What probably made a difference? A Qualitative Study of Anxious and Depressed Women who Exhibited Different Levels of Change after Counselling

S. Naeem, B.S. Ali*, A. Iqbal*, S. Mubeen*, A. Gul*

Departments of Psychiatry and Community Health Sciences*, The Aga Khan University, Karachi.

Abstract

Objective: To study the similarities and differences in the factors that facilitated or hindered change in levels of anxiety and/or depression in women following counselling.

Design: Qualitative: Focus group discussions and in-depth interviews.

Setting: Participants' homes and a welfare hospital in a lower middle class semi - urban community of Karachi, Pakistan.

Participants: Women who showed a change of 5 (+5 to -5) in the scores of The Aga Khan University Anxiety and Depression Scale after counselling (n=27).

Results: Financial, health and relationship problems were found to be common factors and were less severe in the full recovery group. Although women from all the groups had learnt problem-solving and cognitive-behavioral techniques, the women in the full recovery group perceived the benefits as being more long lasting.

Conclusion: The study has given a greater insight into the factors that probably help or hinder recovery from anxiety and/or depression after counselling (JPMA 53:242;2003).

Introduction

Different psychological techniques have an established place in treating anxiety and/or depression.[1-3] The prognosis for recovery when such techniques are used is dependent on the relationship between certain personality traits and social variables.[4] Physical ill health, bereavement and positive family history of depression are known to be associated with poor outcome.[5] This paper explores the similarities and differences in the factors that facilitated or hindered recovery from anxiety and/or depression in women who had received counselling.

Methodology

This paper is the qualitative arm of a conventional randomized controlled trial, which was conducted to see the effectiveness of community counselling by minimally trained counsellors in reducing the level of anxiety and/or depression in women from their own community. Through systematic sampling, 366 women with anxiety and/or depression were identified and randomly divided into an intervention and a control group. The instrument used to assess the levels of anxiety and/or depression was the Aga Khan University Anxiety and Depression Scale (AKUADS), an indigenous screening instrument, it has been developed from patients' symptoms as expressed in the local language Urdu, and has been validated keeping the psychiatrist's diagnosis (according to DSM III - R) as the gold standard. The cut-off for caseness is a score of 19 and above.[6,7]

Due to refusals and dropouts, only 70 women who had an initial AKUADS score of 19 and above, completed 8 counselling sessions from the intervention group. The counselling was mostly supportive with some problem-solving and cognitive-behavioral components, because use of cognitive and behavioral strategies by women recovering from depression has been reported.[8] A statistically significant reduction in the post counselling scores was found in 59 women; 35 out of them were no longer anxious and/or depressed as their scores fell below 19 (Full recovery, group I). Post counselling scores of 24 women showed a

significant reduction from their initial scores but remained above 19 (Partial recovery; group II) while 10 women had worsening of their AKUADS scores (Worsened scores, group III).

Selection criteria of women for focus group discussions (FGDs) and in-depth interviews from the above groups was based on a positive or a negative change of 5 points or more in the post counselling AKUADS scores. For both groups I and II, FGD as well as in-depth interviews were conducted, however for group III, no FGD was conducted as only three women fulfilled the inclusion criteria of a change of 5 negative points.

The two FGDs were conducted at a welfare hospital located at the site of the study and in-depth interviews were conducted either at the participants' homes or at the hospital. Semi-structured guidelines were prepared for conducting FGDs and in-depth interviews with the intent to explore the perceptions and feelings of participants regarding counselling. In the FGDs besides a facilitator and an observer a rapporteur was also present. The FGDs and the in-depth interviews were audio-taped and the interviewers also took extensive notes. Average time for FGDs and interviews was about 1-1/2 hours. The investigators carried out all the FGDs and interviews, which were transcribed and documented. A content analysis of the data were gathered.

Results

The sociodemographic characteristics of study subjects are given in table 1. The themes that emerged from the FGDs and the interviews are provided in table 2. The relevant quotes (given in italics) highlighting the similarities and differences (given in bold) between the three groups are provided. The verbatim (quotes) have been translated into English from originals that were expressed by the participants in the local language 'Urdu'. The level of severity of issues was determined by the number of times an issue was raised and the intensity with which it was expressed.

Discussion

Table 1 demonstrates the beneficial effects of education. Education has been found to confer protection in many studies[9-11] as it is known to improve coping mechanisms in more than one-way; it raises the self-efficacy and therefore the self-esteem of women. It also makes women feel less helpless in difficult situations and gives a greater sense of control over their environment.[12]

The relationship between causal and correlational factors is complex in psychiatry, but the risk factors that emerged from the FGDs / interviews were financial, health and relationship problems. The association between the above long-term difficulties and depression has been known

Table 1. The attributes of women belonging to different FGDs and in-depth interviews.

Qualitative tools	Attributes	Group I Full recovery	Group II Partial recovery	Group III Worsened
		n=7	n=7	
Focus group discussions	Age range	30-40 years	29-50 years	No FGD was conducted because of less number of women in this group
	Marital status	All married	All married	
	Number of children	2 - 6	2 - 7	
	Educational status	Only five were educated	Only one was educated	
		n=6	n=4	n=3
In-depth interviews	Age range	23 - 40 years	21-48 years	30-40 years
	Marital status	5 married	3 married	All married
	Number of children	1-6	2-8 (1 had no child)	5-6 children
	Educational status	All of them were educated	Only 2 were educated	Only 1 was educated

Table 2. Themes developed and their manifestation in the three groups.

Themes	Group I (Full recovery)	Group II (Partial recovery)	Group III (Worsened)
A) Casual factors			
i) Financial crisis	**Less severe** "I have to get rid of my debt".	**More severe** "We have no source of income, relatives or neighbours keep helping	**More severe** "I live in a rented house and our expenses are more than our income".
ii) Relationship problems and abuse	**Strained relationship problems with husband and in-laws but no physical abuse** "My husband never involved me in any decision, that's why we are facing financial problems".	**More strained relationship problems with husband or in-laws including abuse** "...men do not respect women, what is a woman supposed to do if she is abused?"	**More strained relationship problems with husband and children including abuse** "...When my husband does not have any work (job), he holds me and the children responsible for the financial crisis, beats me up and asks me to leave the house".
	"my sister-in-law and my brother's wife torture me emotionally".	"...my in-laws make fun of me and my family when we are in trouble".	"...its like you plant a tree and wait for its shade and fruits, but its very distressing if this does not happen. Same is the case with my son, I used to think that being my son he will share my sorrows but he proved to be useless".
iii) Health problems	**Minor personal health problems** "... I have a backache problem and feel frequent need for urination".	**Severe and chronic health problems in the family** "... my mother is an epileptic patient for the past 2 years and now my younger sister has the same symptoms".	**More severe and chronic personal health problems** "... I am in a lot of pain, I am unable to eat anything and feel weak. At times it is difficult to breathe. I get tense because of all these illnesses".
iv) Low self-esteem	**Not reported**	**Low self-esteem reported** "... I see no quality in myself. I feel very inferior"	**Extremely low self-esteem reported** "... when my husband used to irrirate me or abuse me, I would go out of the house thinking that I will end my life and save myself from these daily arguments and fights".
B) Strategies used	**Strong faith**	**Strong faith**	**Strong faith**
i) Acceptance	"... whatever the difficulties, if we accept them, there would be fewer problems"	"... one should face difficulties and be courageous".	"... one should accept the ups and down in the life and should always be optimistic".

ii) Prayer and faith in God	"... one needs help of people and of God"	"...when I am very scared, I get hope and peace of mind by offering prayers".	"... Allah gives me the courage to face the problems. With HIS help we cannot lose".
C) Sharing problems with a counsellor	**Shared easily** "... relatives won't sympathize with you whereas a stranger (counsellor) would"	**Shared easily** "... it is easier to share with a stranger (counsellor) than with a family member"	**Shared easily** "... discussing problems with others (family/relatives) makes things more complex. It's much easier to discuss problems with a counsellor".
D) How counselling helped			
i) Effectiveness of sharing	**Effective** "... talking/sharing helps in reducing "tension" by letting out what's inside us".	**Effective** "... by sharing we used to feel relaxed"	**Effective** "... sharing problems with the counsellor helped me reduce tension. My mental distress seems to be less after counselling".
	"... she (counsellor) helped me reduce my "tension". She created an awareness in me that I can do something worthwhile".	"... I got 'temporary' relief by sharing problems with the counsellor".	"... I liked it when counsellor used to come. I wanted her to sit with me for a longer time".
E) Skills learnt during counseling			
i) Cognitive behavioral	**Learnt more skills and practice them effectively.** "... I've stopped thinking excessively". "... before taking any wrong step, we should think of its consequences"	**Learnt some skills and practiced them effectively.** "... initially I used to think of my life as a burden, but now whatever happens, I don't take it on my nerves because if you take it on your nerves you become sick."	**Learnt few skills and practiced them effectively.** "... I used to worry a lot, cry, get irritated with children and used to think of committing suicide. Now I don't think that I will commit suicide or run away from home".
ii) Anger management	"... I noticed a change in my thoughts, while dealing with my husband. I realized that it is posible to resolve matters by being calm and not by quarreling".	"... now when I feel angry, I can tell myself not to do any thing that could make things worse".	"... in the beginning I used to feel angry but there have been no fights since the counsellor came to me. If now he (husband) is angry and says something to me, I do not answer back".
iii) Stress management and problem solving skills	"... I don't quarrel with my husband now".	"... initially I used to compel myself to help my husband in revenue generation, but now I help him with my own free will".	"... intially I used to take eight sleeping pills daily, but since the time the counsellor is coming I have reduced them".

	".. if we sit together and talk things out, the mind can be at peace".	"... a woman should get education and must work".	
	"... a woman should learn some skills to generate revenue".	"... financial support from relatives would help".	
	"... I now try to set my worries aside and divert my attention to some work. If I am not able to cook, I leave it, read a book or the Quran".		"... when I become tense, I go out and spend some time with my neighbors".
F) Attitude of family members towards the community counsellors	**More supportive** "... my husband is an educated man, he encouraged me to talk with the counsellor".	**Less supportive and discouraging** "... my husband was not in favor of the counsellor coming to our house".	**More supportive** "... my husband or children never objected when counsellor used to come to my house".

for years.[13,14] In a local study[15] ongoing financial and relationship difficulties (particularly with husband and in-laws) were identified as risk factors for depression and this study confirms the same.

Strained relationships were a major problem and women from group III specially mentioned that their eldest sons who had not come up to their expectations of financial and emotional support had disappointed them.

The psychological impacts of violence and abuse are known to contribute to anxiety, depression and low self-esteem.[16] All the groups reported verbal abuse; however, groups II and III also reported physical abuse. Low self-esteem though reported by both groups II and III was more severe in the latter leading to suicidal ideation as result of feelings of extreme worthlessness.

Minor health problems in group I did not obstruct recovery but the severe personal and family health problems did hinder recovery as found in groups II and III.

The association of religious involvement and spirituality with low levels of anxiety and depression is also known.[17] The coping strategies used by our study subjects had a common theme of 'acceptance' and 'praying' (faith in God'). Other helpful themes that emerged were 'sharing easily with a stranger who was an attentive listener' (counsellor) and 'release of tension by sharing'.

All the groups were found to be using the "anger management skills" learnt, but the women from the full recovery group were using their cognitive-behavioral and problem - solving techniques much more effectively than the participants of the other two groups, and perceived the benefits of counselling as being more long lasting, while the women from group II felt the beneficial effects to be ransitory.

The effectiveness of cognitive therapy in terms of improving psychological symptoms and social functioning has been reported[18] and similar changes were observed in the women of group I in this study, while the women of the other two groups were mainly looking towards external sources of financial help to overcome their anxiety and/or depression.

AKUADS score of women from group III had increased but counselling was still perceived as beneficial. These women had severe personal physical health problems. AKUADS has 'somatic' and 'psychiatric' stems. Any increase in somatic symptoms would cause an increase in the total score even when psychiatric symptoms could have been reduced.

In order to make an impact on anxiety and/or depression which are emerging as major public health concern with a higher prevalence in women, large scale mental health promotion efforts including counselling, stress/anger management and violence prevention programs are required. However, to make such efforts effective, what is required is a major structural societal change ensuring equitable distribution of financial resources, access to health care and preventing abuse in families, as this is what will probably make a difference!

Limitations

Financial problems, interpersonal difficulties, chronic health problems and adverse life events can precipitate/perpetuate depression or be a result of depression itself and it is difficult to decide which came first.

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