

The Onset and Duration of Benefit from Counselling by minimally Trained Counsellors on Anxiety

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Abstract

Objective: To assess the onset and duration of benefit of counselling by minimally trained community counsellors on level of anxiety and/or depression in women of their own community.

Methods: A randomized controlled trial for assessing the effectiveness of 4 and 8 weeks of counselling by minimally trained community women in reducing the levels of anxiety and depression was carried out in a lower middle class, semi-urban community in Karachi, Pakistan. In the baseline survey, 366 anxious and/or depressed women were identified and randomized to intervention and control arms. The intervention arm was re-screened for anxiety and depression after 4 and 8 weeks of counselling and again 8 weeks after the last counselling session. As the results showed a significant benefit in the intervention arm, for ethical reasons the controls were also counselled; and were screened in the same way. This study is a sub-analysis from the RCT specifically looking at the onset and the duration of benefit.

Results: A significant reduction in the mean scores of both the groups was found after 4 weeks of counselling which further improved at 8 weeks. The gradient of improvement was steeper at 4 weeks. At 8 weeks post counselling some loss of effect was detected but the levels still remained below the initial mean score.

Conclusion: This study indicates that literate women from semi urban communities can be trained as counsellors and their counselling can lead to a significant benefit in just 4 counselling sessions of 1 hour each, and could last at least till 8 weeks after the last session. Keeping in view the current high prevalence, the available facilities for treatment and the stigma attached to psychiatric treatment in our communities; this modality of intervention at the PHC level could be an alternative strategy for the management of depression (JPMA 54:549;2004).

Introduction

Counselling and psychotherapy have evolved as forms of interventions for anxiety and depression.^{1,2} Brief psychotherapy or cognitive behavior therapy is being widely used in general practice, and patients referred to counsellors have shown a statistically significant improvement compared to those receiving treatment from general practitioners only.^{3,4} Controlled trials have shown that cognitive behavioral therapy and interpersonal psychotherapy have achieved results comparable to antidepressants⁵⁻⁷ and the delay in the onset of benefit is the same for both interventions.⁸ Several attempts have been made to assess the persistence of the gains after different intervals of having stopped psychotherapy/counselling.⁹⁻¹² A relapse rate after 1 year of stopping pharmacotherapy is being reported as 80% and that after cognitive behaviour therapy is said to be 25%. It is being said that these findings make sense as anti depressants damp down activity in the lower limbic regions where stress and negative emotions originate, where as cognitive behaviour therapy teaches the cortex to respond to those signals in a healthier way and thus has a more enduring effect.¹³

A systematic review of 11 papers from 6 Developing countries Brazil, Chile, Indonesia, Lesotho, Pakistan, Zimbabwe, rural and urban has indicated a median prevalence of 20-30%.¹⁴ However there is a dearth of studies that examine the effectiveness of counselling in economically disadvantaged individuals particularly in communities where certified counsellors are not available.¹

The population of Pakistan is reported to be 152 million + 3-4 million immigrants, the Health budget is 2% of the GNP and mental health budget is 0.4% of this 2%. The prevalence of mild to moderate psychiatric illness is estimated to be anything between 10% - 66% of general population and another 1% are estimated to be suffering from severe mental illness.¹⁵ A 30 % prevalence of anxiety and depression in women is reported in the

baseline survey done for this study. 16 Encouraged by the WHO's advocacy that mental health problems can be managed in primary health care and our own positive experience of having used community health workers for the promotion of growth monitoring, oral rehydration therapy, breast feeding and immunization it was decided to conduct a randomized controlled trial (RCT) to assess the effects of eight sessions of counselling by minimally trained community based counsellors on levels of anxiety and depression in women of their own community.¹⁷ This paper reports a nested study derived from the RCT describing the onset and the persistence of benefit both in the intervention and the control arms. The latter were counselled for ethical reasons after the RCT results were found to be beneficial.

Methods

A cross sectional baseline survey was conducted for a randomized controlled trial from January 8-February 14, 2001¹⁶ in Qayoomabad, a semi-urban lower middle class community with a population of 80,000. Every 3rd household was systematically sampled. A total of 1226 households were studied. The inclusion criteria were: informed consent, age 18 years and above, ability to understand the local language Urdu, planning to live in Qayoomabad for at least one year, and not having suffered any bereavement in the last six weeks.

One woman who met the inclusion criteria was randomly chosen from each selected household and screened for anxiety and/or depression. Eight participants had to be excluded as they were later as they were found to be less than 18 years of age, leaving a sample of 1218 women, out of which 366 were identified as anxious and/or depressed. As a high refusal rate was expected, we randomized 40% more cases to the intervention group.

Majority of the women (74%) were between the ages of 21 and 40 years, 86% were Muslims rest were Christians, 70% of the study subjects spoke Hindko or Punjabi at home, 41% had never gone to school where as 3% were graduates, 83% were married, 89% were not involved in any revenue generating activity, 53% had been living in Qayoomabad for more than 10 years and only 8% were recent migrants having been there for less than a year. In the univariate analysis the biggest worry had turned out to be financial difficulties but in multivariate analysis by domestic abuse topped the list.

Aga Khan University Anxiety and Depression Scale (AKUADS), an indigenous screening scale

developed in the local language Urdu and validated in the community with psychiatrists interview as the gold standard was used to identify anxious and/or depressed women.^{18,19} AKUADS has been compared with the Self Reporting Questionnaire and has been used successfully in other studies. ^{20,21} The training sessions for community based counsellors were conducted thrice a week for 4 weeks, each working day was of 4 hours, the participatory approach of teaching/learning was used. The trainers included a family practitioner, a psychiatrist, a sociologist and 3 clinical psychologists. The content included information regarding common mental health problems in the community, communication and counselling skills, the latter covered problem solving and simple cognitive behavioral techniques.²² The use of problem solving therapy for depression is being promoted. ^{23,24}

The criteria for selection of community women for training as counsellors were: ability to read and write Urdu, planning to live in Qayoomabad for the next 2 years, having the permission to move about in the community and motivation to work as counselor.

After the training these community based counsellors provided one hour per week counselling sessions to consenting anxious and/or depressed women for 8 consecutive weeks. ¹⁷

A statistically significant improvement was found as a result of counselling. There was a 35% reduction in the mean AKUADS scores of the intervention group ($P < 0.001$). There was a spontaneous reduction of 14% in the control group ($P < 0.001$). This gave a net reduction in the intervention group was 21% ($P = 0.001$) immediately after 8 weeks counselling. ¹⁷

For ethical reasons, the control group was also offered counselling after the RCT was over. This paper analyzes the response to counselling at 4 weeks, 8 weeks and 8 weeks post counselling in both the groups. The original intervention group is called Group A ($n = 82$). The original control group counselled after the RCT was over is called Group B ($n = 91$). The results at 4 weeks, 8 weeks of counselling and 8 weeks post counselling in both the groups are reported separately because of the difference in the timeline shown in the Table. The Flow of participants is shown in Figure 1. Analysis for onset and duration of benefit was carried out only for those participants who could be followed up till 8 weeks post counselling.

[(0)]

Figure 1. Flow of participants is group A & B.

Statistical Analysis

A repeated measure ANOVA model with factor Time (0, 4, 8 and 16 weeks) was used to compare the mean scores between the baseline and at the end of the study for both the groups.

Results

Figure 2 shows that the mean score of group A at the beginning of the RCT was 27.8, it improved to 22.0 after four weeks ($P < 0.001$), and to 18.1 after eight weeks of counselling ($P < 0.001$). It rose to 21.8 eight weeks after the

[(1)]

Table: Time line of AKUADS mean scores in groups A and B.

[(2)]last counselling session ($P < 0.001$).

The mean score of group B (initial controls) at the beginning of the RCT was 29.4, it spontaneously improved to 26.8 at the end of the RCT. After four weeks of counselling the mean score for group B was 21.7 ($P = < 0.01$) and it came down to 20.6 after eight weeks of counselling ($P = 0.36$). It remained at 20.2 eight weeks after the last counselling session ($P = 0.67$).

The effect of time in both the groups was found to be significant (both p-values < 0.001). Both the groups had experienced reduction in the mean scores; however, Group A had experienced a statistically greater reduction in their mean scores as compared to Group B

The 8 weeks post counselling scores in both the groups still remained significantly below their initial baseline scores.

Discussion

There was no significant difference in the group A and B in the initial baseline scores, baseline characteristics or the dropout rate as reported in the RCT.¹⁷ The results of both the groups are reported separately because of the difference in timeline.

In both the groups (Figure 2), the level of anxiety and/or depression in counselled women showed significant decrease at 4 weeks which further declined when counselling was extended to 8 weeks, but the gradient of change was more marked during the initial 4 weeks. At 8 weeks post counselling the scores increased, but still remained significantly lower than the baseline mean scores suggesting that some benefit persisted even after counselling was discontinued. Other researchers have reported similar results.^{25,26} In group B the eight weeks post counselling score did not show a significant rise, suggesting that the effect of counselling was more durable in this group, it could be hypothesized that this was because the

counselors got better with practice.

In group B the mean score at the end of the RCT showed a spontaneously significant improvement as compared to the initial baseline score determined at the start of the RCT. This could be a contaminant effect of counselling of Group A, due to the tendency of regression to the mean of all illnesses or to the more specific remitting/relapsing course of depression, as eight weeks was too short a period to have had any effect due to other known associated factors for anxiety/depression. 16,17

A need for training primary care personnel in problem solving techniques and developing briefer interventions in primary care is being expressed.²³ Benefit after six or more weeks of counselling has been reported.²⁴ This paper suggests that a briefer intervention of 4 weeks carried out by literate women minimally trained in counselling skills is effective. The level of anxiety and depression in counselled women showed a significant decrease after four weeks and continued to decrease till the 8 weeks of counselling. Eight weeks after the last counselling session some increase in the scores was seen although the levels remained below the initial baseline. A loss in beneficial effect after counselling is stopped has also been reported by other researchers.^{25,26}

The experience that community health workers can learn effective counselling after brief training and could be used for reducing levels of anxiety and depression in Primary Health care is a boon, particularly for countries like Pakistan where contemporary psychiatric care is neither accessible nor affordable for a majority of the population. Another advantage of using community based counselling services is that there is widespread stigma and skepticism attached to conventional psychiatric services that act as barriers for using such services even when available.

Limitations

The findings of the study cannot be generalized due to the small sample size in each group and as the study is limited to a single semi urban community.

What is already known on this topic? The beneficial effects of counselling by certified counsellors/psychotherapists is well known.

What this study adds? This study provides new information about the onset and duration of effectiveness of counselling by minimally trained counsellors.

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