18 women on the list who agreed were enrolled into the study. Eight women dropped out before the start of the intervention because of a house move (2), visiting Pakistan (2), family commitments (3) or physical illness (1). One woman attended only the first session but was then stopped by her husband from attending subsequent sessions. This left nine women in the study.

Assessment

The outcome measures administered at baseline and the end of treatment were the Urdu versions of the 20-item Self Reporting Questionnaire (SRQ) (WHO, 1994), already validated in this population to assess current symptoms of depression (Ghangrekar, 2003; Husain et al., 2000; Husain et al., 2006), and the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) interview (WHO, 1994). The participants attended 10 weekly group sessions. These sessions were described in a manual developed during the course of the project. The aim of the study was to decrease the severity of depressive symptoms in these persistently depressed women by engaging them in a series of social activities in a group setting by providing social support, stimulation, education on mental and physical health needs and giving them a break from their distressing environment. We also wanted to assess the dynamics and feasibility of bringing out these depressed women and running such groups in the community.

Results

Nine women with a mean age of 54.1 years (SD = 9.0, range = 41–66 years) attended 10 weekly sessions between August 2003 and October 2003. Four were married, three divorced and two widowed. Chronic difficulties primarily in the domains of interpersonal relationships with family (7) and husbands (5) followed by health (4), financial (3) inability to speak English (1) and asylum problems (1) were reported by the participants.

All the women attended at least 6 of the 10 sessions. At the end of the intervention eight out of nine subjects reported a decline in self reported symptoms on the SRQ. Post

intervention there was a significant reduction in mean SRQ score. The baseline SRQ score of 15 (SD = 3.08) came down to a mean SRQ score of 11.7 (SD = 5.95). (Paired t test $p = 0.039$. At the post-intervention SCAN interviews two women were found not to have depressive disorder whereas all had been depressed at baseline. After 10 weeks of intervention, three of the participants reported a reduction in suicidal ideation.

Anecdotal feedback from the participants identified that the relationships developed between the participants and facilitators was the most important component to the success of the groups. Provision of transport was also an absolute necessity as only one woman could drive and others would have found it difficult to attend the sessions using public transport. Over the 10 weeks period the women eagerly looked forward to attending the groups and used the terms ''mood became fresh'' and ''forgot their problems'' as a way to describe their very positive experience which resulted in lifting of their self confidence. The opportunity to talk to other women was reported to be very therapeutic and in the last session women also reported feeling sad as the groups were ending. Participants wanted to continue to maintain the social networks that were formed during this period.

Discussion

Recognition of depression in women of Pakistani origin would not be useful unless it is also accompanied by specific treatment that overcomes the chronic social difficulties faced by this population. Our intervention was based on the social difficulties, isolation and low access to primary care observed in chronic depression among Pakistani women. Our work suggests that appropriate intervention should begin with the development of informal networks that engage these women in social contacts and link them with appropriate mental health treatment. This project in conjunction with the voluntary agencies has been successful in bringing together isolated, depressed Pakistani women for group activities, including offering them a better understanding of depression and its treatment.

This pilot study has formed the basis of a Medical Research Council funded exploratory trial of a complex intervention which will further develop this intervention and test it in a

Table I. SRQ scores and suicidal ideation.

	SRQ score		Suicidal ideations		
Subjects	Pre Intervention	Post Intervention	Pre Intervention	Post Intervention	Sessions
1	16	18	Yes	Yes	7 sessions but for 3 came very late.
2	13	12	No	No	6 sessions
3	18	15	Yes	No	9 sessions
4	18	17	Yes	Yes	8 sessions
5	17	15	Yes	No	8 sessions
6	12		No	–	Attended only 1st session
7	19	15	Yes	Yes	8 sessions
8	15	06	No	No	6 sessions
9	10	08	No	No	7 sessions
10	12	00	Yes	No	9 sessions
Mean score	15 (SD = 3.08)	11.7 (SD = 5.95)	6/10 (60%)	3/9 (33.3%)	

later large randomized controlled trial. This trial aims to test the hypotheses that for chronically depressed Pakistani women, the beneficial effects on severity of depression and social functioning of (i) social group therapy including psycho-education will exceed protocol guided antidepressant treatment, and that (ii) combined social therapy group with protocol guided antidepressant treatment will exceed social group therapy alone.

Authors' contributions

All authors contributed to the development of the protocol and writing of the manuscript. NC and SB administered the intervention. WW and NH contributed in data analysis. FC supervised the project.

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