Developing a Culturally Adapted Cognitive Behavioural Therapy Based Intervention for British Pakistani Mothers with Persistent Postnatal Depression

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Abstract of thesis

Introduction. Recent reports indicate inequalities for ethnic minority women in maternal health and a need for tailored maternity services to improve access to care. High rates of postnatal depression among British Pakistani women have been reported. These women tend to suffer from persistent depression and have both, poorer access to and outcomes from evidence based psychosocial interventions, compared to the majority of the population. Trials for Cognitive Behaviour Therapy based interventions for postnatal depression appear to improve clinical outcomes and patient satisfaction. However, no study to date has developed an intervention for this group of women that is culturally sensitive. The overall aim of this thesis was to explore a culturally adapted psychosocial intervention with British Pakistani women with persistent postnatal depression, and use the results of these investigations to develop a culturally adapted cognitive behavioural therapy (CBT) based intervention to the meet the needs of persistently depressed British Pakistani women.

Methods. This thesis employed a two-phase design based on the Medical Research Council's (MRC) complex intervention framework. In the first phase, qualitative interviews were conducted to explore the experiences of British Pakistani women with persistent postnatal depression and the type of help they would find acceptable. These interviews were analysed using framework analysis. Following the findings from phase 1, a culturally adapted CBT based manualised intervention was developed in phase 2, to target the British Pakistani women's needs and measured participants' satisfaction and engagement.

Results. Three emergent themes from qualitative interviews with fifteen British Pakistani women with persistent postnatal depression were identified. These were: 1) causes of persistent postnatal depression; 2) impact of the depression; 3) past help sought and current treatment required for management of persistent postnatal depression. A feasibility study of a culturally adapted CBT based manualised intervention for persistent postnatal depression resulted in high levels of service user satisfaction and engagement. These women found the intervention, both accessible and acceptable for their needs. Fifteen women with persistent postnatal depression took part in the intervention. Significant improvements were found in depression, marital relationships, quality of parenting, and health. Significant improvements in perceived social support were not found.

Conclusions. This systematic mixed method approach to the development and testing of a manualised culturally appropriate intervention will provide a framework for those developing culturally adapted interventions for British Pakistani women. A culturally adapted group CBT based intervention was acceptable to British Pakistani women with persistent postnatal depression. A larger trial is currently underway to investigate efficacy of this intervention in terms of reducing depression, and improving social functioning, marital and parental relations, and health.

Declaration

I declare no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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List of abbreviations

BSI - Bradford Somatic Inventory

CBT - Cognitive Behavioural Therapy

CES-D - Centre for Epidemiological Studies Depression Scale

CIDI - Composite International Diagnostic Interview

EM's – Explanatory Models

EPDS - The Edinburgh Postnatal Depression Scale

GHQ – General Health Questionnaire

HADS - The Hospital Anxiety and Depression Scale

IAPT – Improving Access to Psychological Therapies

IDS - The Inventory of Depressive Symptomatology

IPT – Interpersonal Psychotherapy

LEDS - Life Events and Difficulties Schedule

MINI (5) - The Mini International Neuropsychiatric Interview version 5

MSPSS – Multidimensional Scale of Perceived Social Support

MRC - Medical Research Council

NICE - National Institute of Clinical Excellence

PND - Postnatal Depression

PRAMS - The Pregnancy Risk Assessment Monitoring System

SADS - Schedule for Affective Disorders and Schizophrenia

RDC - Research and Diagnostic criteria.

SCAN - Schedules for Clinical Assessment in Neuropsychiatry

SCID-I - Structured Clinical Interview for DSM-IV

SPI - Standard Psychiatric Interview

SPSS - Statistical Package for the Social Sciences

SRQ - Self-Reporting Questionnaire

ZSDC - Zung Self-Rating Depression Scale

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Dedication

I would like to dedicate this thesis to: My late Grandfather, Haq Nawaz khan, who taught me the importance of caring. My children, Maham and Ibraheem, as an example of work that was motivated by care. My parents, for their endless love and support, and for not only giving their time to our children but loving them so much. My sister Urooj, for being my pillar, and without whom, I would not have come this far.

Above all, I wish to dedicate this thesis and express my love and gratitude to my dearest husband, Zubair, for encouraging me with my ambitions and believing in me.

Overview

An increased rate of postnatal depression has been established among Pakistani women living in Pakistan (Husain 2006; Rahman and Creed 2007) and living in the UK (Husain, Cruickshank et al. 2012). Recent reports indicate inequalities for ethnic minority women in maternal health and a need for tailored maternity services to improve access to care (Knight 2009). Trials for Cognitive Behaviour Therapy based interventions for postnatal depression appear to improve clinical outcomes and patient satisfaction. However, no study to date has developed an intervention for this group of women that is culturally sensitive.

There is substantial evidence that Cognitive Behavioural Therapy (CBT) is an efficacious intervention for postnatal depression, improving symptoms and social functioning (Stuart, O'Hara et al. 2003). However its acceptability to British Pakistani women with persistent postnatal depression is unknown. Following the MRC guidelines for developing complex interventions (Craig, Dieppe et al. 2008), this thesis reports on findings from qualitative interviews and a feasibility trial of culturally adapted Cognitive Behavioural Therapy based intervention, both of which explored service user satisfaction and intervention acceptability.

Chapter one in this thesis looks at the varying rates of postnatal depression in the developed and developing countries and will move onto specifically looking at the persistent nature of postnatal depression across cultures in the first year and beyond. The factors associated with the development and maintenance of postnatal depression across cultures will be explored, as well as the impact of postnatal depression. The available interventions for postnatal depression and the lack of interventions for persistent postnatal depression will also be discussed. The case for culturally adapting interventions will be argued.

Chapter two of this thesis focuses on the methodology. This chapter will describe the methods of three stages of the study: Stage 1 consisting of the methodology for the qualitative study employing framework analysis; Stage 2 consisting of the methodology for the development of a culturally adapted intervention and for the feasibility trial of a culturally adapted CBT based intervention; Stage 3 includes methodology for the post intervention study for testing the acceptability of the intervention.

Chapter three will present the results of the: 1. qualitative study; 2. the feasibility study: and 3. the acceptability of the intervention.

Chapter four discusses the findings. It will summarise the findings and discuss the clinical implications. Ideas for further research will be recommended in this chapter.

1. Chapter 1: Introduction

This chapter looks at the varying prevalence rates of postnatal depression in the developed and developing countries and then moves onto specifically looking at the persistent nature of postnatal depression across cultures in the first year and beyond. It identifies the persistent nature of postnatal depression. The factors associated with the development and maintenance of postnatal depression across cultures are also explored as well as the impact of postnatal depression. The available interventions for postnatal depression and the lack of interventions for persistent postnatal depression are discussed. The case for culturally adapting interventions is presented.

1. 1. Postnatal depression

Postnatal depression (PND) can be defined as a particular mood disorder, which occurs after childbirth. It can occur in any social, economic or cultural context. Table 1 in the following section consists of many studies that have identified and described postnatal depression across different cultures. It consists of a range of depressive symptoms and syndromes that women may experience after childbirth. These range in severity from the mild and transient 'baby blues' to postnatal psychosis, which usually requires hospitalisation.

1.1.1. Diagnosis of postnatal depression

There are two main classification systems used within psychiatry: The American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders now in its fourth revised edition (DSM-IV-TR 2000) and the 10th edition of the International Classification of Diseases, (ICD-10), published by the World Health Organization (World Health Organization, 1993). The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR 2000) does not recognise postnatal depression as a discrete diagnosis but applies the term "postnatal onset" as a specifier to major depression to explain the context and the time frame (i.e., onset within 4-6 weeks of childbirth) in which the depression occurs (DSM-IV-TR 2000).

The DSM-IV-TR (2000) is a widely used manual in most of the research on mental disorders. The criteria for major depressive episode in the DSM-IV-TR is: five (or more) symptoms during the same two week period, representing a change from previous functioning. At least one of the symptoms is either depressed mood or loss of interest or pleasure.

The symptoms for major depression according to the DSM-IV-TR are:

1. Low mood
2. Lack of drive/enjoyment
3. Reduced energy
4. Insomnia
5. A decrease in appetite or weight loss
6. Impaired concentration
7. Psychomotor retardation
8. Negative cognitions (e.g. helplessness, uselessness, hopelessness)
9. Self harm ideas/plans

Generally in many research studies, and in clinical practice, the DSM-IV-TR definition is viewed as too narrow in both its application of "postnatal onset" to only major psychiatric disorders (major depression, bipolar disorder, brief psychotic disorder), and its time frame for the postnatal period. Some studies have defined 'postnatal' as two or more weeks of persistent depressive symptoms and functional impairment (Treloar, Martin et al. 1999; Lee 2007). A recent update of the postnatal depression literature showed that according to the US Department of Health and Human Services 2000 data, up to 50% of postnatal cases go undetected (Lee 2007). In addition, this review also highlights that only 10% of the women in developing countries receive treatment for postnatal depression due to an absence of systematic screening. Similar information highlighting postnatal depression is not available for the UK.

1.1.2. Symptoms of postnatal depression

The symptoms of postnatal depression are similar to symptoms of depression at other times of life. A depressed mood, tearfulness, lack of drive and enjoyment, social withdrawal, poor appetite, impaired concentration, insomnia, and feelings of uselessness and helplessness are common symptoms. In addition to these symptoms, the differentiating symptoms for postnatal depression include; feeling emotionally detached from the infant and showing no affection towards family members (Lee 2007). Some women may feel worthless and isolated due to the physical and emotional stress during delivery and the dilemma in meeting the demands of infant care and other family members (Lee 2007). Women may also feel as if they are inadequate mothers, causing them to have feelings of guilt and embarrassment. It has also been characterised by, feeling despondent, having poor memory, fatigue, and irritability (Robertson, Grace et al. 2004). Bodily symptoms, such as wound pain, headache and back pain, and ideas about self-harm and suicidal plans have also been reported (Lee 2007).

1.1.3. Prevalence of postnatal depression

The prevalence of Postnatal Depression (PND) varies across the world. Internationally, the rate varies from 4% in Malaysia (Kit, Janet et al. 1997), to 62% in Australia (Dudley, Roy et al. 2001). Within countries, the rate also varies, for example, in Australia, 17% (Brown and Lumley 2000) to 62% (Dudley, Roy et al. 2001). Table 1 represents the diverse prevalence rates of postnatal depression in different countries.

The significant variation in reported prevalence rates of postnatal depression may be due to different criteria of measurement, such as self-report, clinical interview, general practitioners or psychiatrist's diagnosis, different time intervals, as stated earlier, and different study designs.

The studies identified in table 1 measure postnatal depression at different time-points after childbirth. The most prominent measure used in most of these studies is the EPDS (Cox, Holden et al. 1987). The 10-question EPDS is an efficient way of identifying patients at risk for "postnatal" depression; however it is not a diagnostic tool. These studies have used varying cut off scores (12–13) for measuring postnatal depression. Most of the studies have used EPDS cut off point of 12, with the exception of one study, which used a cut off point of 13 in a sample of Turkish mother's; and some studies have not provided this information (Danaci, Deveci et al. 2002). Therefore the actual prevalence rate could be higher or lower than found.

A US based study (O'Hara, Zekoski et al. 1990) found a prevalence of 10% in American mothers using the EPDS and a 23% prevalence of postnatal depression was found in another study using the BDI (Stuart, Couser et al. 1998). However, sample methodologies differed in both studies. The O'Hara et al (1990) sample was randomized and controlled. The Stuart et al sample was a convenience sample from a higher socioeconomic grouping. Studies also varied in terms of sample methodologies (including a high representation of mothers with a previous history of emotional problems (Patel, Rodrigues et al. 2002; Rahman 2003).

There is a discrepancy in the prevalence rate for postnatal depression in Japan and Pakistan too. In 2001 a 17% prevalence rate of postnatal depression in Japanese women was reported (Yoshida, Yamashita et al. 2001); however a more recent study reported a rate of 5% (Kitamura, Yoshida et al. 2006). In a similar study carried out in Pakistan, a prevalence of 28% was detected (Rahman 2003); whereas a later study found an increased rate of 36% (Husain, Bevc et al. 2006). However, this was due to the use of different research methodologies employed in these studies as all of these studies used different instruments to detect the prevalence of postnatal depression.

The instruments used to detect the prevalence of depression can also influence the rate that is identified. Some of the studies in table 1 (Ho-Yen et al, 2007, Evans et al 2001, Rich-Edwards 2005, Chaaya et al, 2002, Danaci et al 2002, Fisher et al 2004, Dudley et al 2001, O Hara et al 1990, Stuart et al 1998) did not use a diagnostic instrument for depression and instead used the percentages from the screening instrument Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden et al. 1987) and Beck Depression Inventory (BDI) (Beck, Steer et al. 1996).

A meta analysis reported that postnatal depression affects approximately 10-15% of all mothers in Western societies (O'Hara and Swain 1996). This has generally been a consistent finding; with the exception of Australia and South Africa. A recent systematic review of prevalence rates of postnatal depression in the US indicates that 19% of new mothers may have major or minor depression in the first three months after delivery, with as many as 7% having major depression (Gavin, Gaynes et al. 2005).

Overall, the highest detected prevalence for postnatal depression (Table 1) is mostly in the eastern countries such as Pakistan (36%), Vietnam (33%), India (23%), Japan and Morocco (17%), The United Arab Emirates (16%). A recent systematic review also found that prevalence of postnatal depression was higher among women in developing countries (31%) than among women in developed countries (21.5%) (Villegas, McKay et al. 2010).

Table 1: International rates of postnatal depression

Country	Rate (%) of PND	Diagnostic Instruments	Author
Australia	62%	EPDS	(Dudley, Roy et al. 2001)
	17%	EPDS	(Brown and Lumley 2000)
Pakistan	36%	EPDS	(Husain, Bevc et al. 2006)
	28%	SCAN	(Rahman 2003)
South Africa	35%	SCID	(Cooper, Tomlinson et al. 1999)
Vietnam	33%	EPDS	(Fisher, Morrow et al. 2004)
India	23%	EPDS, Diagnostic Interview	(Patel, Rodrigues et al. 2002)
Lebanon	21%	EPDS	(Chaaya, Campbell et al. 2002)
Japan	17%	EPDS, SAD	(Yoshida, Yamashita et al. 2001)
	5%	CIDI	(Kitamura, Yoshida et al. 2006)
Morocco	17%	EPDS, MINI	(Alami, Kadri et al. 2006)
United Arab Emirates	16%	EPDS, SRQ	(Ghubash and Abou-Saleh 1997)
Zimbabwe	16%	CIS-R	(Nhiwatiwa, Patel et al. 1998)
Turkey	14%	EPDS	(Danaci, Deveci et al. 2002)
China	13.5%	SCID	(Lee, Yip et al. 2001)
Portugal	13%	EPDS	(Augusto, Kumar et al. 1996)
	24.5%	SADS, EPDS	(Areias, Kumar et al. 1996)
Brazil	12%	EPDS, Clinical Interview	(Da-Silva, Moraes-Santos et al. 1998)
	21%	EPDS	(Tannous, Gigante et al. 2008)
USA	8%	EPDS	(Rich-Edwards, Kleinman et al. 2006)
	10%	EPDS	(O'Hara, Zekoski et al. 1990)
	23%	BDI	(Stuart, Couser et al. 1998)
Switzerland	10%	EPDS	(Cox, Holden et al. 1987)
UK	9%	EPDS	(Evans, Heron et al. 2001)
	18%	EPDS	(Huang and Mathers 2001)
Germany	7%	EPDS, HAM-D	(Ballestrem, Strauss et al. 2005)
Nepal	5%	EPDS	(Ho-Yen, Bondevik et al. 2007)
Malaysia	4%	EPDS	(Kit, Janet et al. 1997)

1.1.3.1. Prevalence of postnatal depression in the UK

In the UK, 8-15% of Caucasian women suffer from postnatal depression with long term consequences for maternal mood and child development (Chew-Graham, Sharp et al. 2009). A study by (Evans, Heron et al. 2001), as part of the Avon Longitudinal Study of Parents and Children (ALSPAC) study team in the UK used a large cohort (n = 9028) of both experienced and first-time mothers. The EPDS was used with a cut off score of 13. They reported prevalence rates of 9% and 8% at 8 weeks and 8 months, respectively. However, this study does not provide information about the sample characteristics, such as ethnicity. Huang and Mathers found prevalence rates of 18% in the UK using the EPDS and a cut off of 12 (Huang and Mathers 2001).

A report by the Royal College of midwives (2007) highlighted that the actual number of women who have postnatal depression could be two to three times higher than previous estimates. The report presented results from a sample consisting of 500 women across the UK interviewed over the telephone. A prevalence rate of postnatal depression was obtained as 20% currently in the UK and 21% in the North of England. However, though this sample was nationally representative, it may not be culturally representative. It is not obvious from the report, for example, whether the sample only included White women or were women from other ethnic backgrounds included too. Further, were women who did not speak English included or excluded from the study.

1.1.3.2. Ethnic variations of postnatal depression in the UK

Variations in the rate of postnatal depression have been reported in ethnic minorities in the UK (Kumar 2003). A study looking at high EPDS scores in women from ethnic minorities found ethnicity as a significant risk factor in developing postnatal depression (Kumar 2003). Forty-nine percent of the ethnic minority group (including Black, Asian and other ethnicities) did not respond to the study questionnaire (EPDS) compared to 24% of the White group. A significantly

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higher proportion of women in the ethnic minority group (27%) scored in the depressed range on the EPDS than in the White group (15%). This finding suggested a significant percentage of depression may be undetected in the Asian sample due to the low response rate. The issue of cultural appropriateness of measures in the study is also noted as only the English version of the EPDS was sent out. Therefore women who were illiterate in English were excluded and this may be one of the possible explanations for the low response rate in this group.

Little is known or understood about the natural course or duration of postnatal depression. In the general population, the average length of a depressive episode is approximately five months. In postnatal depression, the natural course and length of time until remission are unknown. Some studies indicate that postnatal episodes resolve more quickly than episodes in the general population (Beck et al, 2004); other studies report episodes of similar duration (Gavin, Gaynes et al. 2005). The following literature suggests that postnatal depression can be persistent and experienced beyond the first postnatal year.

1.1.4. The persistence of postnatal depression

To examine the persistence of postnatal depression, an OVID online search was conducted jointly with the faculty librarian. The MeSh terms used included Postpartum, Postnatal, Depression and Persistent. Within OVID, the Medline database produced 41 hits and Psychinfo produced 34 hits. Eight studies specifically measured the persistence of postnatal depression beyond the first postnatal year. All eight studies are included in table 2. (The letter of support from the librarian can be found in Appendix 1).

Some authors claim postnatal depression can be peristent and continue for up to four years after birth (Kumar and Robson 1984). Although a large number of studies (table 1) have reported the rates of postnatal depression, there is currently a gap in research in identifying the persistent course of postnatal depression. The following eight studies have been identified in this area, (Kumar and Robson 1984; Small, Brown et al. 1994; Campbell 1997; Viinamaki, Niskanen et al. 1997; Horowitz and Goodman 2004; McMahon, Barnett et al. 2005; Blabey, Locke et al. 2009; Uguz, Akman et al. 2009; Campbell 1997).

Kumar et al (1984) in a prospective study looked at new onset depression after childbirth. Women who had given birth in the last month were approached and went through a two-stage assessment. A total of 79 women were identified with postnatal depression, and were followed up to 4 years postnatal. An overall depression rate of 28.6% was found. Out of the 79 women depressed at birth, 17% remained depressed at 3 months, 13% at 6 months, 8% at 12 months, and 9% at 4 years postnatal. Bereavement and preterm birth were the only life events related to the onset of depression. However this study had a small sample and a high attrition rate of 28%.

Small et al (1994) in an Australian study conducted a postal survey of all the women who gave birth in the state of Victoria in a one week period in 1989. Results of the study were used to assess the contribution of birth events, satisfaction with care and social differences to depression after birth. The survey was mailed to women eight to nine months after birth. The researchers employed a survey method to identify the prevalence of depression using the EPDS. The survey was sent to 1107 women and 790 of these women responded (71%). However, the sample had underrepresentation of young women, single women and women of non-English-speaking background. In addition, depression was assessed using the EPDS score of 13 or above which is not a diagnostic instrument. The prevalence rate of depression found was 15%. Persistence rate was 34% from those women who were depressed at nine months and remained depressed at 20 to 26 months postnatal. Risk factors for depression included being unmarried, first generation immigrant and non-English-speaking background, and being dissatisfied with care in labour and after birth.

Viinamaki et al (1997) assessed postnatal depression in 139 mothers at 4-8 weeks postnatal and again two years later. Postnatal depression was assessed using the GHQ and *Zung Self-Rating Depression Scale (ZSDS)*. A 28% prevalence of postnatal depression was detected in the sample at 4-8 weeks postnatal. In the follow up two years later, 9% of affected mothers remained impaired with depression two years postnatal. Higher depressive levels after childbirth, poor financial situation, poor social support, problems with a partner and perceived stress predicted maintenance of depression, whereas lower depressive levels predicted recovery. The study also found that women with postnatal depression symptoms 24 months following delivery consumed high amounts of alcohol, smoked more and reported experiencing more stressful life events than women who did not identify themselves as still depressed. Partners of women who experienced postnatal depression also expressed that relationships with their partners started deteriorating during pregnancy. These relationships had not improved when the same group of women was surveyed again two years later. Of the persistently depressed mothers, 92% had not become pregnant again.

Campbell and Cohn (1997) in a study based in the US, followed up 70 women meeting the criteria for clinical depression. The study measured depression using the Depression Scale of Schedule for Affective Disorder and Schizophrenia (SADS; Endicott and Spitzer 1978). The rates of depression reported were: at two to fours months postnatal, 48% continued to be depressed; At six months, 30% remained depressed; at nine months; 25%, at 12 months; 24%, at 18 months; 18%, and at 24 months, 13% of these women continued to meet the clinical criteria for depression. For a longitudinal study, it is limited by a small sample size. The study does not provide details of attrition rates.

Horowitz and Goodman (2004) also conducted a longitudinal study on 62 mothers who scored 10 or above on the EPDS at 2-4 weeks postnatal. At 2-4 weeks postnatal, 42% had depressive symptoms, at 10-14 weeks, 35.5%, at 14-18 weeks, 27%, at 2 years, 31% of these women had depressive symptoms. They found that a history of depression, low social support, and high parental distress were associated with high depression scores amongst mothers at two years postnatal. An initial decrease in depression scores suggested that postnatal depression symptoms posed a problem for many women at a specific time-point, with peak occurrence from 4-8 weeks postnatal. However, for many women depressive symptoms persisted at two years postnatal. Previous depression, limited current support, and parental distress increased depression symptom severity. The study was limited by its use of the Beck Depression Inventory (BDI) as a screening instrument to detect the prevalence of depression, and small sample size.

McMahon et al (2005) prospectively investigated the factors underlying the maintenance and persistence of postnatal depression. They looked at 100 first time English speaking mothers who had been admitted to a publicly funded parent craft centre for a 1-week program of support with infant difficulties such as feeding, settling and sleeping. These women were invited to participate in a longitudinal study of postnatal depression and child development. The sample was recruited when infants were between two and four months old. A high percentage of women

(90%) agreed to participate in the study, giving an initial sample of 127 mothers. The retention of participants across the two assessment periods was very high. The Composite International Diagnostic Interview (CIDI, World Health Organisation, 1997) to used to establish whether the women met diagnostic criteria for an episode of major depression post birth. Women were also assessed for depression at both four and 12 months using a self-reporting scale, the Centre for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). Women with a total score of 16 or more at the 12-month assessment were considered to have persistent depression.

Of the 100 women, 62% met diagnostic criteria for a major depressive episode in the four months since the baby had been born. At both four and 12 months, 30% of mothers scored above the clinical cut-off of 16 or more. Sixty percent of mothers who scored 16 or more on the CES-D symptom measure at four months also scored above 16 on the CES-D at 12 months. This study shows that a significant proportion of women with postnatal depression (30% of the total sample and 60% of those with elevated symptoms at four months postnatal) continued to report heightened symptoms of depression 12 months after birth. However this study had many limitations. A restrictive eligibility criteria was used to select the participants, for example only women living with a partner were recruited into the study. The sample was skewed as only mothers having difficulties with children were included in the study. Therefore results did not reflect the experiences of women with limited parenting difficulties and not living with a partner, and can only be generalised to English speaking cultures. The study also had a high retention rate, particularly amongst young mothers.

Blabey et al (2009) looked at the prevalence of postnatal depression that continued beyond the postnatal period. This was a population-based public health surveillance project that collected self-reported information on maternal attitudes and experiences 2-6 months postnatal and two years postnatal. They used the Pregnancy Risk Assessment Monitoring System (PRAMS) which measured depression with two questions, each with ordinal response categories. The first question measured

depressed mood by asking, "How often have you felt down, depressed, or hopeless since the new baby was born" and "How often have you had little interest or little pleasure in doing things?" They also looked at the association between persistent postnatal depression and number of partner threats reported. This study did not specifically measure postnatal depression as it did not use a first or second stage diagnostic interview to assess postnatal depression. Their method of identifying depression was through use of The Pregnancy Risk Assessment Monitoring System (PRAMS). They reported that 10% of the women reported depressive symptoms two years postnatal.

Uguz et al (2009) looked at a total of 38 women with high symptoms of postnatal depression according to the EPDS during the six weeks postnatal period. The study took place in Konya, Turkey and was part of a larger prospective study. Out of the 38 women, 19 had a diagnosis of depression according to EPDS at six weeks postnatal, and 19 women also had a diagnosis for new onset major depression according to the Structured Clinical Interview for DSM-IV (SCID-I). These women were assessed one year later with the EPDS. The rate of persistent postnatal depression one year postnatal was 32%.

1.1.4.1. Summary of findings on persistence of postnatal depression

The rate and course of persistent postnatal depression varies across the world. Two of the studies (McMahon et al 2005 and Uguz et al 2009) found very similar rates of persistent postnatal depression. Furthermore, the two studies also used similar methodologies, including similar time-points to measure depression scores and both used diagnostic interviews for depression. The two studies were conducted in different countries, one in a developed country (McMahon et al 2005) and one in a developing country (Uguz et al 2009). However, similar rates were found across two different cultural groups.

A limitation of the Uguz et al (2009) study is their sample size. In addition, only half of the women had a diagnosis of depression and the other half only had high scores on the EPDS. Therefore their rate of persistent depression may not reflect clinical depression but symptoms experienced similar to that found in the Blabey et al (2009) study. Both of these studies employed a longitudinal design, but very small numbers limit the generalisability of their results. Longitudinal studies are also limited with high rates of attrition. The need for studies measuring the specific course of postnatal depression beyond the first postnatal year with robust methodologies still remains.

It should also be noted that these studies did not include a control group of non-postnatal women, so the extent to which the findings can be indicative of a distinctive pattern of the course of postnatal depression rather than depression in general is still to be confirmed. Conversely, these results do show that some women do experience a continuity or recurrence of depressive symptoms for a long period of time after childbirth.

Table 2: The persistence of depression from birth to four years postnatal

Country	Sample	Assessed time -point	Author	Rate (%) of Persistent PND	Diagnostic Instrument
Australia	Australian	9 months postnatal 20-26 months postnatal	Small et all 1994	15% at 9 months 34% of those depressed at 9 months remained depressed at 20 to 26 months	EPDS
UK	Caucasian	3, 6, 9, 12 months postnatal 4 years postnatal	Kumar et al 1997	17% at 3 months 9% at 4 years	SPI
Finland	Finnish	4-8 weeks postnatal to two years postnatal	Viinamaki et al 1997	28% at 4 to 8 weeks 9% at two years	GHQ
US	Caucasian	4 months postnatal to two years postnatal	Campbell et al 1997	48% at 4 months 13% at 24 months	SADS RDC
Australia	Caucasian	4 and 12 months postnatal	McMahon et al 2005	30%	CIDI CES-D
US	Unspecified	2 – 6 months postnatal to two years postnatal	Blabey et al 2009	10%	PRAMS
US	Caucasian	From 4 weeks postnatal to two years postnatal	Horowitz et al 2004	42% at 4-8 weeks 31% at 2 years	BDI
Turkey	Turkish	6 weeks postnatal to two year postnatal	Uguz et al 2009	32%	EPDS SCID (I)

1.1.5. Persistent depression in women of Pakistani ethnic origin

The literature search revealed three studies that have investigated the persistence of depression in Pakistani women up to one year postnatal. Two of these studies looked at the persistence of depression from pregnancy to the postnatal period with Pakistani women living in Pakistan (Rahman et al, 2007, Husain et al, 2011) and one study looked at Pakistani women living in the UK (Husain, Cruickshank et al. 2012). Pakistani women have been found to experience high rates of persistent depression. Some research suggests that persistent depression is more commonly experienced by Pakistani women living in the UK (Husain et al., 1997; Gater et al., 2009; Gask et al., 2010, Chaudry et al., 2009 and Husain et al., 2012). No study has been identified in the literature that provides the prevalence rate for the persistence of postnatal depression after the first postnatal year. The persistent nature of Pakistani women's depression and the high rates of depression identified, warrant further attention.

Research conducted in rural Pakistan (Rahman and Creed 2007) looked at the persistent nature of postnatal depression. This was the first study conducted in a developing country looking at the persistent nature of postnatal depression. The study consisted of 701 married women aged 17 to 40 in their third trimester of pregnancy, identified over a period of four months. Women were identified by obtaining official lists from 120 government-employed Lady Health Workers (LHWs), who are the equivalent of community midwives in the UK, and these LHW's routinely collected data on new pregnancies. Out of the 701 women identified, 670 women (95%) agreed to take part. The study followed good ethical practise by obtaining informed consent from all participants after the procedure had been fully explained. Exclusions were made of women with a physical illness or a complicated pregnancy, with an anxiety disorder or a learning disability. After exclusions were made, 160 women were diagnosed with ICD-10 (WHO, 1993) Depressive Episode, giving a prevalence rate of depressive disorder in the antenatal period of 25%. Out of these 160 women, 129 women were assessed at three, six, nine, and 12 months postnatal. Psychological assessments were carried out at all

time-points by two trained and experienced clinicians using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). All interviews were carried out after translation, using back-translation method and after cultural adaptation, raising the content validity of the measures used. Psychological symptoms were assessed during pregnancy by the same interviewers using the Self-Reporting Questionnaire to ascertain depressive symptomatology (SRQ-20) (World Health Organization, 1994).

Of the 129 women, 121 (94%) were depressed at three months, 98 (76%) at 6 months and 80 (62%) at 12 months. Out of the 129 identified depressed mothers, 80 mothers (62%) remained depressed at 12 months postnatal but seven of these had not been depressed at 6 months; thus 73 (57%) were depressed at all time-points. These percentages show the persistent nature of depression in Pakistani mothers. The study used standardised and valid instruments to diagnose depression and was conducted in a naturalistic community setting which also reflects good ecological validity. However, common physical health problems such as underactive thyroid and vitamin D deficiency, which have also been linked to depression, were not screened in the mothers in this study. Other limitations include a relatively small sample size and the fact that all the women came from one sub-district of Rawalpindi, which only makes the results generalisable to poor rural population. The self rating questionnaire was administered by someone else thus going against the self rating aspect of the scale and may appear to have face validity but the responses of participants may be influenced by the interviewer, interviewer bias, or the participants may be rating themselves in a way that they feel is expected of them by the interviewer in order to please the interviewer, thus leading to participant bias. The SRQ responses were based on the participant's experiences over the past 30 days, thus increasing chances of memory bias.

Husain et al (2011) conducted a recent study in one of the largest cities in Pakistan, Karachi. A large sample size of 763 women who were assessed for depression using the Edinburgh Postnatal Depression Scale (EPDS) post birth were reassessed

three months after childbirth (Husain, Parveen et al. 2011). A 38% prevalence rate of persistent postnatal depression was found at three months postnatal. This rate is considerably lower than the rate found in the Rahman et al (2007) study conducted in rural Pakistan, where they found a rate of 94% at three months postnatal. This study did not use a second stage diagnostic procedure and relied only on a self report instrument of depression (EPDS).

In a UK based study in Manchester (Husain, Cruickshank et al. 2012), British Pakistani women were assessed for postnatal depression. This is a UK based prospective cohort study. Pregnant women in their third trimester attending antenatal clinics were recruited and screened with the EPDS. Those women who scored 12 or more on the EPDS were interviewed using the SCAN and the LEDS. Social support was assessed with the Multidimensional Scale of Perceived Social support (MSPSS). These women were reassessed at six months postnatal using the same measures. A 17% prevalence of depression was found in the antenatal period and 19% in the postnatal period. Twenty-six per cent of these women remained persistently depressed at six months postnatal. The depressed mothers presented with more non-health related difficulties, such as housing, financial and marital problems. They also had less social support and were socially isolated. Social isolation and non-health related difficulties were found to be independent predictors of depression. However, the study lacked inter-rater reliability testing between the individuals carrying out diagnostic interviews. The study sample did not accurately represent the general population and information about the origins of depression in this group of mothers was limited.

1.1.6. Summary of prevalence of postnatal depression

The prevalence rates of postnatal depression vary. The highest rates have been found amongst women from developing countries. Some women, particularly Pakistani women, have been identified in more than one study with experiencing persistent depression. Currently the course and duration of postnatal depression is

not established.   The next section will look at the factors associated with the development and maintenance of postnatal depression.

1.2. Factors associated with the development of postnatal depression in the developed and developing countries

Studies looking at factors associated with the development of postnatal depression have provided a number of explanations. These can be divided into three categories: biological, psychological and social. Some factors may only be present in some women and not others. The following factors have been identified in women in the developed and developing countries. These factors are also summarised in table 3.

1.2.1. Factors associated with the development of postnatal depression in developed countries

Findings from a meta-analyses of over 14,000 subjects, and subsequent studies of nearly 10,000 additional subjects suggest that the following factors were the strongest predictors of postnatal depression in developed countries: depression during pregnancy, anxiety during pregnancy, experiencing stressful life events during pregnancy or the early puerperium, low levels of social support, and a previous history of depression (Robertson, Grace et al. 2004).

A systematic review also reported the above mentioned risk factors related to the development of postnatal depression in women from the developed countries (Villegas, McKay et al. 2011). These included: past depression or psychiatric history, antenatal depression, and recent life events. In addition, this review also reported the following risk factors: having no partner, low self-esteem and past sexual abuse. An unwanted pregnancy has also been stated in the literature (Rich-Edwards, Kleinman et al. 2006).

1.2.2. Factors associated with the development of postnatal depression in developing countries

The risk factors for the developing countries included: sociodemographic characteristics such as being young or single, having low education or husband's low education, low income and small household size; reproductive history including unplanned pregnancy, previous history of abortion, delivering through cesarean section, not breastfeeding, unwanted sex of baby, perinatal death, poor knowledge of infant care, and having more than five children or having 2 or more children under age seven; and sociopsychological problems including prenatal depression, history of depression or mental health problems, stressful life or past-year events, low social support, problems with in-laws, numbers of years married, unhappy marriage, physical abuse during pregnancy and after childbirth, and husband's use of alcohol (Villegas, McKay et al. 2011). Some additional contributory factors to developing postnatal depression are: being an immigrant (Danaci et al, 2002), an unsettled baby (Fisher et al, 2004), poor housing situation (Kitamura et al, 2006, Rahman et al, 2003) and health problems in the baby (Danaci et al, 2002).

1.2.3. Biological explanations for the development of postnatal depression

Postnatal depression can also be caused by a range of biological and psychosocial factors. Genetic factors may contribute to as much as one third of the aetiological variance of postnatal depression (Treloar, Martin et al. 1999). A more recent study showed that siblings of women with postnatal depression also showed a high risk of suffering from the same condition (Murphy-Eberenz, Zandi et al. 2006). Hormonal changes in oestrogen and progesterone may also act as contributing factors to developing postnatal depression, but have found negative results (Zonana and Gorman 2005). Recent findings suggest a possible involvement of Omega-3 acids in the development of postnatal depression (Rees, Austin et al. 2005). However, more evidence is needed to draw firm conclusions. Findings from these studies cannot be generalised across ethnic group as small sample sizes were drawn predominantly from a White population.

1.2.4. Psychological explanations to the development of postnatal depression

The type of personality one has may also have an impact on the development of postnatal depression. A study looked at mothers and fathers of newborns and found neuroticism to be the most significant risk factor for developing postnatal depression (Dudley, Roy et al. 2001). However, although neuroticism was a strong correlate of PND, further analyses of the data suggested that alone, it was neither necessary nor sufficient for developing postnatal depression. Depressed groups of both, mothers and fathers on average scored higher on neuroticism than non-depressed groups. It was also noted, that depression in the father was influenced by the state of the marital relationship; whereas depression in the depressed mother was influenced primarily by her personality and infant related factors.

Table 3: Psychosocial risk factors of postnatal depression

Psychosocial Correlate	Country (Author)
History of Previous Depression or Psychiatric Problems	**USA** (Rich-Edwards et al, 2006, **UAE** (Ghubash et al, 1997), **Australia** (Boyce et al, 2003)
Stressful Life Events	**UAE** (Ghubash et al, 1997), **Morocco** (Alami et al, 2006), **Pakistan** (Rahman et al, 2003), **Australia** (Boyce et al, 2003)
Marital Problems	**Turkey** (Danaci et al, 2002), **UAE** (Ghubash et al, 1997), **Vietnam** (Fisher et al, 2004)
Lack of social support	**UAE** (Ghubash et al, 1997), **Pakistan,** (Rahman et al, 2003), **US** (Campbell et al, 1997)
Financial Hardship	**USA** (Rich-Edwards et al, 2006), **Turkey** (Danaci et al, 2002), **Pakistan** (Rahman et al, 2007)
An Unwanted Pregnancy	**USA** (Rich-Edwards et al, 2006), **UAE** (Ghubash et al, 1997), **Morocco** (Alami et al, 2006), **Vietnam** (Fisher et al, 2004), **Japan** (Kitamura et al, 2006)
Physical Disability	**Pakistan** (Rahman et al 2007)
Health Problems in The Baby	**Turkey** (Danaci et al, 2002, **UAE** (Ghubash et al, 1997), **Morocco** (Alami et al, 2006)
Antenatal Depression	**India** (Patel et al, 2002), **Morocco** (Alami et al, 2006), **Pakistan** (Rahman et al, 2003), **Australia** (Boyce et al, 2003)
Number of Children	**Turkey** (Danaci et al, 2002), 5+ Children, **Pakistan** (Rahman et al, 2007)
Being an Immigrant	**Turkey** (Danaci et al, 2002)
Serious Psychiatric Disorder in the Spouse	**Turkey** (Danaci et al, 2002)
Problems with the Parents in Law	**Turkey** (Danaci et al, 2002)
Occupational Status	**UAE** (Ghubash et al, 1997), **Vietnam** (Fisher et al, 2004)
An Unsettled Baby	**Vietnam** (Fisher et al, 2004)
Gender of the Newborn	**Japan** (Kitamura et al, 2006), **India** (Patel et al 2002)
Poor Housing Situation	**Japan** (Kitamura et al, 2006), **Pakistan** (Rahman et al 2003)
An un educated husband	**Pakistan** (Rahman et al 2007)
Ethnicity	**UK** (Kumar et al, 2003)

1.2.5. Maintaining factors of postnatal depression in the first postnatal year and beyond

Some researchers have identified maintaining factors associated with postnatal depression from birth to up to four years postnatal (Table 4). Factors that were associated with maintaining depression from birth to four years postnatal were: poor social support, marital related difficulties, financial hardship, a history of previous depression, and depression during pregnancy. Mixed findings occurred regarding the association of postnatal depression with history of depression, with some researchers indicating an association between history of depression and depression at later postnatal periods, and some researchers indicating no association. It may be possible that some factors associated with persistent postnatal depression in the early stage may be resolved within the first postnatal year, such as doubts related to being a good mother. However, continued exposure or experience of certain risk factors such as poor social support, financial hardship and marital difficulties may exacerbate the effects of depression, thus manifesting in a persistent nature.

Table 4: Factors associated with persistent postnatal depression up to four years postnatal

Authors (year)	Latest point of assessment in Postnatal Period	Factors Associated with Persistent postnatal depression
Kumar et al (1984)	4 years postnatal	Marital conflict Severe doubts about having the baby
Horowitz and Goodman (2004)	2 years postnatal	Lower income Lower perceived social support Higher depression scores at 4 to 8 weeks postnatal
Campbell et al (1997)	2 years postnatal	Less satisfaction with spousal support
Viinamaki et al (1997)	2 years postnatal	Poor financial situation Inadequate social support History of mental health problems before or during pregnancy Partner relationship problems Higher depression scores after delivery Greater perceived life stress Poor relationship with mother Postnatal alcohol and cigarette use
McMahon et al 2005	12 months postnatal	Having an insecure state of mind regarding attachment
Blabey et al 2009	2 years postnatal	A controlling partner
Uguz et al 2009	1 year postnatal	High baseline EPDS scores Existence of a personality disorder.

1.3. Impact of postnatal depression in the first postnatal year and beyond

This section looks at the impact of postnatal depression on the child and the partner. Some studies have investigated the immediate impact of postnatal depression and others have reported more long-term effects. The following literature looks at the impact of the mother's depression in terms of, disruptions in mother-infant interaction, mother-infant attachment, intellectual development, cognitive development, vulnerability to affective disorders, weight-related problems, and breastfeeding patterns.

1.3.1. Impact of postnatal depression on the child

1.3.1.1. Mother-infant interaction

Weinberg and Tronick compared a non depressed group of mothers with a depressed or anxious group of mothers. The findings reported by the authors suggest that mothers in the depressed/anxious group were more disengaged with their infants than the mothers in the non-depressed group (Weinberg and Tronick 1998). The depressed-anxious group of mothers were found to talk less to their infants, showed few facial expressions of interest, were less likely to refer the infants' attention to objects, and touched their infants less than the mothers in the control group. In return, the infants of depressed or anxious mothers showed less interest, more anger and sadness, and a greater tendency to fuss and cry, than infants of non-depressed mothers during face-to-face play. However this study did not separate the impact of the depression and the anxiety and so it was difficult to distinguish the causes of the children's behaviours.

Campbell et al (1995) found that women whose depression persisted past six months postnatal demonstrated, fewer positive interactions with their infants than women who were not depressed. In addition the depressive symptoms resolved before six months. In this group of women, some authors have suggested that it is the

persistence of depression of mothers, rather than its diagnosis in the postnatal period, that is more associated with negative effects on the child (Campbell, Cohn et al. 1995; Brennan, Hammen et al. 2000). This is supported by a meta-analysis of 19 studies, in which postnatal depression was found to have a moderate to large effect on maternal-infant interaction (Beck 1995).

1.3.1.2. Attachment style of children of mothers with postnatal depression

McMahon et al (2005) looked at the association between postnatal depression and the mother–child attachment. To measure the infant's attachment style they used a robust method using the 'Strange Situation' procedure (Ainsworth, Blehar et al. 1978). Interestingly, they found that briefly depressed mothers were no more likely than never depressed mothers to have insecure attachment relationships with their children. Only 26% of chronically depressed mothers were reported to have securely attached infants, thus confirming that adverse child outcomes are more likely when mothers are chronically and/or severely depressed (Lyons-Ruth, Wolfe et al. 2002).

In another study infants were observed in the "strange situation" phenomena (Righetti-Veltema, Bousquet et al. 2003). Infants of depressed mothers showed more anxiety and were less happy than children of non-depressed mothers. They showed more avoidant attachment as compared to a secure attachment displayed by children of non-depressed mothers. These infants showed less verbal interaction and less playing interaction. Even at 18 months, infants of depressed mothers performed less well on object concept tasks, and were more often insecurely attached to their mothers. Developing an insecure attachment style was another negative effect of postnatal depression on the child (Campbell, Brownell et al. 2004). Campbell et al (2004) found that women with late, intermittent, or chronic depressive symptoms were more likely to have children who were insecure even at 36 months.

1.3.1.3. Intellectual development of children of mothers with postnatal depression

According to Sharp et al (1995), the first year of life, especially the first few months, may constitute a sensitive period for intellectual development. In their longitudinal study they examined the effects of postnatal depression in boys, specifically looking at their intellectual development. The children most at risk were those of depressed mothers and came from families classified as working class. Even when the mother had recovered, these boys continued to show low intellectual scores, thus showing the harmful exposure of postnatal depression in early childhood. However, children whose mother became depressed after the first postnatal year did not show such low scores (Sharp, Hay et al. 1995).

In another study, children of women who reported more chronic depressive symptoms performed more poorly on tests of school readiness and expressive language. These children were rated as having more externalising problems and poorer social skills than children whose mothers were not depressed or whose symptoms were only intermittent (Evans, Heron et al. 2001).

1.3.1.4. Cognitive development children of mothers with postnatal depression

The persistence and severity of depressive symptoms are related to poorer child adjustment and cognitive functioning at school entry (Brennan, Hammen et al. 2000; Arseneault, Kim-Cohen et al. 2005) and in adolescence (Hammen and Brennan 2003). However these studies have high attrition rates and predominantly include women from White ethnic backgrounds. Postnatal depression can also negatively influence the psychological and cognitive development of children. The Millennium Cohort study (Hansen and Joshi 2007) has reported that British Pakistani children are upto one year behind in cognitive development by the age of three. The study also reports the highest rates of behavioural problems in British Pakistani children.

1.3.1.5. Affective disorders in adolescents of mothers with postnatal depression

Postnatal depression has also been associated with higher rates of affective disorders in adolescent offspring (Halligan, Murray et al. 2007). These studies suggest that more chronically depressed mothers not only provide less support for children's emotional and behavioural regulation but also provide less cognitive stimulation and engage their children in less conversation.

1.3.1.6. Weight of children of mothers with postnatal depression

A study conducted with Pakistani women living in Pakistan, suggests that maternal depression is associated with low birth weight (Rahman, Lovel et al. 2004). This is particularly important for British Pakistani women, as their children's birth weights are lower than the national average, even of second-generation women (Harding, Rosato et al. 2004). Low birth weight is also associated with behavioural problems (Weinberg, 1998).

Some researchers have argued that risk of childhood obesity, may be related to increased exposure to postnatal depression (Taveras, Gillman et al. 2010). Wojciski et al (2011) looked at the impact of exposure to postnatal depression on infant growth up to two years postnatal. Infants were weighed and measured at 6, 12 and 24 months postnatal. Exposure to persistent postnatal depression was associated with the child being underweight and with reduced weight gain in the first 2 years of the child's life (Wojcicki, Holbrook et al. 2011).

1.3.1.7. Breastfeeding patterns of women with postnatal depression

Research has also looked at the importance of more basic interaction between the mother and the child. Research has focused on the impact of postnatal depression on breastfeeding (Henderson, Evans et al. 2003). This study reports early cessation

of breastfeeding was found to be significantly correlated with postnatal depression. Therefore infants of mothers with postnatal depression in this study were less likely to receive the health and nutritional benefits of prolonged breastfeeding.

These findings suggest that postnatal depression in mothers has a negative effect on their infants. The findings also suggest that persistence of postnatal depression throughout and beyond the first postnatal period can result in children experiencing a range of developmental problems.

1.3.2. Impact of postnatal depression on the partner

The impact of postnatal depression can have serious implications on interpersonal relationships (Lovestone and Kumar 1993). Lovestone and Kumar found that half of the spouses of depressed women in their sample (12/24) were affected by psychiatric illness. This 50% rate was higher than that in the control group whose partners remained well after childbirth. It was unclear in the study whether the onset of the partner's psychiatric disorder was before or after the onset of the postnatal depression.

A community based study of 200 couples found a 9% prevalence rate of depression in fathers at six weeks postnatal, and 5% at six months postnatal. Postnatal depression in fathers was found to be associated with a previous history of depression and the presence of depression in their wives or partners during pregnancy and soon after delivery (Areias, Kumar et al. 1996).

A recent study looked at the elevated levels of depression in male partners (Davey 2006). Partners in this study were asked to participate in a six week group treatment program specifically tailored for male partners. These men described their feelings towards their partners' postnatal depression as, stigmatising, overwhelming, isolating and frustrating. The treatment programme provided a comprehensive range of therapies, for example cognitive therapy for reducing depressive thinking

styles. As a result of their participation, men reported lowered levels of depression and stress, and higher levels of social support. However a self report measure was used to assess depression.

Evidence suggests that partner support can be a protective factor against postnatal depression even six months after the delivery (Marks, Wieck et al. 1996) and may be used as part of a treatment programme for women with depression (Misri, Kostaras et al. 2000). Burke also provides evidence on the detrimental effects of postnatal depression on partners of depressed women. The author postulates that depressed women need to be educated about the potential effects of their illness on the child and the partner, without being made to feel guilty (Burke 2003).

The majority of the literature cited so far in this introduction discussed the objectively measured aspects of postnatal depression in order to describe the condition. There is a branch of cultural psychiatry that looks at explanatory models of illness. These explanatory models explore the health beliefs of those affected by the condition. The following chapter further explored the concept of postnatal depression using explanatory models of health beliefs.

1.4. Explanatory models of illness

Kleiman (1975) emphasises illness is culturally shaped. Social class, cultural beliefs, education, occupation, religious affiliation, past experiences with illness and services all influence how we perceive, experience and cope with illness and form an 'explanatory model' of illness. Kleinman (1975) further adds that people hold belief's about the aetiology, the onset of symptoms, the pathology and the course of illness and the possible treatments. This affects: how the symptoms are expressed, help-seeking behaviour, and how people communicate with therapists.

A disparity in the explanatory models between patient and doctor can result in problems in clinical management such as poor compliance and poor clinical care. Patients have expectations when seeking treatment (Kleinman, 1975). For example, in Taiwan, patients expected western-style doctors to provide injections, with limited time left to explanations and questions. Chinese-style doctors were expected to prescribe herbs and symptoms and diet would be also discussed. Folk practitioners were expected to show more interest in their patient's problems and show an interest in personal and social issues (Kleinman 1975).

Kleiman (1975) interprets illness, in terms of the difficulties resulting from the illness including the personal, interpersonal, cultural reactions to discomfort and disease and the malfunctioning of biological of psychological processes. The biomedical view in both developed and developing countries focuses on the underlying biology of disease.

Kleinman argues that the biomedical model is less interested in the psychological and sociocultural issues, and more concerned with the curing of the disease, and not managing the illness. Provision of health care services in both developing and developed countries invest in services based on the biomedical model. The biomedical approach is the only model that can systematically recognise and treat

disease and potentially treat the illness. The review suggests ignoring other models is less clinically effective as is less likely to treat both disease and illness (Kleinman and Benson 2006). A negotiation of shared models is suggested. For example, where the patient accepts the use of antibiotics but believes burning incense or wearing an amulet is needed the physician must attempt to understand this belief and not attempt to change it. Where the patient refuses medication due to a belief that penicillin is inappropriate, a 'hot' remedy for a 'hot' disease, the physician must persuade the patient of the incorrectness of their belief.

1.4.1. Culture and explanatory models

The DSM-IV includes an Outline for Cultural Formulation to incorporate cultural issues into diagnosis. DSM-IV classification contains a 'list of key parameters by which a psychiatric patient can be described in terms of the culture to which he belongs:

1. Cultural identity of the person,

2. Explanation of illness in terms of culture,

3. Cultural factors related to psychosocial environment,

4. Cultural elements in patient-doctor relationship.

1.4.2. The application of explanatory models exploring depression in South Asians

Some work has been done on Explanatory Models (EM's) of depression in South Asians. Evidence suggests South Asian women use psychosocial explanations to describe their depression (Bhugra 1996) and use culturally specific expressions to describe mental distress (e.g., ''thinking too much in the heart'', (Fenton and Sadiq-Sangster 1996). These women consider depression to involve the mind or soul (Patel 1998). A recent study found Pakistani women use culturally specific

expressions of anxiety and depression, such as "sinking of heart", "the earth moved from underneath my feet" (Naeem, Ayub et al. 2009).

A qualitative study conducted in New York found that South Asian immigrant women viewed depression quite differently from White women (Karasz 2005). White women attributed symptoms of sadness to a biological cause such as "hormonal imbalance" or "neurological problem". In contrast, South Asian women interpreted the symptoms as a reaction to "life problems" or "situational stress.

So far the studies looked at South Asians as a collective group rather than looking at the specific sub-groups such Pakistani's. There are sub-cultural differences between these groups. Pakistani women in particular, have been identified with high rates of depression. Only a handful of qualitative studies with Pakistani women were found. These studies are presented in the following section.

1.4.3. Qualitative studies exploring postnatal depression in Pakistani women

To date, no qualitative study has explored the nature of postnatal depression in British Pakistani women. A transcultural qualitative study (Oates, Cox et al. 2004) looked at postnatal depression across different countries and cultures. Fifteen centres in 11 countries took part in this study: Bordeaux and Paris (France), Dublin (Ireland), Florence (Italy), Gothenburg (Sweden), Iowa City (USA), Kampala (Uganda), Keele, London, Manchester and Nottingham (UK), Kyushu (Japan), Porto (Portugal), Vienna (Austria) and Zurich (Switzerland). This was the first study to simultaneously explore origins and consequences of postnatal depression. Three different groups of informants were recruited: new mothers; relatives (grandmothers and fathers); and health professionals. In two of the UK study sites, Nottingham and one of two groups in Stoke on Trent (Keele), the mother and relative informants also came from an British Asian ethnic minority group However, within the broader Asian group, specific ethnic groups were not specified.

The interview guide explored the informants' views, understanding and beliefs about the factors contributing to happiness or unhappiness during pregnancy and after birth; their understanding of mental health problems and their causes at this time; their views on what could be done to help, and suggestions for improving health care. For centres studying ethnic minority groups, there were additional probes for health professional informants about whether they thought mental health problems were more or less common and the reasons for them in that particular group of women.

Amongst other themes, morbid unhappiness (or postnatal depression) was recognised by all centre informants as a common phenomenon following delivery. Interestingly, UK Asians, did not use the term 'postnatal depression' to describe this condition, and did not mention hormones as a cause of postnatal depression. It was also clear that the UK Asians in this study did not regard professional or medical help as appropriate or felt that treatment was needed. The strength of the study is

that the interviews were conducted in the native language of the interviewees, reducing language barriers and misinterpretation. However, it does not specify if the interviews were conducted by clinicians or researchers who were fluent in the native language, or lay interpreters. Limitations of this particular qualitative research study lie in the small numbers of informants in individual centres and so findings cannot be generalised to the whole population.

A more recent UK based qualitative study found that Black Caribbean women subscribed to biopsychosocial theories of perinatal depression but tended to privilege social and psychological over biological explanations (Edge and Rogers 2005). Ten of the 12 women suggested that psychological factors such as severe stress, experiencing traumatic labour and delivery, and lack of emotional stability were potential triggers of their depression. However, the women in this study rejected the idea of 'postnatal depression' as a construct for understanding responses to psychological distress associated childbirth and early motherhood. The rejection of depression as illness was mainly to normalise distress and perpetuate a self-concept which stressed the importance of being 'Strong-Black-Women' for maintaining psychological well-being. This identity served to reinforce notions of resilience, empowerment, and coping strategies characterised by the need to problem-solve practically, assertively, and materially.

In another UK based study, White women also attributed a psychosocial aetiology to their symptoms of postnatal depression, relating to the stresses of parenthood, such as changed relationships, reality not meeting expectations, and the birth of the child triggering memories of past events (Chew-Graham, Sharp et al. 2009). Women in this study described insights into and awareness of their symptoms, often because they had suffered from depression in the past. Although these women suggested that the cause of postnatal depression might be different to the cause of previous episodes, it may also reflect the persistent nature of their depression.

General depression in women has been previously identified as persistent in nature through qualitative accounts in the White population (Maxwell 2005; Saver, Van-Nguyen et al. 2007), and in the British Pakistani population (Gask, Aseem et al. 2010). A recent qualitative study (Gask, Aseem et al. 2010) looked at the experiences of persistent depression in 15 British Pakistani women, four British born and 11 born in Pakistan, ranging in age from 23 to 73 years of age living in East Lancashire. All women had a diagnosis of depression, which was persistent or recurrent in nature, by their general practitioner (GP) and had been prescribed antidepressant medication for a period of between 1 and 16 years. Of the 15 women, five women described postnatal contributory factors to their persistent depression and five women described volatile marital relationships as the contributory factors to their persistent depression. These contributory factors were also described as the maintaining factors for their depression. Women reported 'feeling stuck' in the realms of family conflict, social isolation, societal stigma of depression and the depression itself. Limitation of the present study is that it was carried out in only one suburban area of the United Kingdom, East Lancashire, thus limiting the generalisation to British Pakistani women in urban areas.

1.4.3.1. Marital problems and postnatal depression

Relationship disharmony, domestic violence, neglect, separation and divorce, and may interfere with the positive environment needed for the successful transition to parenthood (Nettelbladt, Uddenberg et al. 1985; O'Hara 1986; Fatoye and Fasubaa 2002). Quantitative research has also linked depression to marital difficulties, negative effects on the family unit and the depression being chronic (Boyce 1994; Cooper and Murray 1995; Murray and Cooper 1997). Based on current quantitative research, the strongest predictors of postnatal depression are experience of depression during pregnancy, a previous history of depressive illness, marital problems and low social support (Robertson, Grace et al. 2004). Some studies conducted in the UK and in other Western societies have investigated the corelates of postnatal depression in women of Pakistani origin using qualitative methods (Belliappa 1991; Kumar 1994).

Fazil & Cochrane (1998) identified four culturally specific vulnerability factors of depression in Pakistani women living in the UK (Fazil and Cochrane 1998). These were social isolation, living with an extended family, an unhappy marriage and intergenerational conflicts. These studies also suggest that depression and postnatal depression were strongly associated with marital problems, particularly maltreatment by the husband or family in law (Patel et al 2002, Ulrich, 1987), and show high rates of suicide in the early years of marriage (Singh 2002). British South Asian women have a high suicide rate compared to White women living in the UK (Neeleman, Mak et al. 1997), particularly those with an affective disorder (Hunt, Robinson et al. 2003). Husain et al (2012) suggest British Pakistani women have particularly severe social difficulties in the realms of marriage, health, finance, housing, and they lack supportive relationships. 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 British Pakistani women seek help.

A qualitative study conducted in the USA looked into marriage, depression and illness in the South Asian community in New York City (Karasz 2005). The participants were presented with many vignettes. The focus was on the attributions made by the South Asian women. For the depression vignette, causal attributions referred to a specific family or marital problem. The study concluded that South Asian women in health care settings may be unresponsive to explanations and treatments that emphasise western psychiatric treatments to illnesses. Therefore, when developing such interventions, the experience of these women needs to be considered; as their interactions with, and access to, health care services, and opportunities for social networks and support may differ significantly from other groups. The study also indicated that South Asian women are more responsive to supportive and social or problem-focussed counselling approaches.

The research so far suggested a series of factors associated with the development and persistence of postnatal depression. It is also suggested in many of the earlier stated studies that postnatal depression may exist in nearly all cultures around the world. Contrary to these findings, Stern & Kruckman (1983), in their review of anthropological studies of postnatal depression, question the existence of postnatal depression across all cultures.

Stern & Kruckman (1983) found little evidence of the phenomenon identified in Western diagnoses as postnatal depression. They suggested that the lack of postnatal rituals in Western society might be a cause of postnatal depression. The authors hypothesised that the high status of motherhood, and social support might be protective factors against postnatal depression in collectivistic societies. The authors further add that the effectiveness of counselling in treating the condition may be through its re-creation of postnatal 'structure' and the provision of social support which might formerly have been provided by the extended family and public recognition of the new role. However, this study took place almost 30 years ago and at present some of the points raised in this particular study still stand, such as the protective elements of social support but previously discussed findings suggest high levels of postnatal depression and the risk factors associated with, becoming and remaining depressed (Stern and Kruckman 1983).

The available interventions for postnatal depression predominantly included women from a White background. Therefore a case for developing culturally adapted interventions was subsequently identified and presented in the next section.

1.5. Interventions available for Postnatal Depression

Postnatal depression is a treatable disorder (Pearlstein, Zlotnick et al. 2006). Mild to moderate depression can be treated with talking therapies, such as Interpersonal psychotherapy (IPT) (O'Hara, Stuart et al. 2000; Spinelli and Endicott 2003), nondirective counselling by health visitors (Elliott, Gerrard et al. 2001), psycho-education (Honey, Bennett et al. 2002), and cognitive behaviour therapy (CBT) (Prendergast 2001). The use of baby massage (Onozawa, Glover et al. 2001), exercise (Daley, MacArthur et al. 2007), and group based parent training programmes (Bevc 2004) are also found to be effective. Severe depression can be treated with antidepressants (Wisner, Peindl et al. 1999). The majority of the interventions can be categorised as pharmacological, psychological, and psycho-social. These are as follows.

1.5.1. Pharmacological interventions for postnatal depression

Antidepressant treatment has been used in the management of postnatal depression. Many studies have reported that antidepressants such as Sertraline, Paroxetine, Venlaflaxine, and Nortriptyline, can be used safely by nursing mothers of healthy full term infants (Wisner et al, 1997). However, Fluoxetine has been linked with side-effects including irritability, sleep disturbance, and poor feeding in infants exposed to it in breast milk (Burt, Suri et al. 2001). Little is known about the long-term effects of antidepressants on the child's developing brain. Therefore, many new mothers remain reluctant to take such medication whilst nursing (Burt, Suri et al. 2001).

1.5.2. Psychopharmacological interventions for postnatal depression

There is a need for randomised studies evaluating the pharmacological treatment for postnatal depression. There are only two studies that have done this. One study looked at a comparison of four treatment groups, Fluoxetine plus a single session of cognitive behaviour therapy (CBT), placebo plus a single session of CBT, Fluoxetine plus six sessions of CBT, and placebo plus six sessions of CBT. After

four weeks of treatment, similar improvements occurred among women receiving either six sessions of CBT; or Fluoxetine plus one session of CBT. The results indicate that women's choice of treatment may be guided by their preference of pharmacological or non-pharmacological approaches to treatment (Appleby, Warner et al. 1997).

Another study looked at the comparison of three treatment groups; Interpersonal psychotherapy (IPT), Sertraline, and a Sertraline and IPT combination (Pearlstein, Zlotnick et al. 2006). The results showed that overall there was a reduction in mean depression scores in all three of the treatments combined. However, the authors agree that the sample size was too small to reliably distinguish differential efficacy among these treatments. The results confirm previous findings by Appleby et al (1997) as there was a trend for breastfeeding women to opt for treatment without medication (67%) rather than treatment with medication (33%). There was also a trend for women with previous histories of depression to choose treatment that included medication (86%) rather than a treatment approach without medication (14%). The treatment preferences show that nearly half of the sample (11 of the 23 women) selected IPT alone, two selected sertraline alone, and 10 selected combined sertraline and IPT combined. Interestingly, both of the women selecting sertraline alone cited time constraints which prohibited participation in weekly psychotherapy sessions.

1.5.3. Psychosocial interventions for postnatal depression

Among psychotherapies, Interpersonal psychotherapy (IPT) and Cognitive behavioural therapy (CBT) have shown efficacy in the treatment of postnatal depression, (Prendergast & Austin, 2001; Pearlstein et al 2006, O; Hara et al, 2000; Segre et al, 2004).

1.5.3.1. Interpersonal psychotherapy for postnatal depression

Interpersonal Psychotherapy is a brief and highly structured manual based psychotherapy that addresses interpersonal issues in depression, to the exclusion of all other focus of clinical attention. This approach allowed modification of the original treatment manual for depression to a variety of illnesses (Weissman, Markowitz et al. 2000). IPT is found as effective across cultures. Bolton et al carried out a randomised control trial of Group Interpersonal Psychotherapy (IPT-G) for depression in Uganda. The group receiving IPT-G had a substantially greater decline in mean depression scores than the treatment as usual group (Bolton, Bass et al. 2003).

Zlotnick et al carried out a 4 week intervention using IPT for at-risk pregnant women who had at least one risk factor for developing postnatal depression. Within 3 months of giving birth, 33% of the control group developed postnatal depression compared to none in the IPT group (Zlotnick, Johnson et al. 2001). Another trial looked at IPT versus parenting programmes in the antenatal period. A significant improvement in the IPT group was obtained than the parenting programme, at measures of mood at termination; as well as a 60% recovery rate in the IPT group (Spinelli and Endicott 2003).

Group Interpersonal Psychotherapy (IPT-G) has also been used in recent studies (Reay, Fisher et al. 2006) to assess the potential effectiveness for postnatal depression. The study looked at 18 mothers (with infants 12 months or less) diagnosed with postnatal depression. These women participated in two individual and eight group sessions of IPT-G. A two hour psychoeducational session was also held for the partners of participants. Severity scores on all the measures of depression decreased from pre to post treatment. However, no overall improvement on the social adjustment was noted; although relationship improvement was shown with the partner.

A study conducted in Vienna (Klier et al, 2001) also showed efficacious results of IPT in a group format. Depression scores of 17 women receiving IPT-G decreased significantly from pre to post-treatment. Follow-up assessments at six months continued to show the treatment effect. However, there was no control group for this study. Nevertheless, these results indicate that IPT adapted for a group model has positive implications for the treatment of postnatal depression.

1.5.3.2. Cognitive behavioural therapy for postnatal depression

Cognitive Behavioural Therapy (CBT) is a psychotherapy based on cognitions, assumptions, beliefs, and behaviours, with the aim of influencing negative emotions that relate to inaccurate appraisal of events (Meichenbaum, 1976). The main objectives of CBT are to identify irrational or maladaptive thoughts, the underlying assumptions and beliefs that are related to debilitating negative emotions and behaviours. The aim is to identify how these thoughts, behaviours, assumptions and beliefs are dysfunctional, inaccurate, or simply not helpful. This is done to reject the distorted cognitions and to replace them with more realistic and self-helping alternatives (Dodge , 1993). A number of studies have used CBT in the treatment of postnatal depression and found positive results (Appleby 1997; Honey et al 2002; Prendergast & Austin, 2001).

The Appleby et al, (1997) study mentioned earlier showed promising results for CBT for postnatal depression. An Australian study using CBT for postnatal depression (Prendergast 2001) reports the long-term efficacy of CBT. This was a nurse led intervention under Psychiatric supervision. Early childhood nurses were trained in modified CBT. The results indicated that CBT alone was not sufficient in significantly reducing the severity of depression at the end of the treatment. However, at six months follow-up a greater effectiveness of CBT was obtained. It was suggested that psycho-education may also be important in the treatment of postnatal depression.

1.5.3.3. Psycho-educational interventions for postnatal depression

A psycho-educational group intervention (Honey, Bennett et al. 2002) comprised of three components: educational which included providing information on postnatal depression, strategies for coping with difficult child-care situations and eliciting social support; the use of CBT techniques such as challenging women's erroneous cognitions about motherhood; and the use of relaxation techniques. The intervention was not manualised but a pre-defined structured programme was developed. The results indicated a significant reduction in EPDS scores of women in the intervention group when compared to the treatment as usual group. The reduction was not related to anti-depressant use. Moreover, improvements in mood were not accompanied by changes in coping, perceptions of social support, and marital relationship. Therefore, interventions incorporating more problem-solving techniques with regards to marital difficulties may be beneficial for women with postnatal depression. The authors' suggest the importance of involving partners in such interventions.

1.5.3.4. Intervention using baby massage for postnatal depression

Baby massage can be a very effective way of improving orientation and sleep, and reducing excitability in full-term infants (Field et al, 2004). A study conducted by Onozawa et al (2001) looked at the effects of using infant massage to improve the mother-infant interaction in women with postnatal depression. Postnatally depressed women were randomly allocated to an infant massage class and support group (massage group) or to a support group (control group). The study, although limited by small group numbers and high drop-out rate, did show that that EPDS scores reduced significantly in both groups in just 5 weeks. However, the mother-infant interaction significantly improved only in the massage group. The use of baby massage is a safe and cost-effective intervention for mothers and their infants (Feijó et al, 2006).

1.5.3.5. Intervention using exercise and postnatal depression

Physical exercise has long been associated with improvements in mood, reductions in depression and anxiety (North et al, 1990) and improvement in self-esteem (Palmer, 1995). Women with postnatal depression may benefit from the use of exercise since it is effective in treating mild to moderate depression (North et al, 1990; Cramer et al, 1991). Pram walking is an activity that can be integrated into a mother's life relatively easily; it can be fitted around the demands of the baby and no additional childcare is required (Daley et al 2007). An example of this is the Australian "Stroll your way to well-being programme" (Currie et al, 2001). This is a community based pram-walking programme designed to increase access by mothers to sociable postnatal exercise. Seventy percent of the mothers were still walking at 16 months after the programmes commencement.

A 12 week randomised controlled trial was conducted by Armstrong and Edwards (2003) to investigate the combined effects of exercise and social support (multi intervention group) compared to a control group. The exercise component of the intervention involved the participant to walk three times per week with their infants in a pram, with the group for a period of 30-40 minutes. After the walk, refreshments were provided, and a chat and play with the children was encouraged in a group setting. Mothers in the intervention group significantly, improved their fitness levels and decreased their depressive symptomatology. However, no significant differences in levels of social support were observed between the two groups.

1.5.4. Reviews of interventions for postnatal depression

Stuart et al (2003) carried out a review of psychotherapeutic treatments for prevention of postnatal depression. According to their findings, the majority of the studies carried out in this field, support the efficacy of preventative psychotherapeutic interventions for postnatal depression. However, a few studies failed to show any efficacy (Hayes et al, 2001, Brugha et al, 2000, and Stamp et al,

1995. In addition, the authors also suggest that psychotherapeutic interventions should be used as a first-line treatment, rather than as an adjunct to medication treatment (Stuart, O'Hara et al. 2003).

Dennis (2004) in a critical review of psychosocial interventions for postnatal depression found home visits by a community support worker had no protective effect on postnatal depression and expressed that individually based interventions may be more beneficial than those that are group-based (Dennis 2004). However, none of the studies in this review have conducted a group based therapy programme with the ethnic minorities; in order to see if such interventions work with women from minority ethnic groups. In addition, interventions targeting "at-risk" mothers were found to be more beneficial than those including a general maternal population.

Although the above stated reviews, (Stuart et al 2003; Dennis 2004) have found some support for the effect of psychotherapy for postnatal depression; nonetheless, these reviews did not use a meta-analysis as methods to statistically integrate the results of the individual studies and were not able to test whether different types of therapies differed significantly from each other. A recent meta-analysis of controlled and comparative studies of psychological treatments of postnatal depression looked at seventeen studies which included a control and treatment as usual group, allowing effects sizes to be compared (Cuijpers, Brannmark et al. 2008). The results showed only a decreased number of studies were available to draw conclusions about the relative effects of psychological treatments compared to pharmacological and other treatments. Nevertheless, the studies that were available showed that psychological treatments have moderate effects on depression in women with postnatal depression.

Conversely, this review included women who were diagnosed for postnatal depression through clinical interview and/or self-report questionnaire. This is

problematic as we cannot infer from the findings the true proportion of women who were clinically depressed as opposed to those women who were identified experiencing depressive symptoms above a cut-off point on a self report questionnaire. This review also reflected that such studies were only conducted in developed countries, primarily with Caucasian participants, thus representing a specific sample of women and limiting generalisabilty of results. In addition, the review highlighted that the few studies that compared psychological treatments to other treatments indicated that the other treatments were somewhat more effective. According to the authors, this could be an indication that psychological treatments may not be the treatment of first choice for postnatal depression. However these this finding needs to be treated with caution as the number of studies in the review was too small to draw any definite conclusions.

1.5.4.1. Absence of non-White populations in reviews of interventions for postnatal depression

In the literature identified, there was not a single systematic review to date that looked at the efficacy and/or effectiveness of psychological, social or pharmacological approaches to the treatment of postnatal depression in non-western population from developed or developing countries. Research in this area which in the main has been undertaken in the West may be prone to Western cultural influences. Therefore, the findings from studies mentioned earlier could be considered or termed on Western based constructs. These constructs in the main are used to identify and elicit findings from the predominantly White/Caucasian populations. This clearly reflected the need to identify such studies and report their findings to lend support to empirical data.

There is also little empirical evidence addressing the adaptation of evidence based treatments/interventions to ensure their applicability to specific ethnic communities (Miranda, Bernal et al. 2005; Lau 2006). Randomised control trials (RCTs) identify the impact of interventions by measuring outcomes. The US Department of Health

and Human Services (HSS) report a range of efficacious treatments for most mental health disorders (U.S Department of Health and Human Services, 1999). However a supplementary report also highlights that minority groups are underrepresented in efficacy studies of treatments in mental health (U.S Department of Health and Human Services, 2001).

In the U.S, the HHS report on efficacy studies forming guidelines for the major treatments in bipolar, schizophrenia, depression and ADHD consisted of a total 9266 participants. This included: 591 Black, 99 Latino, 11 Asian American/Pacific Islanders and 0 American Indians/Alaskan Natives. The supplementary report highlighting underrepresentation in efficacy studies saw a decline in number of RCTs that included culturally diverse groups. As stated earlier, RCTs have mainly been conducted in nonminority populations. The literature search identified only two randomised controlled trials that have attempted to treat postnatal depression in non-western populations, (Rahman et al, 2007, Rojas et al, 2007) which will be later discussed.

1.5.5. The need for culturally tailored interventions

Most economically developed nations are multi-ethnic. The following literature argued the underrepresentation of ethnic minority groups. This may be due to barriers encountered by this group when seeking help for mental health problems. The following section looked at demographic rates and health differences in ethnic minorities in north-west England, help seeking behaviours of people from ethnic minorities, the barriers these people encountered, and the recommendations for culturally adapted interventions.

1.5.5.1. Demographics of ethnic minority group in the Northwest England

The proportion of the UK population belonging to a non-White minority ethnic group increased by 53% between 1991 and 2001, (from 3.0 million to 4.6 million). Among the minority groups, South Asians make up over half the ethnic minority population in the UK and are one of the fastest growing groups in Manchester (ONS, 04). The largest ethnic minority group in the Northwest is of Pakistani family origin (UK census 2001). This group of people show prominent cultural differences to the majority population in the UK. Among ethnic minority groups, British Pakistani women have the highest birth rates (Large and Ghosh 2006; Leon, Moser et al. 2008). If current demographic trends continue, societies will become more ethnically diverse.

1.5.5.2. How is ethnicity defined?

Ethnicity has been shown as hard to monitor and record (ONS, 2002) and only became mandatory in publicly funded mental health services in 1995. South Asian People from the Indian subcontinent might want to define themselves as, for example, Pakistani, Gujarati or Punjabi; but in the 2001 Census they were offered the options of 'Indian', 'Pakistani', 'Bangladeshi' or 'other Asian'. The National Institute for Mental Health in England (NIMHE) suggested that self-identified ethnicity should be documented routinely (NIMHE, 2003).

1.5.5.3. Demographic health differences

Black and Ethnic Minority (BME) groups in particular experience higher levels of social and material deprivation compared to majority White group. They have poorer morbidity experience, and long standing illness and a registered disability (Nazroo 1997). Current research is starting to discover that despite higher levels of ill health and disability, ethnic minorities appear to have poor access to particular types of medical care (Feder, Crook et al. 2002). Amongst the BME groups, British Pakistanis have reported significant mental health problems. In a UK based survey,

British Pakistanis and Bangladeshis were 50% more likely to describe their health as fair or poor compared to Whites (Nazroo (1997). South Asian groups presented a similar socioeconomic profile to African-Caribbean groups, but with marked language, religious and cultural differences (Nazroo, 1997).

1.5.5.4. Help-seeking behaviour

Studies have looked at help-seeking behaviour in the White and Black population with common mental disorders, but there is little information on the help-seeking patterns of British South Asian population. Some of the information found suggested that South Asian people in the UK try to access help for their mental health problems but fail due to a number of barriers to treatment. A national survey conducted in the UK found, people classified as Asian or Oriental experiencing a depressive episode had the highest consultation rates with physical complaints, after the White group (Meltzer, Gill et al. 1995). Within the Asian/Oriental group, depressed women between the ages of 25 to 34 were the most at-risk group and had almost double the rate of presentation with somatic symptoms to the GP (30%) when compared to men (16%). Within the Asian group, British Pakistani's had the highest GP consultation rates than any other ethnic group in the UK (Balarajan, Yuen et al. 1989). However, little is known about the quality of these consultations.

A number of barriers to mental health treatment for people from British South Asian background have been identified. These include; misidentification of symptoms by health professionals, lack of information on services available for treatment of mental health, and language barriers.

1.5.5.4.1. Misidentification of symptoms by health professionals

Evidence suggested most individuals from South Asian backgrounds with common mental disorders were not identified by the GP (Jacob 1998). This may be due to difficulties in communication, or cultural differences in the presentation of

symptoms (Abas 1996). This may also be due to the differing explanatory models between the physician and the patient, which often result in the patient remaining undiagnosed and untreated (Jacob 1998). Another possibility was cultural stereotypes that can misdirect diagnosis and treatment pathways (Burr 2002). The misidentification of symptoms may explain the variations in mental health service use by ethnic minorities in the UK.

1.5.5.4.2. Lack of information on services available for treatment of mental heath

A survey of 27 000 participants with mental health problems found ethnic variations in the experiences of mental health service users in England (Raleigh, Irons et al. 2007). The survey showed when compared to the White population, the Asians (including, Indian, Pakistani, Bangladeshi, Asian other) were provided with significantly less information about mental health services, had a shorter duration of contact with mental health services, and less contact with community psychiatric nurses. Furthermore, compared to the White population, a significantly fewer number of Asians received any form of talking therapies or care plans.

1.5.5.4.3. Language barriers

A local qualitative study in Manchester found language barriers to be an important factor in designing interventions for British Pakistani women (Wood, 2007). This study was carried out by the Manchester Public Health Development service with a group of British Pakistani women who were involved in a focus group. A number of issues were explored and themes that emerged included; perceptions of mental health and illness, factors affecting mental health and stigma, and barriers to seeking help. The most emphasised aspect of the focus group by the British Pakistani women was language and cultural barriers. It was also found that a lack of understanding about existing help and services prevented most of these women from accessing formal support.

1.5.5.5. Government recommendations and guidelines for services for ethnic minorities

The UK population has become increasingly diverse. Tailoring practice to an area's demographics is crucial to providing effective treatment. The National Service Framework for Mental Health (DoH 2003) reaffirmed the issue of inappropriate services for Black and ethnic minority (BME) communities such as British Pakistanis. Among other DOH policy documents NSF-MH, Inside Outside the Department of Health (DoH 2003) has published a report on Delivering Race Equality in Mental Health Care, which is a five-year action plan for tackling discrimination and achieving equality in services for ethnic minority patients and communities (DoH 2005). Standard one requires working with both individuals and communities so that disparities can be combated, and that the mental health services work against social exclusion, especially with regards to people from black and minority groups.

The Department of health (DOH) has also allocated substantial funds for Improving Access to Psychological Therapies (IAPT) in the UK. Its principal aim is 'to implement NICE guidelines for people suffering from depression and anxiety disorders'. The document specified BME groups are 'hard-to-reach groups' and must have better access to psychological therapies in the UK.

The NICE Guidelines suggested that women who develop a mental disorder during pregnancy or the postnatal period, should be given culturally sensitive information at each stage of assessment, diagnosis, course and treatment about the impact of the disorder and its treatment on their health and the health of their foetus or child (NICE 2007). The guidelines also made recommendations for culturally sensitive services and suggested that the NHS Trusts must identify a board member to take responsibility for diversity and ethnic issues. Responsibilities must include adequacy of service provision, training on cultural difference, monitoring service

usage by ethnicity, consultation with local BME groups and achieving targets set in advance on a year by year basis (NICE 2007).

These guidelines suggested that people from ethnic minorities should be provided with culturally appropriate mental health services. In particularly, the NICE guidelines also stated that women from ethnic minority groups should be provided with culturally sensitive information and treatments for postnatal depression. The next section focused on what is involved in the process of developing culturally adapting interventions.

1.6. How can interventions be culturally adapted and developed to meet needs of specifically targeted cultural groups?

In order to answer the above question, we need to be clear on what is meant by cultural adaptation and what is involved in this process. A systematic methodology also needs to be followed to drive this process in order to show the evidence base for the selected intervention. Interventions targeting specific groups can be complex in their nature. The Medical Research Council (MRC) has developed a guide to developing complex interventions (Craig, Dieppe et al. 2008).

1.6.1. What is cultural adaptation?

"Cultural adaptation" refers to program modifications that are culturally sensitive and tailored to a cultural group's traditional world views" (Kumpfer, Alvarado et al. 2002). The primary aim in cultural adaptation is to generate the culturally equivalent version of the treatment/intervention. Translation from one language to another is the most obvious form of treatment adaptation. Avoiding activities that create cultural conflict with a cultural group's values or traditions is also a process involved in cultural adaptation. For example, a western approach to assertiveness sometimes teaches women to express themselves openly. This can conflict with cultural norms in traditional British Pakistani families, for whom it is inappropriate for a woman to question the husband's authority. Using culturally appropriate material in the intervention, for example using culturally specific case studies, role play, handouts, exercises is also another form of culturally adapting an intervention.

As stated previously, one of the aims of culturally adapted interventions is to generate the culturally equivalent versions of treatments/interventions. One of the ways in which this can be targeted is through qualitative exploratory methods. These methods can be useful in identifying the explanatory models of illness employed by participants. Qualitative testing can also provide means of developing interventions that target specific areas. One of the areas that can be particularly useful to identify is the theoretical framework of the intervention. Research in this

area in the main has been undertaken in the West. This research may be prone to Western cultural influences. Therefore, the findings from studies mentioned earlier could be considered or termed on Western based constructs. These constructs in the main are used to identify and elicit findings from the predominantly White/Caucasian populations. According to Gilbert (2001), treatments or interventions can be extrapolated into different cultures. However in order to do this, we need to pay attention to the most crucial aspect on the intervention or treatment, the theoretical base.

1.6.2. Theoretical base of treatments and interventions

Gilbert (2001) claims that our approaches to working with people are based on specific theoretical and cultural assumptions, particularly in relation to the "self". The "self" as in the need to understand the client's inner world, and also the "self" in relation to developing the personal skills and self knowledge of the helper. All Western therapies, of whatever theoretical orientation, are based on the premise that greater knowledge and understanding of one's own self determines one's capacity to help and understand another. These theoretical understandings of "self" are rooted in North American/European culture and it can sometimes be forgotten that these assumptions regarding the experience of "self" may not apply to those from very different cultural backgrounds. Gilbert (2001) also argues that some cultures, such as South Asian, Eastern Asian, and tribal cultures socialise their peoples predominantly in an interdependent view of self. This view of self prioritises the relatedness of individuals to each other, attending to others, fitting in, and harmonious interdependence with them. On the other hand, cultures of the North assume an independent view of the self in which establishing and maintaining independence from others and discovering and expressing unique inner attributes is given priority.

These cultural assumptions have profound implications for how an individual experiences him/herself and what is considered emotionally "mature" adult

behaviour. In cultures with an interdependent view of the self, maturity is considered to be the control and reduction of one's own individual views and needs, and establishing a social position within a host of inter-relationships and networks. However, in cultures with an independent view of self, separateness and independence are culturally valued, and the capacity to express one's own views and opinions is considered an essential part of self development.

Applying Western approaches to cultures with different assumptions about "self" is intrinsically problematic because all the underlying theoretical assumptions stem from the individualistic culture of North America, in which an independent view of the self is implicitly assumed. Can such theoretical assumptions have relevance to a culture with an interdependent view of self, such as that of the Pakistani or Latina cultures? Do these approaches have any value in a culture with very different implicit assumptions, and, if so, how should such approaches be modified?

An example of a study that displayed the need to understand the theoretical background of the population that was being studied and treated was by Bhui et al (2008) which looked at religious practises within the Muslim population, but also across two different cultures (Pakistani and Bangladeshi) who followed the same religion. They found intercultural differences within Muslim participants with psychological distress and in terms of their coping mechanisms. Bangladeshi Muslim participants in this study showed the greatest reliance on religious practises for coping. The Bangladeshi Muslims (more so than Pakistani Muslim) participants tended to embrace distress and become more adherent to orthodox religious practice as a way of remedying distress. For example, some participants distanced the self from bad (irreligious) feelings such as greed.

Listening to religious words on tape was used as a way of distancing oneself from worries and diverting one's mind. There was a more accepting attitude and a desire to offer service to people, to offer hospitality and respect. Doing this led to "feeling

good inside". Prayer also served a similar function which led to having little or no worries. Prayer helped to clear the mind and see the problem as there was relative perspective to a problem. Reciting religious verses and also using prayer beads were other ways of inducing these states of no worry. The Bangladeshi respondents emphasised living in the right way and a responsibility to God that included not making a problem out of their distress. If the respondents had a difficulty then it was evidently acceptable to God; and so they felt they also had to accept it as natural life events and circumstances. This may indicate the use of religion as a coping mechanism when considering interventions within the Bangladeshi population with psychological distress (Bhui, King et al. 2008).

1.6.3. Process of adapting psychosocial interventions

According to Barrera and Castro (2006), the process of adapting psychosocial interventions involves targeting specific community groups and identifying the target problem, ways of measuring effectiveness of intervention, socio-cultural context, symptom presentation, levels of engagement in study, and that the process needs to be driven by empirical findings (Barrera and Castro 2006).

1.6.4. Stages of adaptation

Barrera and Castro (2006) further describe the stages of adaptation. This is initiated by comparing two or more sub-cultural groups, in terms of their engagement, action theory and conceptual theory. The latter stages involve observing all three stages and identifying effective adaptations by information gathering, preliminary adaptation depending on the information found and testing the intervention by preliminary adaption tests, which then help with the refinement of intervention. Interventions targeting specific groups can be complex in their nature. The Medical Research Council (MRC) has developed a guide to developing complex interventions (Craig, Dieppe et al. 2008).

1.6.5. MRC Framework for developing Complex Interventions

As stated earlier, the Medical Research Council (MRC) have provided a framework for development and evaluation of RCT's for complex interventions to improve health care (Craig, Dieppe et al. 2008). The framework describes Complex Interventions (CI's) to be made up of several components. All of these components may be essential to the proper functioning of the intervention, and act dependently or interdependently. There are different types of complex interventions. Some are intended to improve Individual patient care (e.g. a novel form of CBT). Some can also be delivered in the form of Organisational or service modification (e.g. Introducing a CBT therapist in the primary care service). The intervention can also be Targeted on the health professional (e.g. educational interventions in the form of treatment guidelines) and/or Delivered at a population level (e.g. media delivered health promotion campaign). The following is a framework for developing and evaluating randomised controlled trials of complex interventions (Craig, Dieppe et al. 2008).
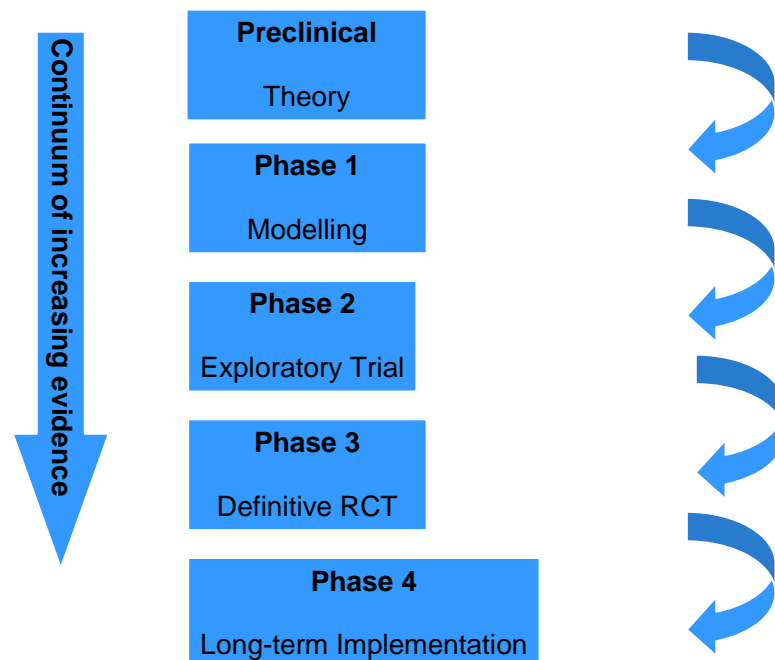
Figure 1: A Framework for Trials of Complex Interventions

The framework consists of the five following stages demonstrated in figure 1. The Pre-clinical or Theoretical stage consists of assessing the theory and evidence for example through the use of literature searches; and critically evaluating previous work in the field. It also allows one to incorporate the relevant theory to ensure best choice of intervention and hypothesis, for example the pre and postnatal depression research. At this stage predict major confounders and design issues can be explored.

Phase 1: This is the modelling stage. It deals with developing an understanding of the intervention. The components are designed with a understanding of the interrelationship between the components. This can be done through the use of qualitative interviews or using a focus groups.

Phase 2: This is the exploratory trial. This has been described as a crucial stage to the main randomised control trial (RCT). It has been regarded as a flexible stage that allows adaptive experimentation with the intervention, i.e. study design, analyses. At this stage evidence that supports theoretically expected treatment effect can be obtained. Also the identifcation of appropriate control groups is made possible and the use of outcome measures is tested. Moreover, the estimates of recruitment for the main trial are acquired as well as any other requirements of such trials.

Phase 3: This is the main trial or the definitive RCT. It is a more rigid and structured intervention. This is the central step in the evaluation of the complex intervention. Therefore it is more attentive to standard issues of adequate power, randomisation and blinding, outcome measures, the procedural aspects of obtaining consent from participants, and other features of well designed trials.

Phase 4: This phase is involved with the the long term implementation of findings. A separate study needs to establish the long term and real life effectiveness of the intervention. This stage is most likely to involve an observational study.

1.7. Culturally adapted interventions for ethnic minority groups with depression

There are no identified culturally adapted treatment/intervention studies for Pakistani women with persistent postnatal depression. There are four culturally adapted intervention studies that have attempted to treat general depression in Pakistani women, (Ali, Rahbar et al. 2003; Chaudhry 2009; Gater, Waheed et al. 2010; Naeem, Waheed et al. 2011), and one for postnatal depression in the first year (Rahman, Malik et al. 2008). There are six other culturally adapted interventions with other ethnic minority groups. Two interventions look at depression in general (Miranda et al, 2003, Bolton et al, 2003); three are preventative interventions for postnatal depression (Munoz et al, 2007, Grote et al , 2009, and Crockett et al, 2008); and one in the first postnatal year, (Rojas et al, 2007). The details of these studies are as follows.

1.7.1. Culturally adapted interventions for general depression

Miranda et al (2003) looked at women from particular minority ethnic groups, Latina women born in Latin America, African American women and White women born in the United States. They argued that minority women are less likely to receive appropriate care for depression than White women. The lack of evidence for the effectiveness of guideline-based care for depression with impoverished minority women, who were most likely to not seek help, was not highlighted.

The aim of the study was to determine the impact of an intervention to deliver guideline-based care for depression compared with referral to community care with low-income and minority women. A randomised controlled trial involving women living in a suburban area, experiencing current major depression, was conducted. Participants included three groups of women: Black and White women born in the United States, and Latina women born in Latin America. These

women attended county-run Women, Infants, and Children food subsidy programs and Title X family planning clinics.

The Hamilton Depression Rating Scale (HDRS) was used monthly from baseline through six months to measure depression. Instrumental role functioning and and social functioning were measured using the Social Adjustment Scale (SAS) and the Short Form 36-Item Health Survey (SF3). These were measured at baseline, three months and at six months.

Eighty-eight participants were randomly assigned to an antidepressant medication intervention, 90 to a psychotherapy intervention (eight weeks of manual-guided cognitive behaviour therapy) and 89 were referred to community mental health services. The results showed that participants in both, the medication intervention and the psychotherapy intervention reduced depressive symptoms more than the participants in the community referral group. The medication intervention also resulted in improved instrumental role and social functioning. The psychotherapy intervention only resulted in improved social functioning. The women randomly assigned to receive medications were twice as likely to achieve a Hamilton Depression Rating Scale score of seven or less by month six as were those referred to community care. The results also showed that more women engaged in a sufficient duration of treatment with medications compared with psychotherapy, and outcome gains were more extensive and robust for medications.

The promising results from the medication group may have been achieved as consultations were with Psychiatrists and Nurses, who may have unknowingly also given the participants a therapeutic encounter as well as providing medication. One of the major elements of CBT is the educative component, but women in the medication group also received four educational sessions, therefore matching the educational aspects of CBT. This can lead to questioning of beneficial elements of the medication. That is, would the benefits be seen if participants were prescribed medication by General Practitioners as opposed to mental health professionals

such as Psychiatrists? The nurses in this study scheduled weekly telephone calls to assess adverse effects, adherence, and treatment effects. This is not normally done in routine primary care services and participants are mostly left to their own devices and are asked to attend only in case of experiencing adverse effects. In the CBT group, if after eight weeks of treatment a participant's scores were still elevated, an additional eight-week treatment was offered. Therefore some participants could have potentially received 16 sessions and some received eight. The question arises regarding the nature of this type of intervention: i.e. Brief CBT or longer term CBT? Regardless of what the intervention was aimed to provide, the uptake of the intervention was poor as women were less likely to complete an adequate course of CBT, 48 (53%) received four or more CBT sessions, and 32 (36%) received six or more sessions.

Nevertheless the study shows steps were taken to be culturally sensitive to the sample needs. Firstly bilingual therapists treated all Spanish-speaking women and all written materials, including psychotherapy manuals, were also available in Spanish. Of the six psychotherapists, one was Black and three were Spanish speaking. None of the four nurse practitioners were Black, and two were Spanish speaking. In addition, all psychotherapists and nurse practitioners had extensive experience with and commitment to treating low-income and minority patients. Despite the measures for cultural adaptation, the study shows poor engagement of women and the researchers were unable to obtain telephone diagnostic interviews for nearly one third of the women who screened positive for depression, despite persistent attempts. All measures were read to participants based on the high proportion of women who had not finished high school (Miranda, Chung et al. 2003).

Bolton et al (2003) found that only a few controlled intervention trials related to depression in African populations have been published. They aimed to test the efficacy of group interpersonal psychotherapy in alleviating depression and to evaluate the feasibility of conducting controlled trials in an African population.

A similar cluster randomised controlled clinical trial to Miranda et al (2003) was conducted. Thirty villages in the Masaka and Rakai districts of rural Uganda were selected. Fifteen villages were then randomly assigned for studying men and 15 for women. In each village, adult men with self identified depression or depression identified by other villagers were interviewed using a locally adapted Hopkins Symptom Checklist and an instrument assessing function. Based on these interviews, lists were created for each village totalling 341 men and women who met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition *(*DSM-IV*)* criteria for major depression or subsyndromal depression.

Interviewers revisited the participants in order of decreasing symptom severity until they had 8 to 12 persons per village. Of these, 248 participants agreed to be in the trial and nine refused; the remainder died or relocated. A total of 108 men and 116 women completed the study and were re-interviewed. The intervention group consisted of participants from 8 (out of 15) male villages and 7 (out of 15) female villages and the control group was randomly assigned the remainder of the participants. The intervention villages received group interpersonal psychotherapy for depression as weekly 90-minute sessions for 16 weeks. The main outcome measures were depression and dysfunction severity scores based on scales adapted and validated for local use.

The results showed a mean reduction in depression severity was more apparent in the intervention groups than the control group. There were also significant mean reductions in dysfunction in the intervention groups than the control groups. Following the intervention, a significantly lower proportion of the intervention groups met criteria for major depression (6.5%) than the control groups (55%), when compared prior to the intervention.

The results may be a reflection of the steps taken to ensure cultural sensitivity and adaptation. The study used culturally validated measures. The authors also

focussed on the illness perception model of the population that was being studied and this heightens the chances of developing a culturally appropriate intervention, meeting the needs of the users. The study revealed good engagement into the intervention as the dropout rate was only 8% and 54% of participants attended at least 14 sessions. However, the study could not identify the most active ingredient in the intervention, in terms of reducing the depression. They could not separate interpersonal psychotherapy per se from the group dynamics of simply meeting together. However, some of the participants suggested that the group problem-solving element of IPT was vital, but once again this is not conclusive (Bolton, Bass et al. 2003).

Naeem et al evaluated the efficacy of a culturally adapted CBT intervention in Pakistan (Naeem, Waheed et al. 2011). In a randomised controlled trial, the authors compared a combination of CBT and antidepressants in the treatment arm and antidepressants alone in the control arm of the study. Participants had an ICD-10 diagnosis of depression and were randomised to the intervention and control groups. The Hospital Anxiety and Depression Scale (HADS) and Bradford Somatic Inventory (BSI) were used to measure changes in depression, anxiety and somatic symptoms. Thirty four participants were randomly allocated to one of the two groups. There were no demographical differences between the two groups except for financial status, as more people were in the lower monthly income group in the CBT group compared to control.

The results showed statistically significant improvements on in depression and anxiety scores, and in somatic symptoms, in participants receiving CBT when compared to antidepressant alone group. Six or more sessions of therapy were attended by 82% of the participants attended, showing that an evidence based treatment was effective in reducing symptoms of depression and anxiety in participants of a Pakistani family origin. The study was limited by small sample size. The effect size achieved for the reduction in depression score was found to be

0.60, which is a good effect size. The attendance rates of (82%) reflects the acceptability of the intervention. The compliance rates for medication were also better in the therapy group (65%) compared with those in control group. A close contact with therapists in the therapy group might have led to this improved compliance.

Ali et al (2003) provided counselling sessions to women experiencing depression and/or anxiety. They conducted this study to see if women who were minimally trained as community counsellors could reduce the mean level of anxiety and/or depression in women of their own community. A randomised controlled trial was used as the design and the study took place in a lower-middle-class, semi-urban community in Karachi, Pakistan. A total number of 1226 women were screened for anxiety and depression using an indigenous instrument. Out of these: 366 women were found to have anxiety and/or depression; who were married (83%) and, predominantly Muslim (86%). These women were randomised to intervention and control groups after providing informed consent. Women from the same community were trained in 11 sessions as counsellors. Participants in the intervention group were counselled once weekly for eight weeks by the trained community counsellors. After the eighth session, the screening questionnaire was re-administered to both the groups.

A highly significant reduction was found between the mean anxiety and depression scores of the two groups. This study demonstrated that counselling by minimally trained community counsellors can reduce levels of anxiety and/or depression in women of their own community. However, the results should be interpreted with caution. The women in this study were not experiencing clinically diagnosed depression or anxiety levels. Therefore, the results indicated that low level psychological distress may be reduced through such interventions but not necessarily more serious and clinically diagnosed depression or anxiety. Additionally, the study was not blinded; therefore it was subject to potential researcher and participant bias. Nevertheless, the study showed promising results

for the acceptability of group intervention for Pakistani women during the childbearing age.

A UK based study in Manchester also used a psychosocial group intervention in the treatment of depression in Pakistani women (Chaudhry, Waheed et al. 2009). A pilot study was developed and tested a culturally sensitive social group intervention for persistently depressed British Pakistani women. A total of 55 persistently depressed women were identified and the first consecutive 18 who agreed to participate were recruited 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. The Self Reporting Questionnaire (SRQ) and the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) were used as outcome measures at baseline and at the end of the intervention. Social support was not measured.

The results revealed that all nine women attended at least six of the 10 sessions. The overall mean depression score at baseline was 15 which significantly dropped to 12 at the end of the intervention. In addition, three women reported reduction in suicidal ideas. Satisfaction was portrayed through anecdotal feedback from the participants. The most important factor attributed to the success of the intervention was the relationships developed between the participants and. Provision of transport was also highly appreciated and proved beneficial. Participants reported positive experiences from the intervention resulted in lifting of their self confidence. One of the criticisms of this study is that it did not measure social support which has been measured in previous pilot studies using group intervention (Reay, Fisher et al. 2006).

Gater et al (2010) looked at the efficacy of a social group intervention. They compared three groups: the social intervention group, the antidepressant group, and the combined intervention plus antidepressant group. A total of 123 women with general depression participated in the study. The researchers reflected cultural

awareness in their approach to recruit their participants as multilingual invitation posters were used to encourage recruitment. The study timetable was also planned to avoid recruitment, interventions and assessments during Muslim festivals and school holidays. Language barriers were also eradicated by the use of bilingual research assistants who screened British Pakistani women aged between 16 and 65 years, by communicating with them in English, Urdu or Punjabi. Those with intellectual disabilities or severe mental illness or planning a visit abroad during the next six months were excluded. Participants who were already receiving antidepressants or any psychological intervention were not excluded.

This study also paid particular attention to the cultural sensitivity of the intervention. For example, participants were collected by taxi accompanied by a female transport facilitator. The groups took place in a culturally acceptable venue with provision of childcare facilities. The participants in this study were addressed and greeted in a traditional manner and at the beginning of each session they were reminded about confidentiality in order to prevent non-engagement with services. The selection of group activities was also constructed with cultural appropriateness and food was provided at the end of each session. The social intervention took place weekly for ten weeks at local voluntary agencies.

This study also engaged in user-led developments in the intervention. For example, at the first session, the participants were given the opportunity to choose from a list of indoor and outside activities for subsequent sessions. Incidentally, this may have resulted in women feeling some level of empowerment or equality as a service user and may reflect the acceptability of the intervention. It also included a psycho-educational session, which provided information about depression including its nature, symptoms, causes and treatment.

A strength of the study was that the researchers were appropriately trained and tested to be culturally competent in working with specific cultural groups. Group

facilitators underwent a five-day training programme delivered by psychiatrists experienced in cross-cultural mental health, a group facilitation skills trainer, and a British Pakistani mental health worker. Training included lectures, case scenarios and role play covering principles of randomised trials, communication and group facilitation skills. The format and content of the group sessions were described with particular emphasis on developing empathy, maintaining confidentiality and facilitating engagement. The outcome measures used were severity of depression (Hamilton Rating Scale for Depression), social functioning (self-rating social functioning questionnaire) and service satisfaction (Verona Service Satisfaction Scale) at three and nine months.

The results showed greater improvement in depression in the social intervention group and the combined treatment group compared with those receiving antidepressants alone fell short of significance. There was significantly greater improvement in social functioning in the social intervention and combined treatment groups than in the antidepressant group at both three and nine months. This shows that British Pakistani women with depression found the social groups acceptable and their social function and satisfaction improved if they received social treatment compared with only having antidepressant medication.

1.7.2. Culturally adapted interventions for prevention of postnatal depression

Crockett et al (2008) developed a preventative intervention for postnatal depression, but in a different population of women. They identified postnatal depression in low income African-American women as a major health problem. The aim of the pilot study was to examine the initial acceptability, feasibility, and effectiveness of the intervention named the ROSE Programme (Reach Out, Stand Strong: Essentials for New Moms). This programme was based on IPT and focussed on enhancing social support, familial communication, and managing transitions. IPT had previously demonstrated efficacy in reducing factors associated with perinatal depression and major depression among at risk pregnant women across ethnic groups (Zlotnick et al. 2001, 2006).

Participants in the study were 36 African-American pregnant women at risk for postnatal depression who attended a rural hospital affiliated prenatal clinic. Participants were randomly assigned to either the ROSE Programme or to treatment as usual (TAU). Outcomes included measures of depressive symptoms (Edinburgh postnatal depression scale), postnatal adjustment (Social-Adjustment Scale Self-Report Questionnaire (SAS-SR), and parental stress (Parenting Stress Index) at three months postnatal. At three months postnatal, the study found no significant differences between the two groups in degree of depressive symptoms or level of parental stress experienced. Conversely, women in the intervention group reported significantly better postnatal adjustment at three months postnatal than women in the TAU group. Those in the ROSE Programme also reported improvements in depressive symptoms over time, whereas women in the TAU group did not show such changes.

A major criticism of the study was that it aimed to measure the acceptability of the intervention but ignored to measure a crucial aspect of acceptability, participant satisfaction. No formal measure of participant satisfaction was employed and was indirectly measured by participant's anecdotal feedback and researcher observations

during the sessions. The researchers claimed that their results provide initial effectiveness for the ROSE Programme in improving postnatal functioning in a group of low-income, rural African-American pregnant women. Therefore this intervention was not successful at preventing postnatal depression or parental stress and what is meant by postnatal functioning is vague.

One possible explanation for the failing of this intervention for preventing postnatal depression may be the apparent lack of cultural sensitivity in this study. The original intervention was designed for a different population, White indigenous women, and no measures were enforced to culturally adapt the intervention to the study population. For example, in the Gater et al (2010) study, the participants were also from a low socioeconomic group but measures were put into place to ensure transportation to the intervention. However, in this study, participants who received the intervention faced obstacles getting transportation to sessions. This was already anticipated by the researchers, but no action was taken to overcome this barrier to engagement into the study (Crockett, Zlotnick et al. 2008).

Grote et al (2009) also pilot tested a preventative intervention for postnatal depression. They designed an eight-week individual Enhanced Brief Interpersonal Psychotherapy (IPT-B) intervention designed for low-income, mostly African American and White women during pregnancy, followed by monthly treatment during the first six months postnatal. The researchers identified through literature that depression during pregnancy was one of the strongest predictors of postnatal depression with higher rates found amongst African-American women. The primary question guiding the randomised controlled trial was designed to test whether, culturally relevant, enhanced brief interpersonal psychotherapy (IPT-B) was better at reducing depression in low-income, pregnant women than those women from enhanced usual care in this population.

The Enhanced IPT-B treatment was a multicomponent model of care designed to treat antenatal depression. It consisted of an engagement session, followed by eight IPT-B sessions before the birth and maintenance IPT up to six months postnatal. IPT-B was specifically enhanced to make it culturally relevant to socioeconomically disadvantaged women. The study included 53 non–treatment-seeking, pregnant African-American and White participants receiving prenatal services in a large, urban obstetrics and gynaecology clinic and who scored 12 or above on the EPDS. Twenty-five women were randomly assigned to receive enhanced IPT-B and 28 women for enhanced usual care, both of which were delivered in the clinic. Participants were assessed before and after treatment on depression diagnoses, depressive symptoms, and social functioning.

The results showed that participants in the enhanced IPT-B group, compared with those in the enhanced usual care group, showed significant reductions in depression diagnoses and depressive symptoms before childbirth (three months from baseline) and at six months postnatal and showed significant improvements in social functioning at six months postnatal. These findings suggest that enhanced IPT-B improves depression during pregnancy and prevents depressive relapse and improves social functioning up to six months postnatal.

One of the criticisms of the study is that the information provided for the cultural sensitivity aspect of the intervention is too briefly described and vague in some places. However the study does show cultural sensitivity to the pragmatic aspects of the trial, that included, free bus passes, childcare, and the facilitation of access to needed social services (that is, food, job training, housing, and free baby supplies), sessions were delivered in an office in the large obstetrics and gynaecology clinic to make treatment more accessible and less stigmatising. When participants could not attend treatment, the session was conducted on the phone to maintain continuity, used therapists who were trained in cultural competence and used considerable experience working with persons of racial-ethnic minority groups who were living in poverty, utilised the component of metaphors by displaying culturally relevant

pictures of racially and ethnically diverse infants in the therapist's office, by using stories from the participants' cultural background to reinforce treatment goals.

To address the component of concepts, therapists provided education about depression in a way that was congruent with the participant's culture and used the word "stressed" instead of the word "depressed," in order to reduce stigma of depression. The component of content was addressed by exploring what coping mechanisms and cultural resources had helped participants through adversity in the past and by building on these resources during treatment. Therapists helped clients develop treatment goals that were personally and culturally relevant to them. Finally, methods for shortening treatment to reduce participant burden were also employed.

Some further limitations of the study were that findings are from a small sample of low-income participants with depression who were not on antidepressant medication when they entered the study during the mid-trimester of pregnancy and, therefore, may not be generalisable to other pregnant, low-income African-American and White women with depression. Second, to complete study assessments, the independent raters took extra time and effort to re-establish contact with participants in the control group who were more difficult to reach than participants in the enhanced IPT-B group. Therefore, it is speculated that due to the clear differences encountered in being able to assess participants in both groups, study raters were less likely to remain blind to a participant's treatment condition, posing a threat to internal validity of the study (Grote, Swartz et al. 2009).

Munoz et al (2007) were interested in the effect of a mother's well-being on her child relationship. They acknowledged that a mother has a lot of contact with the healthcare services during pregnancy and afterbirth and so considered this to be the best time to intervene. The purpose of the project was to develop a 12-week Spanish and English preventive group intervention manual in order to reduce the

incidence of major depressive episodes during the postnatal period and evaluate its acceptability. The manual was designed to address the socio-cultural issues relevant to a low-income, culturally diverse population. Its intent was to teach participants to recognise which thoughts, behaviours, and social contacts had influence on their mood, the effect of mood on health, and the benefits of strengthening maternal-infant bonding.

Participants were recruited via flyers, direct referrals from health care providers, and/or by research assistants who approached them in the waiting area and asked them to participate in the study. Recruiters were bicultural and bilingual and trained to be sensitive to recruiting individuals within a busy women's clinic. Approximately 70% of the sample were Spanish-speaking Latina women born in Mexico/Central America, and were on average 19 years of age when they immigrated to the U.S. Therefore having bilingual and bicultural recruiters shows cultural sensitivity and a helpful strategy to recruit and engage women from hard to reach minority groups. They looked at Latino women because based on available literature, this group of women have an increased risk of postnatal depression due to high major depression rates and have a high risk of developing symptoms of postnatal depression. Latinos are the largest ethnic group in the US. Approximately half of the Latino women are in their child-bearing age, where onset of depression is known to peak. Based on a US report on gearing interventions towards ethnically diverse populations they selected a high risk group of women with a history of depression but not depressed presently. These women had high scores or at sub-threshold level of depression.

In total, 408 women were screened and 41 were eligible into the study. There were two groups, the intervention and control group. The intervention group underwent a twelve week mood management course based on CBT principles during pregnancy and four booster sessions at one, three, six and twelve months postnatal. The intervention was administered in Spanish or English to four groups of three to eight pregnant women, led by two group facilitators. Once again, this reflects the cultural

appropriateness of the intervention. A clinical psychologist, provided weekly supervision using face-to-face supervisory meetings and videotape review to ensure consistent adherence to the course content and to discuss salient sociocultural themes elicited by the participants; thus showing good research practise.

As stated earlier, the course intended to prevent depression not treat it. On average, seven sessions were completed and one out of four booster sessions were completed. In the control group, five (25%) out of the 20 developed postnatal depression and in the intervention group, three (15%) out of 21 developed postnatal depression. The study showed good ethical practise as alternative help to people identified with depression was provided. The course was culturally appropriate and sensitive as it was tailored to the needs of the target population and designed with a focus on the educational level, intra group cultural, racial and linguistic differences apparent in this group of women. The acceptability of the intervention was measured through a focus group. Randomisation procedures were used, reducing chances of selection bias. However, one of the rationales for delivering the intervention in a group format was to increase support but support was not measured? An educated sample was also used as women who were illiterate were excluded, thereby, limiting the generalisation of the results (Muñoz, Le et al. 2007).

1.7.3. Culturally adapted interventions for postnatal depression

The Thinking Healthy Programme (Rahman 2007) was based on a cognitive behavioural approach (Rahman, Malik et al. 2008), and particularly focuses on the here and now problem solving techniques. The intervention focussed on training health visitors known as "Lady Health Workers" in Pakistan with the "Thinking Healthy Programme".

The pre-intervention focus group indicated that an intervention should not only include the mother, but other members of the family too. In this intervention, most of the activities for infant development were directed towards the mother. However, these activities may not have been received so enthusiastically by the other members of the family, if maternal depression had been the focus of attention rather than infant development. This study emphasises that interventions targeting maternal depression in Pakistani women should be sensitive to family preferences, in order for the mother to receive support from the family throughout the intervention.

The results of the trial showed highly significant improvements in depression in the intervention group. This suggests that if the agenda for treatment is based on optimising the child's physical and cognitive health, then the intervention should include child centred activities such as baby massage and parenting programmes such as learning through play. A manualised intervention was developed that employed CBT principles to help depressed mothers during pregnancy and in the postnatal period. The intervention focused on problem-solving in the postnatal stage.

Rojas et al (2007) looked at ways to improve recognition and treatment for postnatal depression in developing countries. In their RCT, they compared the effectiveness of a multicomponent intervention with usual care to treat postnatal depression in low-income mothers in a primary care setting in Chile. They randomly allocated

230 mothers with major depression attending postnatal clinics to either a multicomponent intervention (n=114) or usual care (n=116).

The multicomponent intervention involved a psychoeducational group, treatment adherence support, and pharmacotherapy. Usual care included all services normally available in the clinics; including antidepressant drugs, brief psychotherapeutic interventions, medical consultations, or external referral for specialty treatment. The primary outcome measure was the EPDS score at three and six months after randomisation.

The results showed that 208 (90%) of women who were randomly assigned to treatment groups, completed their assessments. The mean EPDS score was lower for the multicomponent intervention group than for the usual care group at three months (8·5) compared to (13). Although these differences between groups decreased by six months, EPDS score remained better in the multicomponent intervention group than in usual care group (11) compared to (12·5). The decrease in the number of women taking antidepressants after three months was greater in the intervention group (59% to 36%) than in the usual care group (17% to 11%).

Some limitations of the study are that the EPDS was used to diagnose depression and this is not a diagnostic tool. The study relied only on one type of recruitment strategy which was through primary care and evidence discussed earlier suggests that minority groups often do not access primary care services for various reasons (Rojas, Fritsch et al. 2007).

1.8. The case for developing interventions for British Pakistani women with persistent postnatal depression

The literature suggested that women from South Asian backgrounds commonly present to their GP's with depressive symptoms. They had poor experiences of mental healthcare. British Pakistani women in particular showed high levels of depression. Compared to other ethnic groups, Pakistani women living in Pakistan and in the UK were also identified with high rates of postnatal depression. Their depression tended to be persistent in nature. Literature also provided support for the persistence of postnatal depression beyond the first postnatal year. There was a gap in research identifying British Pakistani women with persistent postnatal depression.

In order to be better informed about appropriate services and to meet the needs of women with postnatal depression, qualitative research methods have shown to be particularly appropriate in identifying dimensions of care and treatment that matter to health care recipients. These dimensions of care can be used to influence health care decision-making and treatments. Qualitative studies found British Pakistani women with depression had difficulties in the realms of marriage, housing, health, finances, and they lacked supportive relationships. Some of these difficulties were similar to those found in White Europeans but some factors were unique to this population such as language and cultural difficulties. No qualitative work on the explanatory models of British Pakistani women with persistent postnatal depression has been identified.

Postnatal depression has been identified as a treatable disorder (Cooper & Murray, 1998). However the treatment for persistent postnatal depression has not been identified. The importance of developing and evaluating treatments that may prevent the adverse infant outcomes has been discussed. A number of individual and group interventions targeting postnatal depression were identified, but in the majority White population. Only two culturally adapted interventions had been conducted with women with postnatal depression: The thinking healthy programme

in Pakistan (Rahman et al, 2007), and the multi-component intervention in Chile (Rojas et al, 2007).

Such trials in the ethnic minorities in the UK were not apparent in the current literature. This indicated a need for developing culturally appropriate interventions for postnatal depression in the UK. British Pakistani women have the highest birth rate in the UK, and are considered 'difficult to reach' due to language and cultural barriers.

Recent reports indicated inequalities in maternal health and a need for tailored maternity services to improve access to care for women from ethnic minorities. Suggested key projects included: to identify and spread best practice, to build bridges between services, and their local communities and to provide data on exactly what mental health problems women have and the sort of help and care they were being offered (Knight 2009).

The views of British Pakistani women on dimensions of care for persistent postnatal depression have not been identified. Currently, there is also a clear gap in research in developing and providing culturally adapted interventions for persistent postnatal depression for British Pakistani women living in the UK.

1.9. Aims and objectives

1.9.1. Aims:
The overall aims of the study were to develop and test a feasibility trial for British Pakistani mothers with persistent postnatal depression.

1.9.2. Objectives:

- The first objective was to explore British Pakistani women's explanatory models of persistent postnatal depression, their experiences of depression and the type of help they would find acceptable.

- The second objective was to develop and explore the feasibility of a culturally tailored intervention for British Pakistani women with persistent postnatal depression

- The third objective was to explore the acceptability of the intervention.

2. Chapter 2: Methodology

This section includes the methodology in four stages. Stage 1 consisting of the methodology for the qualitative study. Stage 2, consisting of the methodology for the development of the intervention, and testing the feasibility of the culturally adapted group psychosocial intervention. Stage 3 consisting of the methodology for testing the acceptability of the intervention.

2.1. Methodology stage 1: Qualitative study

2.1.1. Design

An interpretive approach was adopted (Ritchie and Lewis 2003) using qualitative methods to explore the views of British Pakistani women with persistent postnatal depression about their illness perceptions of depression and subsequently to inform the development of a culturally adapted intervention for future use with this group.

2.1.2. Setting

The study was conducted in North-West England. Participants were recruited from a high-density area of Pakistani-origin population in Central Manchester. The definition of ethnicity strictly required three out of four grandparents to share the same ethnic group and was also self-defined using census categories.

2.1.3. Selection criteria

2.1.3.1. Inclusion criteria

- Pakistani origin

- Participants over the age of 18

- Have one or more children

- Meet the criteria for mild to moderate current depression

2.1.3.2. Exclusion criteria

- Diagnosed physical or learning disability or psychosis.

2.1.4. Procedure

2.1.4.1. Ethical approval

The meeting for ethical approval took place in Manchester and my Supervisor accompanied me. As the chief investigator, questions were directed at myself about the risk management in the study and the procedures in place for clinical supervision. The impact of the length of the assessments on the participants was also inquired in order to assess the level of burdensome the assessments may have on the participants. These participants were from an ongoing prospective study and had undergone lengthy assessments in the last 18 months. Upon receiving satisfactory answers, the Local Research Ethics Committee and the University of Manchester (Ref: 08/H1006/46) approved the study. This letter can be found in Appendix 2. Written informed consent was obtained before the interview took place and the participants were reminded that they could withdraw at any time (Appendix 3).

2.1.4.2. Recruitment of participants

Purposive sampling was used to ensure that a full range of views and experiences were explored. British women of Pakistani origin from a larger study of maternal depression and infant health were contacted to take part in the current study. A total of forty-seven women residing in Central Manchester were identified as being depressed in their postnatal period. Out of the forty-seven women, eleven could not be contacted. The remaining thirty-six women were contacted by the research assistant from the MHIG project (SMK) around two years postnatal and they were given information about the current study, both in the format of a participant information sheet (Appendix 4) and verbally by the research assistant (SMK). Informed written consent was then obtained prior to recruitment. Once these women gave consent to take part in the study, they were screened for depression using the Edinburgh Depression rating Scale (EPDS). Participants who scored 12 or above on the EPDS were invited to take part in a diagnostic interview for depression, using the Revised Clinical Interview Schedule (CIS-R) (Lewis, Pelosi et

al. 1992). Eighteen out of the 36 women scored above 12 on the EPDS, which is the threshold for depression in this study, and met diagnostic criteria for mild to moderate depression. All eighteen women were interested in the project and were all thus asked to take part in a qualitative interview covering topics to understand Pakistani women's experiences of depression and ways of developing culturally tailored interventions for persistent postnatal depression. Three out of the 18 women could no longer participate and thus opted out of the study. The remaining 15 participants agreed to take part in the qualitative interview. For the recruitment process see figure 2.

Figure 2: Flow chart of recruitment for the intervention
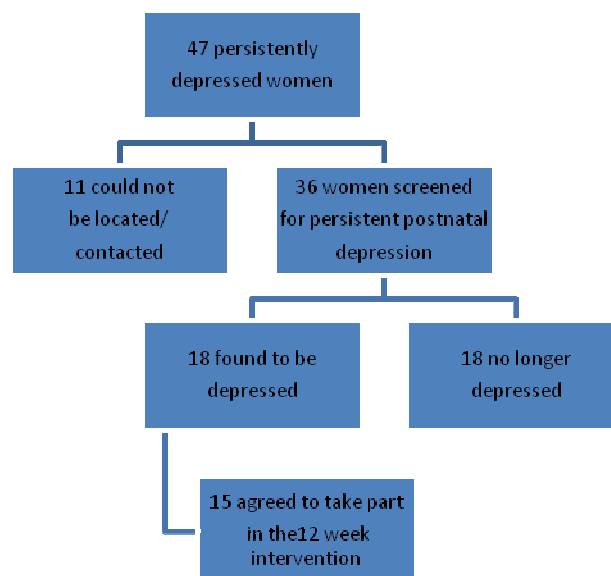
2.1.4.3. The qualitative interview

Fifteen face-to-face qualitative interviews were conducted between October 2008 and February 2009. An interview topic guide (Appendix 5) was developed by SK under the supervision of an experienced qualitative researcher (KL). The questions included in the topic guide were based on themes identified in the literature review. Key areas explored were:

1. Perceived causes of the persistence of depression and how the distress impacted the women's lives (Illness perception)

2. What help they had received for their depression (Accessibility)

3. The type of help they would like to receive (Acceptability)

The interviews were also supervised by KL. They were conducted in the homes of the participants, lasting approximately 40-80 minutes, based around the topic guide but responsive to issues raised by participants. Steps were taken in avoiding any model of illness. Following each interview, new questions which emerged as a result of the issues raised by the participants, were added to the topic guide.

2.1.4.4. Data analysis

All interviews were digitally recorded and transcribed verbatim. Data were analysed using the five stages of framework analysis: familiarisation of the data, identification of a theoretical framework, indexing, charting, and mapping and interpretation (Ritchie J and Spencer 1993) and managed on Microsoft Excel. Following detailed readings of the text a thematic framework was developed. The coding frame was applied manually to the interview transcripts and then pasted to the excel spreadsheets. Using the spreadsheets, two researchers (KL and myself) independently searched data samples by closely reading the transcripts for patterns, mapping connections and seeking explanations from these patterns. This process of developing explanations enabled us to look at relationships between codes. Findings were interpreted and re-analysed within the framework to distil the themes and sub-themes. The researchers then jointly developed a framework of three main

themes and ten sub-themes, and compared the experiences of depression in terms of causes, impact, and help needed. The framework was applied manually to all transcripts and lifted to a Microsoft Excel spreadsheet for charting, where key quotations were labelled and identified for later retrieval when reporting. Responses were anonymised and are reported using participant-assigned numbers, for example (P1). This procedure allowed us to develop an audit trail of the process of analysing the data.

2.2. Methodology stage 2: Development of intervention

The development of the intervention involved a process by which findings from multiple methods, data sources and theories were combined to obtain an in-depth understanding of the issues involved in designing and delivering the proposed intervention. My supervisors and I reviewed the synthesised data to select the theoretical approach most suited to the population that could be adapted in line with conclusions drawn from the data. This process relied heavily on the information obtained in the qualitative interviews. These interviews were conducted in order to find out the type of intervention that will be feasible and culturally appropriate for persistently depressed British mothers of Pakistani origin. The focus of the interviews was on finding the most suitable ways to deliver the intervention in terms of the setting, the name, the content, the duration, and the approach. The overall picture of depression reported in the qualitative interviews indicated that British Pakistani women perceived depression as a holistic experience. There was a range of factors described when talking about the persistence of postnatal depression. These will be discussed in the results chapter. However, it is essential to report them in this chapter in order to describe the process of how the intervention was developed.

Based on the qualitative interviews, four main areas needed to be addressed in the process of developing a culturally specific intervention. These were:

1. To address the sociocultural risk factors for depression in Pakistani women.

2. To target needs specific to the cultural group.

3. To design an intervention based on the culturally specific explanatory model of depression.

4. To reduce cultural barriers to engagement in treatment.

The sociocultural risk factors and specific cultural needs of Pakistani women were identified mainly using qualitative methods. Literature based on Pakistani women with postnatal depression identified the following requirements for a culturally adapted intervention (Rahman 2007). These requirements involve three levels, participant, delivery and facilitation, and the health system level. Rahman et al, (2007) devised the following requirements.

1. Participant = family level

- Should focus on overall maternal health rather than maternal depression
- Should focus on the identified maintaining factors for depression
- Should be active and empowering
- Should be skill based

2. Delivery and facilitation level

- Should be culturally sensitive
- Should be simple and pragmatic
- Should avoid stigmatisation

3. Health system level

- Should be evidence-based
- Should move away from 'medical model' to a 'Psychosociospiritual' model
- Should be community based
- Should be culturally adapted
- Should be cost effective

1. Participant level

- Many women, contrary to their families, viewed depression as a longstanding problem, requiring intervention. However, the lack of support and acknowledgment from their families often discouraged these women to seek help for their depression. Some women felt stigmatised to be labelled

depressed and felt if the intervention was packaged for overall health, as opposed to mental health, it would be more readily accepted and attended. Therefore, if efforts to achieve better health were an agenda, all key family members, including the mother, husband, the extended network of family and friends, would be more receptive towards the intervention. This agenda could provide a window of opportunity by which mothers (and their families) could be accessed for intervention. Within this shared agenda, differences could be put aside and efforts to improve the overall health of the mother could be addressed without much resistance or stigma.

- The risk factors found in the qualitative interviews should be incorporated into the development of the programme components. Each session should be designed to target a specific need found in the qualitative interviews.

- Changes in thinking and attitude had to be accompanied by changes in behaviour and action. Mothers must therefore not become passive recipients of advice but actively participate in seeking and practising health-promoting activities and the interactive exercises should be culturally appropriate and tackle persistent or chronic depression within the childbearing years.

- Women discussed managing their mood in a proactive manner. Therefore the intervention should include a skills based approach, involving teaching women practical skills to manage their mood. This should include a collaborative approach where women could learn and practise these skills in the sessions.

2. Delivery and facilitation level

- The women expressed that a culturally sensitive approach should be adopted in delivering and facilitation of the intervention. This should include having a well-informed therapist in terms of understanding cultural and religious practises, and showing sensitivity towards cultural norms and values.

- The intervention should be simple and pragmatic to carryout. It should be easy to follow. There should be tangible outcomes, which participants should be able to monitor. The contents of the intervention should be tailored according to the needs of the mother.

- The intervention should be called ''programme'' rather than ''therapy'', and the therapist ''facilitator'' rather than ''mental health worker''. This would avoid stigma and emphasise the active and non-medicinal aspect of the intervention. Under the facilitator's guidance, women would share in a group setting depression related problems and health-benefiting goals and desired outcomes. However, some of the women expressed a fear of openly speaking in a group. They wanted to know other people's experiences, but were reluctant to share their own stories. Therefore, for group exercises culturally specific case vignettes should be designed to enable women to identify with the characters and to reduce the pressure of speaking in a group about personal issues. Using the characters representing mothers, infants and other family members, the vignettes were also designed to help women identify problems in thinking and behaviour that might apply to their own situations. Issues such as stigma of attending a group for depressed women should also be addressed by using a non-stigmatising name for the group intervention.

3. Health system level

- Some of the well-known organisations working with British Pakistani women were contacted regarding the facilities they were providing for these women and their depression. A counselling approach was identified at most services by staff who had received minimal to no training, using counselling skills. Therefore, the intervention should be evidence-based to provide these organisations a manual based intervention with an evidence base.

- The most readily available treatment for depression reported in the qualitative study was antidepressant treatment and women expressed a desire to have access to alternative treatments. These women saw depression as a problem that caused not only mental distress, but also physical health and spiritual

problems too. Therefore, women showed an interest towards a more holistic approach to the treatment of depression and thus the focus moved away from a 'Medical model' to a 'Psychosociospiritual' model. The proposed intervention would rely on psychological techniques in a social setting with some focus on spirituality rather than pharmacological therapies.

- Social isolation has been found to maintain the depressive state. The literature review also pointed out social isolation as a risk factor for depression. Therefore a group format should be used to alleviate feelings of social isolation and psychological distress.

- The intervention should be culturally adapted based on the identified cultural needs. Therapies such as counselling were seen as 'western' by British Pakistani women. The intervention should be culturally appropriate. This could be achieved through careful field-testing of the intervention during the development phase. For example, if the intervention was to take place in a group setting during the afternoon, arrangements for a prayer facility should be incorporated on the premises. Careful considerations should be made of the timing of the group in terms of dropping off and picking children up from school, as well as leaving plentiful time for household activities to be completed before attending the intervention, in order to be culturally sensitive to the needs of family members.

- It should be cost-effective and easily accessible in terms of transport and childcare. Existing services for mothers with young children should be made use of in order to best utilise the funds available at these services, such as free childcare and room hire.

2.2.1. Development of the Positive Health programme

Based on the previously mentioned findings and the literature review of empirical culturally based therapies for depression, myself and my two supervisors who were experienced in developing culturally adapted and tailored interventions, chose Cognitive Behaviour Therapy (CBT) as the most suited approach that could be adapted for use with British Pakistani women. The 'here and now' problem-solving CBT approach was felt to meet the requirements reported above and in the qualitative interviews. Based on this approach, a fully manualised intervention called the Positive Health Programme (PHP) was developed. The key elements of this programme are outlined in the following table.

Table 5: Key elements of the Positive Health Programme (PHP)

Theoretical basis	Based on principles of Cognitive Behaviour Therapy (CBT)
Delivering agent	Minimally trained Clinical Health Research Facilitators. Mental Health Graduates such as Assistant Psychologists IAPT Psychological wellbeing Practitioners Intervention is simple enough to be delivered by anyone trained in mental health
Structure of intervention	12 sessions, each session approximately 60-90 minutes
Structure of session	Group welcoming and connecting, Introduction to the session topic, Group discussion, Engaging in skill based activities, Planning Individual goals and Homework setting.
Areas covered	Identifying the pressures and expectations of being a woman Understanding and managing self-esteem "Keeping up with the Joneses" Exercise, looking good and ways of building motivation Religion and spirituality Relaxation: "Taking time out" Assertiveness and confidence building Breaking Social isolation and building social networks Practising CBT and assessing change Developing relapse prevention plans
Tools	Group CBT based manual with step-by-step instructions for conducting each session Activity workbooks and handouts for mothers
Training	Ongoing training and development from clinical staff including a Senior CBT therapist and a Senior Psychiatrist
Supervision	Weekly supervision from a Senior CBT therapist
Additional features	Use of culturally appropriate vignettes to encourage group participation Use of Culturally appropriate behavioural exercises

2.2.1.1. Cognitive behavioural therapy for depression

Cognitive Behavioural therapy was also seen as the most suitable therapy to use as the theme of controlling irrational thoughts was quite prominent in the interviews. The relationship between thoughts affecting behaviour and feelings was understood well by these women. Some of them reported the vicious cycle of negative thoughts in the qualitative interviews and wanted to restructure the way they perceived their environment and the events that took place in that environment. The model that was used to demonstrate the role of thoughts, feelings and behaviour was the ABC model (Lang, 1979) of cognitive behavioural therapy (Beck, 1976). Figure 3 illustrates the model used for depression to explain the interaction between cognitions, behaviours, emotions, and physiological responses with an emphasis on social factors.

Figure3: CBT based Model of Depression

Past experience

Beliefs/Dysfunctional Assumptions/

Predisposing Psychological Factors

Social

Climate

Cognitions

Behaviours

Emotions

Relationships:

Marital, Family,

Social

Current Life

Circumstances

Physiological Responses
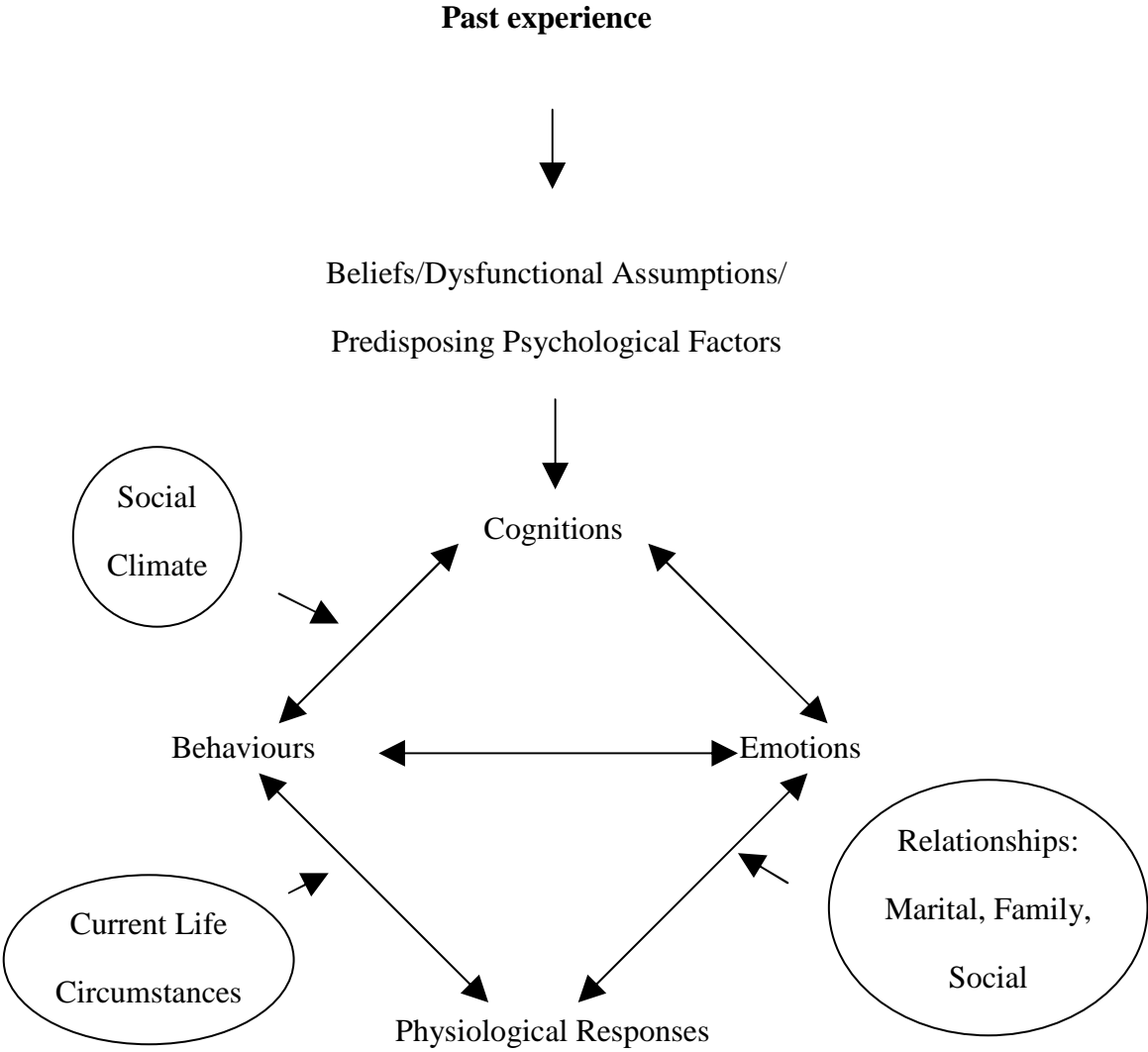
2.2.1.2. The five areas model within a CBT framework

The five areas model within a CBT framework (Williams and Garland 2002) was incorporated in this intervention as the factors described in the qualitative interviews fitted within the five areas model. The model provided a clear structure to summarise the range of problems and difficulties a person can experience in each of the following domains illustrated in figure 4.

Figure 4: The Five Areas Model of Depression
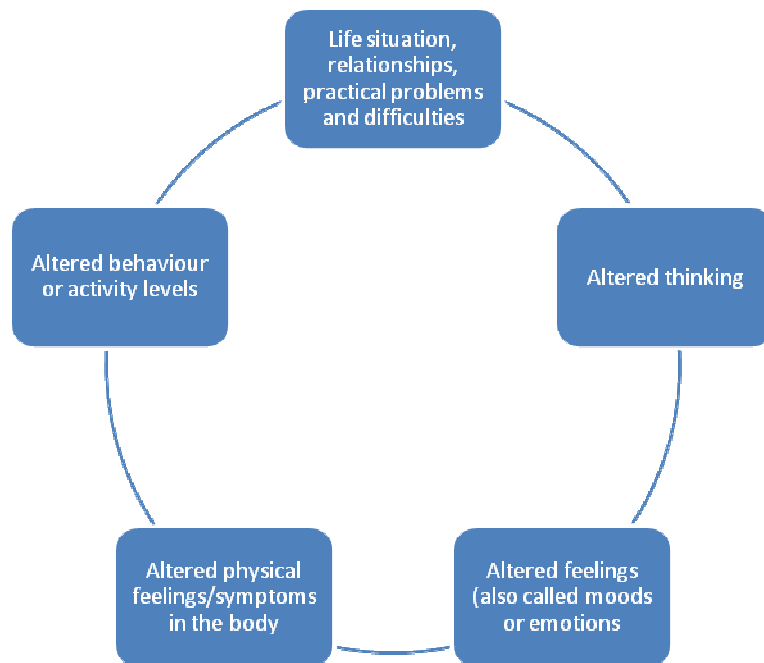
2.2.1.3. The role of the vicious cycle of depression

The role of the vicious cycle of depression was incorporated to be used extensively to describe the persistence of depression (illustrated in figure 5). The persistent nature of depression was described, by explaining the process in which physical and emotional feelings are coupled with extreme and unhelpful thinking styles. These unhelpful thinking styles can often result in reduced activity. As the thoughts become more negative, positive behaviour is reduced resulting in further negative thinking and reduced positive behaviour. The following example was included and was designed to be used in the first group session to explain the vicious cycle of depression.

Figure 5: An example of the Vicious Cycle of a depressed woman

Thought: 'I'm incapable of anything'

Tired
no appetite

Depressed
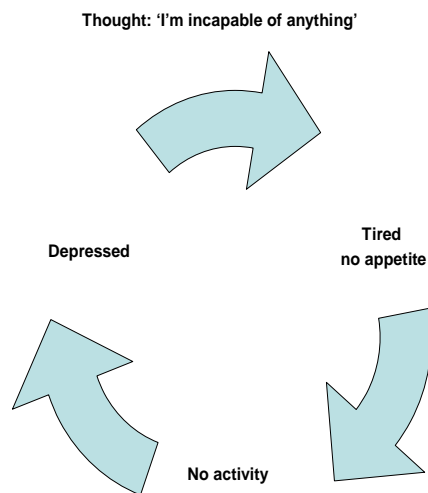
No activity

This example was used to explain the negative nature if depression, in that, negative thoughts lead to depressed feelings, lack of activity, and tiredness/loss of appetite, and are in turn reinforced by each of these symptoms. The symptoms on the bottom line also interact with each other in vicious cycles e.g. feelings of depression can lead to loss of appetite, while lack of proper nutrition is likely to leave the person more vulnerable to feelings of depression.

2.2.1.4. Cognitive triad of depression

Beck's (1979) cognitive triad in the following figure (figure 6) was also included to explain the maintenance of negative thoughts. The triad involves negative thoughts about: the self (i.e., the self is worthless), the world/environment (i.e., the world is unfair), and the future (i.e., the future is hopeless). It has previously been used in order to demonstrate the role of thinking in maintaining low mood (Beck 1979).

Figure 6: Beck's cognitive triad
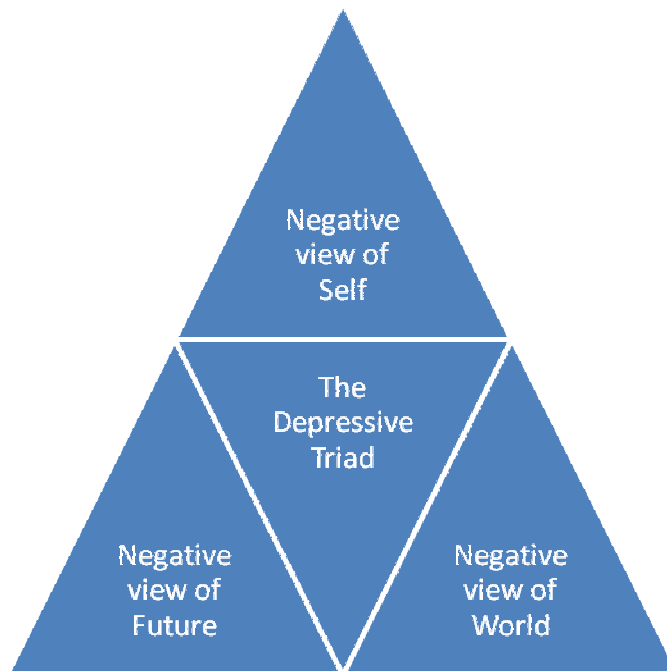
2.2.1.5. The application of CBT techniques in the intervention

Some of the techniques designed to be used in the intervention included: identifying irrational thoughts, making use of the dysfunctional thought records, setting realistic goals and doing homework, and using behavioural activation exercises as a way of increasing activity levels. A collaborative approach to recovery was used as well as the technique of guided discovery. An educational element was added to this intervention, to teach the British Pakistani women signs and symptoms of persistent depression and the impact of depression, in order to detect the early signs and symptoms of depression and to prevent future relapses.

In order to design a structured and repeatable intervention, a manual was needed. The idea of the manual was to provide the intervention facilitators with a structure and a format to follow in the sessions.

2.2.2. The development of the manual

The manual was developed and written by SK under the supervision of KL (a trained and experienced Professor and Cognitive and behaviour therapist) and was designed with a view in place that it was to be used by minimally trained research or clinical staff in the area of mental health. During this development phase particular emphasis was placed on ensuring that the intervention is culturally appropriate. As mentioned earlier, the theoretical basis of the manual included Cognitive and Behavioural principles using the Cognitive-Behavioural model (Beck, 1976). The manual was divided into 9 distinct sections that came up in the qualitative interviews, targeting areas that needed addressing in Pakistani Mothers with persistent postnatal depression. For example, qualitative interviews showed a lack of empowerment in these women and very low self-esteem and self-confidence. Based on this, the intervention pays particular focus on different exercises to improve self-esteem and confidence. Table 6 includes the key tasks for each of the 12 group sessions.

Table 6: Key tasks in the 12 Sessions of the Positive Health Programme

Group session	Key tasks
Session 1	Refreshments Group Introduction to intervention Setting ground rules Explanation to the origins of depression Persisting nature of depression Maintaining factors of depression Introduction to the principles of CBT
Session 2	Identifying daily pressures Expectations from self and others Lowering pressures and expectations using CBT principles
Session 3	Understanding and managing good self-esteem Identifying barriers or threats to good self esteem Ways of improving self esteem Identifying unhelpful thinking patterns and replacing these with positive self schemas Identifying culturally specific threats to self esteem
Session 4	Targeting negative feelings and beliefs resulting from comparing self to others in a better position Re-inventing positive feelings and beliefs about the self
Session 5	Describing link between exercising and feeling better Explaining the physiological benefits of exercising (i.e. production of endorphins in the brain reducing stress levels) Psychological benefits such as breaking the vicious cycle Social benefits such as making new friends. Practical exercises include identifying ways of incorporating exercise in the women's daily routine as well as building the motivation to exercise. Discussion on barriers to maintaining healthy lifestyle and ways of minimising barriers Behavioural activation exercises and motivational work.
Session 6	Discussion on subjective ideas of depression and religion Challenging negative or dysfunctional thoughts using factual information on a religious perspective of depression and its causes E.g. Guilt related concepts such as religious perspective on abortion, on looking after elderly parents, the role of past sins haunting present life etc.
Session 7	Managing time using time sheets to plan activities for relaxation Practising mindfulness techniques and breathing techniques for reducing anxiety or panic. Discussions on more further ways of relaxing Goals setting in order to incorporate time to relax in daily schedule.
Session 8	Discussion on assertiveness in terms of what it is and how to achieve Threats to assertiveness A group role play exercise demonstrating ways of being assertive Outline of benefits of being assertive as well as the costs of not being assertive
Session 9	Identifying social networks to alleviate distress caused by social isolation Ways of improving social support Building social confidence Threats to becoming socially active
Session 10	Measuring positive changes in lifestyle Identifying lack of changes and the barriers to making positive changes Practicing CBT skills Discussing challenges of using CBT skills and techniques and becoming comfortable with practising the techniques used in the intervention
Session 11	Introduction to relapse prevention plan Women identify early signs and symptoms of their depression Signposting to other available agencies Managing depression in the early stages of recurrence.
Session 12	Award Ceremony for the completion of the Positive Health Programme Free play session Women talk about what they have learned and intentions on using techniques in future. Session in a social setting (bowling game and lunch)

The Intervention Manual can be found in Appendix 6.

2.3. Methodology stage 3: The feasibility study

2.3.1. Study design

A within-groups before and after design was used. In this design instead of comparing two groups, a control and an experimental, you compare the same group before and after the intervention and so participants act as their own control.

2.3.2. Participants and procedures

Purposive sampling method was used. This is usually done for the purpose of selecting (not randomly) the individuals that will provide the best information for the study. The 15 women who took part in the qualitative study mentioned earlier were asked if they remained interested in taking part in a 12 week culturally tailored intervention for persistent postnatal depression. If yes, they were briefed by the Researcher (SK) about the nature of the intervention and were informed that they would receive a letter containing the practical details about the intervention, such as the dates, the details about the venue and car parking facilities etc. A flyer would also be included with information about the topics discussed in each session. The idea of attending this intervention was welcomed by 15 participants and the participants were reminded that they could withdraw at any time during the intervention. These women were assessed using the baseline measures administered by a trained researcher fluent in English and Urdu. The assessments took place in the participant's homes.

2.3.3. Assessments and measures

2.3.3.1. Primary assessments

As this is a feasibility study, it looks at the feasibility of the intervention in terms of accessibility and the acceptability as its primary measures. There were two aspects to the primary assessments. The first was the attendance relating to the accessibility

of the intervention. The second aspect was related to the acceptability of the intervention, which will be described in the next section.

2.3.3.1.1. The attendance procedure for the intervention

The accessibility of the intervention was one of its primary measures. It is measured by the attendance records for the group sessions. At the beginning of each session out of the 12 sessions, the group attendance was noted by one of the group facilitators. Those women who were absent were followed up after the session and the facilitator discussed the reason for their absence and made a note of the reasons in order to report them as part of the results of the intervention.

2.3.3.2. Secondary assessments

The women were assessed at baseline, end of intervention and six months after the intervention. The women were also assessed at four and eight weeks with the EPDS for depression ratings. All the measures were translated into the Urdu for participant's whose first language was not English and preferred to be interviewed in Urdu/Punjabi (the two most prominent languages spoken in Pakistan). The presence of depression was assessed with the Edinburgh postnatal depression scale (EPDS) a self-report measure, at baseline, week 4 and 8 of the intervention, end of intervention and 3 months after the intervention. The diagnostic interview for depression, the Clinical Interview Schedule Revised was also used only at baseline. Quality of life was measured using the EQ5D. Marital relationship was measured using the Dyadic Adjustment Scale, and social support was measured using the Multidimensional Scale of perceived social support. The HOME inventory was used as an observational method to measure mother-child interaction in the natural environment. At the end of the intervention the acceptability of the intervention was measured using the Brief adapted Verona Service Satisfaction Scale and eight semi-structured interviews. The methodology for the eight semi-structured interviews is described in the consecutive section.

2.3.3.2.1. Diagnostic measure of depression

The Revised Clinical Interview Schedule (CIS-R) (Lewis, Pelosi et al. 1992) was used in a structured interview format as the diagnostic tool for depression. This instrument has 14 sub-sections: somatic symptoms, fatigue, concentration, sleep problems, irritability, worry about physical health, depression, depressive ideas, worry, anxiety, phobia, panic, obsessions and compulsions. Scores for sub-sections range from 0 to 4. The ratings obtained at interview provide a score for each section, which together can be summed to yield an overall score. The CIS-R score may be analysed in three ways:

i. As a continuous score, along a single continuum of severity (Krueger, 1999)

ii. As a dichotomous variable (case threshold of 12) (Lewis et al. 1992)

iii. As ICD-10 diagnostic categories (Meltzer et al. 1995; Singleton et al. 2001).

The third option was used in this study. Diagnostic algorithms for use with the CIS-R cover depressive episodes classified as mild, moderate or severe. It is a valid and reliable assessment and highly standardised instrument, which has been tested internationally and can be administered by "lay interviewers". The CISR was used in the UK based Empiric study (Weich, 2004) with many ethnic groups, including first and second generation Pakistani women. It was also used to detect common mental health disorders by other UK based studies, Bebbington 2000, Bhui, 2001, Mumford, 1989 , Jenkins 2003, Gater et al 2010 etc.

2.3.3.2.2. Screening measure for depression

The Edinburgh Postnatal Depression rating Scale (EPDS) (Cox, Holden et al. 1987) is a 10 item scale used in the perinatal period. It was used to assess the severity of depression. It includes the assessment of the following symptoms: anhedonia, self-blame, anxiety, fear or panic, inability to cope, difficulty sleeping, sadness, tearfulness, and self-harm ideas. Responses are scored 0, 1, 2, and 3, increasing with severity of symptoms. The total score is calculated by summing all item

scores. The final score ranges from 0 to 30 with higher scores indicating greater severity of postnatal depression. This scale has been used with Pakistani women with postnatal depression in previous studies, Rahman 2008 and 2009, Husain 2006, Husain 2009 and 2010.

2.3.3.2.3. Measure for assessing quality of parenting and home environment

The HOME Inventory (Bradley and Caldwell 1988) was used to assess the quality of parenting and the home environment provided for a child. This inventory uses an interview and observation format to assess the social, emotional and cognitive support available to the child in the home setting. The HOME consists of 45 "yes" or "no" items divided into six subscales: 1) verbal and emotional responsivity of mothers, 2) avoidance of restriction and punishment, 3) organisation of the child's physical and temporal environment, 4) maternal involvement with the child, 5) provision of appropriate play materials, and 6) opportunities for variety in daily stimulation. The HOME instrument has been used extensively around the world in research studies and has satisfactory reliability. This tool has not been used in the Pakistani depressed population.

2.3.3.2.4. Measure for assessing marital relationship

Marital relationship was assessed using the Dyadic Adjustment Scale (Spanier 1976). This is a 32 item self-report measure of relationship adjustment. Four factors are reported: dyadic satisfaction, dyadic consensus, dyadic cohesion, and affectional expression. This scale has not been used in the Pakistani depressed population.

2.3.3.2.5. Measure for assessing perceived social support

Perceived Social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem et al. 1988). It is a validated 12-item instrument designed to assess perceptions about support from family, friends and a significant other. The scores can range from 1 to 7. A high score

indicates high levels of perceived support. In a UK based study of postnatal depression in Pakistani women, the Urdu translation of the MSPSS was found to have good construct validity, and the internal consistency (Cronbach's alpha) of MSPSS was 0.92 (Akhtar, Rahman et al. 2010).

2.3.3.2.6. Measure for assessing perceived health-related quality of life

Data on quality of life was collected using the EQ5D (EuroQol Group, 1990), a nondisease-specific instrument for describing and valuing health-related quality of life. It is often used as an outcome measure in both clinical and health care services research. The EQ-5D provides a descriptive profile of health related quality of life as well as a subjective overall rating of the participant's own health state on the day of administration by means of a visual analogue scale. In a UK based study, the EQ5D was used in the Urdu-language version for Urdu-speaking patients (Duddu, Husain et al. 2008).

2.3.3.2.7. Measure for satisfaction with support and treatment

The Brief adapted Verona Service Satisfaction Scale (Tansella, 1991) was used to measure satisfaction with support and treatment. Six items were extracted from the scale and tailored for this intervention and were collectively named "Satisfaction with support and treatment". This scale has been used in the previous MRC funded trial with British women of Pakistani origin (Gater, 2010).

2.3.4. Setting

The intervention took place in a Children's Surestart Centre in Central Manchester.

2.3.5. The CBT-based culturally adapted group intervention

The intervention consisted of 12 sessions. Women met at a Surestart children's centre for 12 weeks for 1.5 hours each week. The group was led and facilitated by two females of Pakistani family origin (myself and SMK). The lead therapist was a

highly experienced Cognitive Behavioural Therapist (KL) and I was the research therapist who led this group with some training in cognitive behaviour therapy and leading depression groups using CBT skills and principles. Regular supervision was provided by a CBT therapist and a Psychiatrist (KL and NH). The previously described manual developed for this group was used as a template for running the sessions and the topics discussed in each session are displayed in table 7. Crèche facilities were provided by the Children's Surestart Centre and transportation was also provided upon request. Regular supervision was provided by an experienced CBT therapist (Professor Karina Lovell). The group facilitator took notes on the content of the discussions in the group and participants were provided with handouts containing information about the session. The participants who were unable to attend any of the sessions were given a phone call to discuss their absence and were briefly informed about the topic discussed in the session.

The intervention did not take place consecutively for 12 weeks. School holidays and bank holidays were taken into consideration. The intervention took place on Friday afternoons from 12.30 – 2.00. It started with a warm welcome from the facilitators and group members were given 10-15 minutes to re-connect. Refreshments were provided for the initial sessions. However, the women opted to bring a dish themselves from session two onwards, each session on a rotary system. Only those who wanted to bring refreshments were on this rotary system and the remaining women were not made to feel obliged to bring something. This was also seen as part of the behavioural activation process for women who enjoyed cooking as these women saw this as an opportunity to start cooking again for pleasure and not as a chore.

Table 7: Topics discussed in the intervention

First session	Introduction Rules of the group Cognitive Behavioural Therapy and the ABC model of depression
All other Sessions	Identifying the pressures and expectations of being a woman Understanding and managing self-esteem "Keeping up with the Joneses" Exercise, looking good and ways of building motivation Religion and spirituality Relaxation: "Taking time out" Assertiveness and confidence building Breaking Social isolation and building social networks Practising CBT and assessing any change Talking about relapse prevention plans Award Ceremony for the completion of the programme

2.3.6. Statistical analysis

Friedman's K related non-parametric tests were performed to measure pre and post intervention scores on depression, social support, quality of parenting, marital relationship, and quality of life.

2.4. Methodology stage 4: The Post intervention study

This section looks at the acceptability of the intervention. It consists of semi-structured interviews of women who attended the group sessions.

2.4.1. The acceptability interview

2.4.1.1. Instruments used for conducting the interview

The researcher under the supervision of the Clinical Supervisor (KL) designed the questions for this semi-structured interview. The aim of the questions was to find out the women's views about the intervention.

2.4.2. Participants

Out of the fifteen women who took part in the intervention, eight women took part in these interviews. Three of the women had moved away after the intervention and could not be located. Three women discontinued to take part in the intervention due to practical problems such as committing to attending the intervention on a specific day and so did not want to be interviewed and the remaining one woman had health problems and was not able to take part in the interview. Out of the eight women who had time for the interview, four women had time for a long, detailed interview and allowed the interviewer to record the interview. The remaining four women did not want to be recorded as they felt the recording would stop them from openly expressing their opinion about certain aspects of the intervention. These four women did not want to displease the research team as they felt happy about the team, but not other aspects of the intervention, which will be later discussed in the results chapter.

2.4.3. Setting of the interview

The interview took place in the women's homes. The women opted this as the most practical and comfortable environment for them. These women expressed that there

was an added pressure in arranging child-minding facilities or bringing children to the interview in a new setting.

2.4.4. The interviewer

In order to counteract participant bias and interviewer bias, an impartial Psychology Research Assistant (UK) conducted this interview. The interviewer had not been involved in the intervention or previous assessments and this was the reason she was chosen to conduct this interview. The interviewer was bilingual and from the same ethnic origin as these women and was trained at Masters Level in Psychology. She was trained in conducting semi-structured interviews by the research team.

2.5.5. Procedure of the interview

The interview started with an explanation about the structure and duration of the interview and women were asked if they had any questions before the initiation of the interview. The first question was on the context of the intervention. Women were asked why they had decided to take part in the research study, with specific probes on benefits to their self or to others (i.e. helping the research agenda to find new ways of designing culturally appropriate interventions for Pakistani women etc). They were then asked about any barriers to receiving the intervention. For example, possible barrier may have been their uncertainty about attending the intervention or issues around confidentiality in the group, etc. Women were further probed when they discussed barriers and enablers to attending the intervention.

The women were then asked about the process of the intervention in terms of what their initial expectations of the intervention were and what they thought about accessing treatment in a group and how their therapy sessions took place and what they thought about the format and frequency of the sessions. The women were probed on how often and how long they thought the sessions should have been or whether they were content on the duration and the frequency.

The second set of questions was about the therapists. Women were asked about the qualities they liked or disliked about the therapists. Specific probe questions were around intervention factors such as goal setting, knowledge of the therapists, and non specific factors such as qualities of the therapists such as warmth, empathy, listening skills, and a non-judgemental attitude.

The women were then asked if they would have preferred to have met the therapist in a different way, such as telephone sessions or one-to-one therapy in a home setting; if so, why and what they thought might have been the advantages and disadvantages of meeting in different ways.

Questions were then asked about the handouts given in the sessions on 'Managing Low Mood'. Women were probed on the usefulness/non-usefulness, the relevance/irrelevance, helpfulness/unhelpfulness of the vignettes used, the choice of intervention techniques, the information on specific topics discussed in the sessions, the layout, and the ease of reading. They were also asked about how often they used the material, whether they read the handouts once or not at all, whether they read handouts throughout the intervention or a once off, whether the booklet added anything new in their lifestyle, and if they did the activities. If so, how often did they do the activities and which activities did they find useful.

The final set of questions was around the outcome of the intervention. The women were asked about how they felt after the end of the intervention compared to when they first started the intervention. The probes used were on mood or depression (depending on the term women preferred to use), functioning in terms of social, occupational, private, leisure, family relationships, and anxiety and stress.

The women were asked if they were finding it easier or more difficult to manage everyday life and their feelings at the time of the interview. Depending on the answer, they were then asked about what they thought might have accounted for

their present feelings. If the women were feeling better in their mood, they were asked if the change was specifically related to the intervention. If so, they were asked which specific aspect of the intervention led to the change; whether it was the booklet, the therapist, the group and/ or other factors such as change in circumstances, other treatments, or all of it. If the women were feeling low in mood, they were asked to report factors that may have contributed to their low mood.

Finally, the women were asked if they would recommend this intervention to a friend or family member who was experiencing similar difficulties and were probed on their answers on reasons for their response. The women were then thanked for their participation and for their time and information. The interview lasted approximately between 45 minutes to an hour.

3. Chapter 3: Results

This chapter presents the results of the qualitative study, as well as the feasibility and the acceptability of the CBT based group intervention.

3.1. Results of the qualitative study

A total of 18 participants who scored high on the EPDS and had a clinical diagnosis of mild to moderate depression were identified and invited to participate. Three women declined to take part in the interview due to work commitments and time constraints. Fifteen women were interviewed. The characteristics of these 15 participants are detailed in table 8. To summarise, the age range was from 23 to 41 years with a mean age of 33 years. The women had an average of three children, ranging from one to five numbers of children. Eight of the women were first generation Pakistani and seven of the women were second generation Pakistani. Twelve of the women were living with their husbands, two were divorced and one separated. At the time of the interview, 11 of the participants were housewives, two working fulltime and two working part time.

Table 8: The characteristics of the 15 participants

Participant	Age	Occupational status at interview	Number of children (n)	Marital status	Immigration status
1	27	Works Part-time	3	Married	First Generation
2	33	Housewife	3	Married	First Generation
3	40	Housewife	3	Divorced	First Generation
4	23	Housewife	2	Married	First Generation
5	38	Housewife	2	Married	First Generation
6	29	Works Part-time	3	Separated	Second Generation
7	29	Works Full-time	3	Married	First Generation
8	41	Works Full-time	1	Married	Second Generation
9	25	Housewife	1	Married	Second Generation
10	38	Housewife	5	Married	Second Generation
11	31	Housewife	2	Separated	Second Generation
12	30	Housewife	3	Married	First Generation
13	38	Housewife	3	Married	First Generation
14	34	Housewife	3	Married	Second Generation
15	38	Housewife	5	Married	Second Generation

Three main themes emerged from the data related to depression, and included:

- The perceived causes of persistence of depression
- The perceived impact of the persistence of depression
- Previous help sought for depression and the type of help required

3.1.1. Theme 1: The perceived causes of persistence of depression

All 15 women in this study clearly understood the term "depression" as a medical condition, often triggered by psychosocial and spiritual causes and were aware of the impact of depression on their lives. This may be due to their involvement in the previous study regarding antenatal and postnatal depression. None of the women used a medical explanation, for instance hormonal imbalance, to describe the persistence of their depression. Instead, a psychosocial model with spiritual explanations was used. The main social causes for the persistence of depression were a lack of support (10) and marital problems (8) social isolation (7), financial hardship (6), bereavement (3), which are in line with previous findings. The unique causes found in this study were low self esteem (4), punishment from God for past sins (3), having a disabled child (1) and a volatile maternal relationship (3). All four of the above mentioned factors were a direct consequence of women's negative relationships with family members, particularly with their husband.

3.1.1.1. Marital disharmony as a causal factor for the persistence of depression

Marital difficulties have been highlighted to a large extent in this study and specific help for marital problems is required. Poor marital relations equated to a lack of practical and emotional support and often resulted in physical violence. The women also expressed the need to stay in a poor marriage for the sake of their children's future and a lack of choice in terms of financial dependence on their husband:

"Basically he is very violent by nature. He could beat me up at any time. When he is stressed he beats me up, he beats me up at anytime. And he abuses me physically and verbally". (P3)

"I'm living with him for the sake of the kids. I've seen kids who grow up without a father. They can't seem to make a good life for themselves. They (children) are scared of their father and get some support from him. If I had found another

supportive man I would've long left him. When I see my life, I feel like throwing him out of the house before dark. But when I see him with the kids, I can't do that. He is there for them. Tomorrow if I separate and I can't provide for my kids and they astray, what will I do? If they start staying out till late, how will I discipline them, what would I do if they don't listen to me?" (P13).

3.1.1.2. Lack of support as a causal factor for the persistence of depression

Lack of social support has been reported as the most commonly associated factor of depression. A change in these women's family structure, from an extended to a nuclear system, may have contributed to the depression as all of the women in this study lived in a nuclear household, potential support networks may have been lost. Feelings of loneliness were often reported and the majority of the women had not shared their feelings with anyone in fear of disrupting the peace with their husbands:

"I'm not getting any support or the support that I need. People do come to me, help me out but I haven't got the support that I need. My mum just recently passed away in June. I've been really depressed since then. I've had no support". (P10)

"The depression started when I moved from Pakistan to here. I was pregnant at that time. It was my first pregnancy. I thought people cared about you, but they don't. There was no one to talk to. Just being alone all the time". (P14)

3.1.1.3. Spirituality and depression

Alongside social and psychological factors, spiritual elements were also perceived to contribute to the Persistence of depression. A previous study found that Black women were more likely to seek help from spiritual sources for depression than White women and perceived spirituality as a coping mechanism (Edge 2005). Notwithstanding, women in this study stopped their spiritual practices as a result of their feeling punished by God for their past sins. God was no longer seen as the source of support and women ended up with continuing feelings of remorse and persecution. These feelings can be seen as a perpetuating factor in the persistence of depression. The underlying mechanisms for the fear of punishment from God often arose from feelings of guilt for various reasons, for example, undergoing an abortion, rebelling against parent's wishes, and neglecting elderly parents. The fear of punishment and eternal suffering prolonged depressive symptoms of hopelessness and helplessness:

"Sometimes, I think I am being punished by God for what I did to my dad, making him upset you know, getting married without his will. That's why, even though I've got kids now, healthy kids, I'm still not happy". (P6)

"There's just an evil eye on this family, especially me. I used to be such a happy person but since I did that one thing (abortion) that's going to take me to hell, this is God's punishment to me. I can't get out of this web". (P15)

3.1.1.4. Financial problems

In line with previous findings from different ethnic groups (Husain, Creed et al. 2000; Rahman, Iqbal et al. 2003; Edge 2005) financial problems were seen as causal aspects of depression. Women described feeling persistently low in mood and stressed due to financial burdens. Their lack of financial contribution to the household caused these women to feel unworthy and disempowered, and this sometimes resulted in marital disharmony:

"Our financial worries make me sad. We are so dependent on my husband's brother. He supports us so much. All of this is from him. I sometimes wish that we didn't have to ask anyone or live on someone else's money. It's shameful in our community isn't it? So I do feel very sad and ashamed in front of my other relatives. I didn't ever imagine a life like this". (P2)

3.1.1.5. Volatile relationship with the mother

The link between parental maltreatment and increased risk of a chronic episode of depression in White women has previously been identified (Brown, Craig et al. 2008). Nonetheless, no study to date has identified this link in the Pakistani population. In this study, women spoke openly about the negative influences of their mothers on the persistence of their depression. Volatile relationships with their mothers and the mothers lack of understanding and denial of depression, led to many of these women suffering the effects of depression in silence:

"My mother has always been a big problem. She is very aggressive and angry. She treated her daughters like dirt, felt embarrassed of us in public and shouted at us in public. Slapped us and hit us and talked to us as if we were supposed to be treated this way. Emotionally, verbally she was very aggressive". (P8)

"I can only talk about my mum. If she sees me crying, she says, "Why are you crying? There's nothing wrong with you. You're just being yourself, you do this all the time, you cry for no reason, you're happy, you're here, you have a nice husband, and you have no major responsibilities like I did so pull yourself together". (P14)

3.1.1.6. Low self esteem

The role of low self esteem in the development and persistence of depression was also found to be an important factor. The reasons for having low self esteem varied from dissatisfaction with appearance to a lack of career achievements. Low self esteem due to negative marital relationship was also evident. Studies on White women suggest a link between low self esteem and poor marital relationships (Brown, Bifulco et al. 1990; Brown, Bifulco et al. 1990):

"He makes me feel bad about myself? Why am I so ugly that he doesn't want to know me, but it's been so many years now since we've been married. I was a confident person at that time, but over the years I lost it. Then I did a self-esteem course and that picked up my confidence but then I lost it again". (P10)

I just don't feel very worthwhile. I've struggled in life. I feel meaningless, unsubstantial. I feel I have no value, pointless, useless, everything about me. What have I achieved? It's almost as though I have lacked achievement. It just keeps coming back. It's constantly affecting my relationship, my work, it's affecting everything. It's constantly hovering around me." (P6)

3.1.2. Theme 2: The perceived impact of persistent postnatal depression

The participants reported several impacts of depression on their lives over the years. These were categorised as impact on psychological health, physical health, and their relationship with their children.

3.1.2.1. Impact on psychological health

The most commonly reported mood related symptoms were constant crying (11/15), guilt (9/15) and poor concentration (6). Other reported symptoms were loss of interests and hobbies, feeling angry, agitated, low in self esteem and confidence, hopelessness, overeating, poor sleep, panic, negative thoughts.

The crying was described as:

"It's like from inside I just want to cry, and spend the day crying you know. Even though nothing has happened, but I can't help crying. I cry and let things get on top of me." (P6)

"I cry a lot, and get agitated with the kids, not at the kids but just with myself and the situation." (P4)

"I just have a panic attack and cry it out. When it comes to migraines, I also cry it out or shut myself out and stay in bed." (P11)

The feelings of guilt were mostly around neglecting elderly parents, especially the mother and the lack of practical support these women offered to their mother:

"Recently my depression is about my mum's death. I can't get the guilt out of my head that my mum died when she was alone, I should have been there for her. I can't get these thoughts out of my head. (P10)

3.1.2.2. Impact on physical health

Women reported a range of physical health problems such as frequent headaches or migraines, back and shoulder aches, problem with joints, swelling of hands and feet, Vitamin D deficiency, anaemia, underactive thyroid, irregular heartbeats, and problems with pregnancies.

"The other major problem is migraines. The doctor say's it tension headaches, but I don't know what they are, when they start, I'm in agony, and then it's really hard to deal with the kids and the housework." (P2)

3.1.2.3. Relationship with children

The women stressed the quality of the relationship with their children was very important to them and was disrupted due to mood related symptoms such as constant agitation, unnecessary shouting, a lack of attention. Feeling angry and agitated particularly towards the children was also found in a study conducted with Indian women living in Goa (Rodrigues, Patel et al. 2003). As a consequence of the negative interactions between the women and their children, they perceived their children to exhibit behavioural problems:

"I take all my frustration out on my kids. I don't play with them, I even shout at them for no reason. I really want to be a good mother but I just can't seem to stop feeling depressed". (P6)

3.1.3. Theme 3: Previous help sought for depression and the type of help required

3.1.3.1. Previous help sought

The majority of the women expressed their reluctance towards taking antidepressant medication due to side effects and perceived anti depressants as "numbing the pain" rather than addressing the issue. Antidepressant medication was prescribed initially to 11 of the 15 participants. However, 7 out of the 11 participants were then offered counselling at some point. Four out of the 15 participants had never approached the GP for any type of help for their depression as it was seen pointless and the type of help that was available was not perceived as useful:

"I got treatment at that time, when I had my first child. I was really bad at that time. I was depressed all the time, just really bad. It got worse with my second child. They gave me some antidepressants. I didn't really take a lot of them. I didn't want to. I just didn't want to take any tablets." (P11)

"Doctors can't do anything. They just say here you go have some pills. For the panic attack they gave me some kind of depression tablets and I refused to take them because they're addictive and have side effects to them." (P11)

Out of the 7 participants who were offered counselling, only 3 attended the counselling sessions. The counselling was seen as helpful to an certain extent; however it lacked certain cultural knowledge sensitivity which in turn made all 3 of the participants not attend the full course treatment. These women emphasised the importance of having a therapist who was culturally trained or was from the same culture as them:

"The type of depression that we have is different. Our depression is different to White people. They don't have the same issues regarding family life and family feuds with the in-laws. For these issues, we have to deal with them ourselves, get out of the house, and talk to other people." (P12)

"My counsellor does tell me how to cope but she says things like, leave your husband. And I know she is right but I can't do that." (P5)

3.1.3.2. The type of help British Pakistani women wanted for persistent postnatal depression

The majority of the women favoured a group psychosocial treatment to reduce social isolation and to increase social support. Although women wanted the

treatment to have a supportive element, support alone was not seen as sufficient to overcome depression. These women expressed the need for a more directive and problem focussed approach. Help was required to improve self esteem and self confidence, to learn coping skills such as assertiveness, problem solving, time management, relaxation, anger management. The participants also wanted help with managing negative thoughts:

I would love that (group treatment), just to share your emotions with people, talk to people because I can't just go out there and talk to anybody. I can't find anyone who can mix with me". (P11)

"You need more problem focussed approaches that provide solutions. You should provide knowledge about the areas that are causing the problems." (P7)

The women also showed an interest in exercise, building social networks, practising religious activities and emphasised that religious activities should be incorporated in modern day psychosocial interventions. These women believed having faith in religion had previously helped them cope better in life, prior to the onset of their depression.

"We should incorporate practising prayers in the intervention, then read the translation of the Quran and try to follow what it says. Put some blind faith into God." (P13)

"I don't really know. I mean what can anyone do? I need to do something myself. I need to perform my prayers again. I used to be so good with my prayers before I got married. I used to feel at ease but now I've totally lost my routine." (P1)

"I think prayer is the best thing, I don't pray, I know I should. I feel really guilty about it. Prayer makes you feel good and it makes you closer to God." (P10)

The lack of family interventions for Pakistani families was strongly emphasised by women who were experiencing marital problems. These women highlighted the need for specific services for Pakistani men as they were seen as the main perceived cause of their persisting depression. According to these women, not enough is being done to engage Pakistani men into treatments for marital related problems.

"I think it's mainly these marriages. Because in our marriages everything stays within the four walls other people don't know what's going on. Even though at times when we have been screaming, the voices don't go outside." (P10)

"Our problem is not with ourselves but it's with the minds of men. Someone needs to sort them out. What's the point sorting us out, making us feel better when they will make us feel bad again?" (P11)

. "There should be more counselling services for men. A place where they can be advised on what to do. In what aspects they are right in and where they are going wrong." (P13)

The perceived barriers to attending treatment were lack of transportation to services, unavailability of childcare, language, workload, time of day, and mainly the husband. Over half of the women believed that their husband would prevent them from receiving any treatment for depression. Therefore, it was expressed that the treatment should be advertised to family members as a course for positive ways of coping with motherhood and the positive and beneficial outcomes for the children should be expressed more than the benefits to the woman alone. This was also suggested to eradicate some of the stigma associated with mental health issues and treatment for mental health problems. Therefore the women suggested a non-stigmatising name for the treatment.

"I mean if my husband finds out that this a group for women, he's not going to let me come to it." (P11)

"Yeah the husband, if he's having problems with her, he's not going to want her to get all strong now would he. Or his mum might not let her get out." (P15)

"There are still some people who think you are less competent if you are depressed and feel sorry for you and look down at you as a charity case. Because having depression means not coping with life, and some people think that you are not coping with life because you are a weak person. But sometimes circumstances can make you weak". (P5)

3.2. Results: The feasibility of the culturally adapted CBT based group intervention

3.2.1. Demographics

Fifteen women agreed to take part in the intervention. The demographics of these women are presented earlier in the qualitative results chapter in table 8. The following demographics (table 9) consist of the ten women who completed the culturally adapted CBT based group Intervention: Positive Health Programme (PHP). These 10 women were aged between twenty-five and forty and the mean age in years was thirty-three. Eight out of the ten women were married, with a mean number of years married as eight. One of the women was divorced and one was separated from her husband. The mean number of children was three, ranging from one to six. All of the women were housewives except for one who was working on a part-time basis. Half of the women were first generation Pakistani and the other half were second-generation British–Pakistani women. All, but two of the women could speak English, fluently. These two women could understand basic English but struggled with the more complex terms, which were explained to them by the bilingual therapist. All of the women were educated at least up to the GCSE level. Table 9 contains the demographical information.

Table 9: Demographics of the ten women who completed the PHP

Demographics of Participants who completed intervention (N=10)	Frequency	Percent	Mean
Age	25-40 (Range)		33
Marital status	1-16 (Range)		
Married	8	80	
Separated	1	10	
Divorced	1	10	
Number of Children	1-6 (Range)		3
1	1	10	
2	1	10	
3	6	60	
5	2	2	
Employment Status			
Housework	9	90	
Working Part-time	1	10	
Immigration Status			
First Generation Pakistani	5	50	
Second Generation Pakistani	5	50	
Highest Qualification			
GCSE or Equivalent	4	40	
A level or Equivalent	2	20	
First Degree	3	30	
Higher Degree	1	10	

3.2.2. Primary variables: attendance of the Positive Health Programme (PHP)

Attendance to the intervention was used to measure the feasibility and acceptability of the intervention. Table 10 displays the attendance to the intervention. The Positive Health Programme (group intervention) was designed to consist 12 sessions. However, session four was cancelled due to the unavailability of a room at the Children's centre. This session was incorporated in the remaining eight sessions. Out of the possible eleven sessions, six participants (40%) attended ten sessions, 1 participant attended 9 sessions (7%), 2 participants (13%) attended six sessions, 1 participant (7%) attended 4 times, 1 participant (7%) attended 3 times, one participant (7%) attended only once, and 3 participants (20%) did not attend any of the sessions. One of these three women was severely ill at the time the intervention started, one was in full-time work and the other could not travel to attend the intervention as she lived over 20 miles away from where the intervention was held.

Table 10: Number of group sessions attended

Number of Sessions Attended	Number of Participants (N = 15)	Percentage of participants
0	3	20%
1	1	7%
3	1	7%
4	1	7%
6	2	13%
9	1	7%
10	6	40%
Total	15	100%

3.2.2.1. Attendance of PHP completers

Completers were defined as women who remained in the study at the end of the intervention. The PHP was completed by ten out of the possible 15 women. However, not all of the ten women who completed the intervention attended every session. Sixty-percent of the ten women who completed the intervention attended ten out of the eleven possible sessions. The following table displays the attendance figures for these 10 women. The median number of sessions attended by the ten women who completed the intervention was 10 and the mean number of sessions attended was 8.

Table 11: Sessions attended by PHP completers

Number of Sessions Attended	Number of Participants (N = 10)	Percentage of participants
3	1	10
4	1	10
6	1	10
9	1	10
10	6	60
3	1	10
Total	10	100%

3.2.2.1.1. Attendance of session one

In this first session, none of the possible 15 women who had agreed to take part in the intervention attended. All of fifteen women were contacted via the telephone to enquire about the reasons for not attending the session. The following reasons (table 12) were given for not attending the group; six out of the 15 women reported health-related problems with themselves or to a family member which restricted them to coming to the session, three of the women reported prior commitments such as attending work and attending a fulltime course at college, one was involved in a car accident, one of the women forgot to attend, one of the women was on holiday, one was out celebrating her birthday with friends and one was busy preparing for her holiday. One of the women was not allowed to attend the group by her husband. At the request of this woman, the staff visited her home on three occasions to provide her husband with information about the intervention. Still, he resisted in his decision about his wife not attending the intervention and she withdrew from the study at this point. Another three women also withdrew from the study at this point due to various other commitments. Two of the women withdrew due to having work commitments and not being able to attend the group at the set time and day. Another woman reported having severe pregnancy related sickness and informed the researchers that she could no longer commit to the group.

Table 12: A list of reasons for not attending group session one

• Ill child (2)	• Involved in a Car accident (1)
• Ill themselves (4)	• Forgot (1)
- Flu	• On Holiday (1)
- Food poisoning	• Husband did not allow her to attend (1)
- Pregnancy sickness	
- Severe back pains	• Celebrating Birthday with friends (1)
• Prior Commitments (3)	
- Attending work (2)	• Busy with holiday preparations (1)
- Attending Higher Education College (1)	

3.2.2.1.2. Attendance of the remaining sessions

The attendance of the remaining sessions is detailed in table 13. By session two another woman who only attended this session also withdrew from the study. Her reasons for withdrawing were predominantly around 'not fitting in with the group'. She described experiencing the set of women in the group as, 'On a different level'. When asked to explain what she meant, she described the group to have a collective set of problems that were related to the Pakistani culture. She did not see herself as belonging to this culture and felt that the issues discussed in the group were irrelevant to her problems and decided to pursue therapy in a more Western form and preferably one-to-one as opposed to group therapy. By session three, there were ten women left in the intervention.

Table 13: Attendance of intervention

Session	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
Attendance of participants	Group = 0	Group = 10	Group = 9	Group = 0	Group = 9	Group = 8
	N = 15	**N = 11**	**N = 10**	**N = 10**	**N = 10**	**N = 10**
Reason for absence from group	Busy = 2 Car accident = 1 Forgot = 1 Holiday = 1 Husband = 1 Ill child = 2 Illness 4 Work = 2 College = 1	Ill = 1	Holiday = 1	**Group Cancelled- No room available**	Holiday = 1	House decoration = 1 Holiday = 1
Session	**Session 7**	**Session 8**	**Session 9**	**Session10**	**Session 11**	**Session12**
Attendance of participants	Group = 10	Group = 10	Group = 7	Group = 10	Group = 9	Group = 8
	N = 10	**N = 10**	**N = 10**	**N = 10**	**N = 10**	**N = 10**
Reason for absence from group			House decoration = 1 Ill = 1 Court case = 1		House decoration = 1	House decoration = 1 Ill = 1

3.2.3. Secondary variables

3.2.3.1. Depression

The Revised Clinical Interview Schedule (CIS-R) diagnosed nine out of the ten women with a diagnosis of mild depression and one had a diagnosis of moderate depressive episode at baseline, using the ICD-10 classifications for depression. Reduction of depressive symptoms was measured using the Edinburgh Postnatal depression scale (EPDS) at five different time-points, baseline, week four and eight of the intervention, end of the intervention and three months after the intervention finished. A highly significant reduction was found across the five time-points, X^2 = 30.1, df = 4, P < 0.01. At baseline the mean EPDS score for depression was 20 which reduced to 13 by week four and 10 by week 8. It dropped to half of what it was at week 8, which is 5, by week 12 of the intervention (table 14). The drop in depression scores remained consistent even three months after the intervention finished. The graph is displayed in figure 7.

Table 14: EPDS scores across five different time-points

Time-points	N	Minimum EPDS	Maximum EPDS	Mean EPDS	Std. Deviation
Baseline EPDS Scores	10	13	26	20	4.4
EPDS Scores at 4 WEEKS	10	8	22	13	5.1
EPDS Scores at 8 WEEKS	10	5	13	10	2.5
End of Intervention EPDS Scores	10	0	21	5.5	5.9
Three month post Intervention EPDS Scores	10	3	9	5	1.6

Figure 7: A line graph to represent the drop in depression scores across five time-points
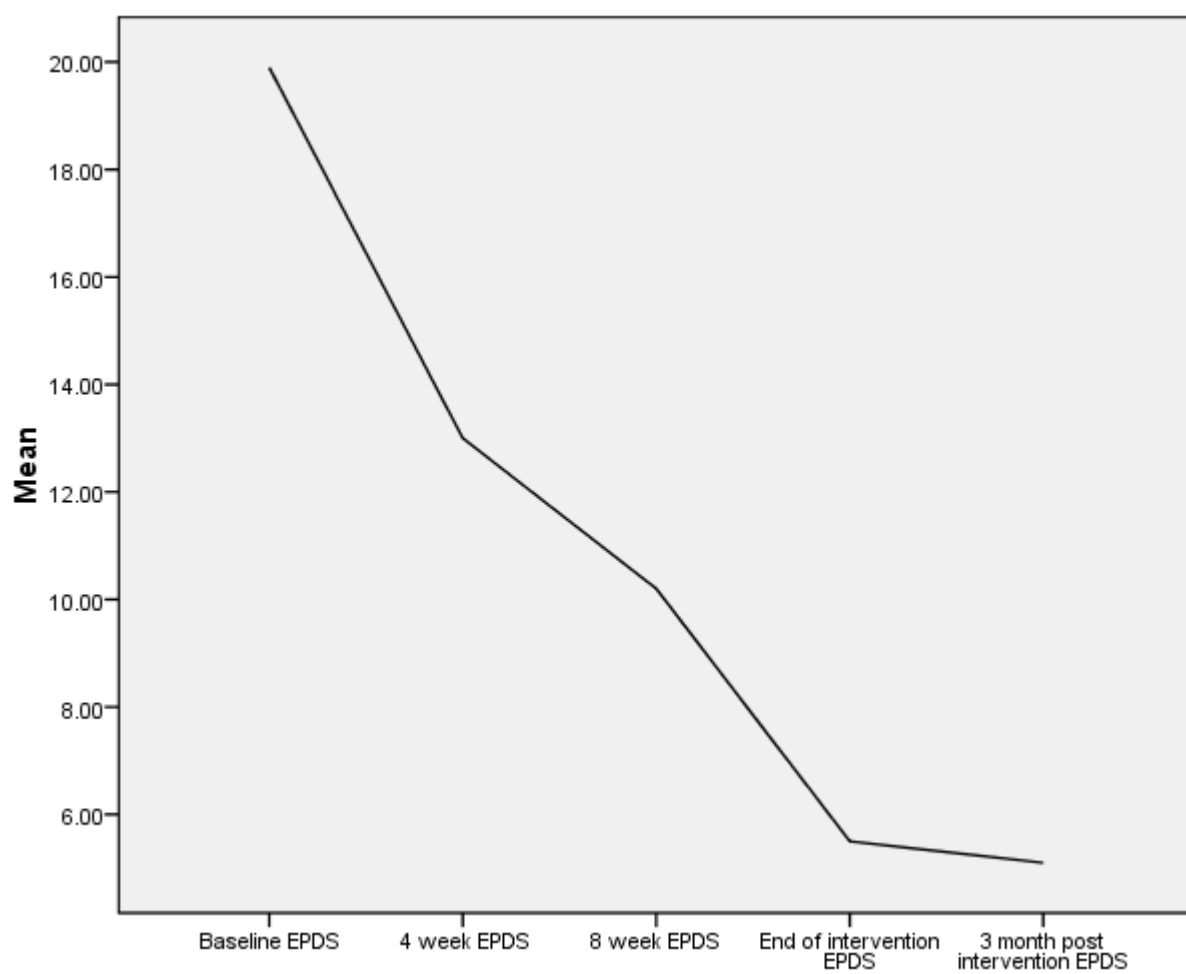
3.2.3.2. Quality of parenting and home environment

Significant improvements were also found in quality of parenting and home environment, $X^2 = 10.2$, df = 2, P < 0.006. With reference to table 15, in terms of the mother's responsivity to the child, women were scoring above the median even at baseline, which remained consistent across the three time-points. The possible score women could obtain for acceptance towards their children was 8 and the women in this study scored substantially below the median score of 6, matched it by the end of the intervention and sustained this score even three months after the intervention. Women scored above the median for organisation at the end of the intervention and once again the score remained above the median even three months after the intervention. In terms of providing learning material to their children, women scored nine out of nine at the end of the intervention but this dropped to six three months after the intervention. This was also noted with women's involvement with their children where the scores went up from three to six at end of intervention but dropped to five at three months follow-up. Women also jumped up the median score at end of intervention for providing variety to their children.

Table 15: Median HOME scores across three time-points

Subscale	Possible Score	Median	Baseline Median Score	EOI Median Score	3month Median Score
I. Responsivity	11	9	10	10	10
II. Acceptance	8	6	3.5	6	6
III. Organisation	6	5	4	6	6
IV. Learning Materials	9	7	4.5	9	6
V. Involvement	6	4	3	6	5
VI. Variety	5	3	3	4	4
Total Score	**45**	**32**	**28**	**41**	**37**

3.2.3.3. Marital relationships

Table 16 shows the improvements in marital relationships, as the higher the score, the better the marital relationship. A significant improvement in marital relationships was obtained, $X^2 = 8.97$, df = 2, P = 0.01.

Table 16: Mean Marital Scores across three time-points

Time-points	N	Minimum DAS	Maximum DAS	Mean DAS	Std. Deviation
Baseline DAS Scores	10	22	107	55	30.3
End of Intervention DAS Scores	10	22	117	78	34.8
Three month post intervention DAS Scores	10	22	112	76	32.1

3.2.3.4. Social support

Table 17 shows the means for perceived social support. No significant improvements in women's perceived levels of social support were obtained, $X^2 = 1.8$, df = 2, P = 0.407.

Table 17: MSPSS mean scores across three time-points

Time-points	N	Minimum MSPSS	Maximum MSPSS	Mean MSPSS	Std. Deviation
Baseline MSPSS Scores	10	26	58	38	9.2
End of Intervention MSPSS Scores	10	53	72	62	7.6
Three month post intervention MSPSS Scores	10	40	72	59	9.7

3.2.3.5. Health

Table 18 shows the mean perceived health scores. A significant improvement in health was also obtained, $X^2 = 18.5$, df = 2, P < 0.00. At baseline the mean percentage of health was 50%, which went up to seventy-two percent at the end of the intervention and dropped at follow three months follow-up to 68%.

Table 18: EQ5D mean scores across three time-points

Time-points	N	Minimum EQ5D	Maximum EQ5D	Mean EQ5D	Std. Deviation
Baseline EQ5D Scores	10	6	14	8.5	2.5
End of Intervention EQ5D Scores	10	1	8	6	2.0
Three month post intervention EQ5D Scores	10	0	5	1	1.5

3.2.4. Positive health programme sessions

3.2.4.1. Introduction to the Positive Health Programme

Women sat around a round table in a room consisting of refreshments and tea/coffee making facilities. They were given an opportunity to settle the young children in the crèche in order to relax and be comfortable during the session. The group members were introduced and ground rules for the group were set. A general introduction to depression was given by the lead therapist, as well as a brief description of the available treatments of depression. The principles of Cognitive Behavioural Therapy were introduced in very simple terms. For example, the women were informed about the persisting nature of depression and some of the factors that may contribute to the persistence. This was done mainly by focussing on factors such as the nature of irrational thoughts and the vicious cycle.

3.2.4.2. Identifying the pressures and expectations of being a woman

This session was about looking closely at the pressures these women faced in their daily lives and they were taught techniques to try to lower some of those pressures and expectations using CBT principles.

Some of the women discussed some of the activating events in Pakistani families that lead to negative beliefs and thoughts. For example, one of the women expressed that Family Politics in Pakistani families play a vital part in her persisting depression. This opened up the discussion leading to some more women identifying with this concept and sharing their stories. The common theme was that 'politics in Pakistani families will never go away'. Some women discussed how even when living away from the family in-law, there is interference in their own homes as most of these family problems are not left behind even after separating from the family in-law. Some women described the outcome of such experiences as becoming very angry and taking their anger out on other people, including their children. They also described how the 'in-laws' used tactics to put them down, for example, by being

derogatory about their physical appearance, or their cooking etc. According to these women, they were all part of 'power games' people play. For example; the comparing of one daughter in-law with another in order to encourage competition and conflict between them. The women said this caused insecurity in them and making them feel unworthy and low about their self and believing that nothing they do is good enough. We then discussed ways in which we can improve our encounters with the family in-law and alter behaviours in these situations towards more neutral or positive outcomes as opposed to negative outcomes. The task for the week, for the women who were experiencing this problem, was to avoid challenging behaviour by understanding the impact of the behaviour. We discussed some of the ways of thinking that could lead to more positive or neutral outcomes. For example, one of the women said she would like to maintain her relationship with her family in-law without becoming too emotionally involved with them.

3.2.4.3. Understanding and managing self-esteem

This session looked at barriers or threats to good self esteem, ways of improving self esteem and identifying the individual's unhelpful thinking patterns and replacing these with positive attitudes and feelings towards oneself. It specifically looked at culturally specific threats to self esteem such as volatile relationships with the family in-law, as discussed in earlier sessions, in the literature review and in the qualitative interviews, were found to be more prominent in South Asian cultures compared to Western cultures. A specific example is of one of the women, who talked about pressures of motherhood and womanhood. She described how she felt overwhelmed with the demands made by her children caused her too much pressure. She wanted practical support but had nobody to turn to. She felt particularly bitter about her husband who she forced to leave due to his drug abusing behaviour and the impact his behaviour was having on her home life. She discussed her negative self image, 'I am not a good mother' and the lack of self belief to survive this situation. Notwithstanding, she also disclosed that she had previously attended a parenting course and started going to a gym to improve her negative self image. Another woman talked about her negative self image and how that lead her to

attempt suicide twice in the past. Her thoughts about the situation were that she was only living for her children and had nothing more to live for in life. She described how her husband used financial threats to prevent her from leaving the physically and emotionally abusive relationship. Nevertheless, she found the courage to leave him and was at the time of the intervention, going through court procedures for a divorce. Her main problem at the time was the lack of self belief and self image. She considered herself to be a 'weak' person.

In both of the above cases, the remaining women in the group gave their input regarding their perceptions of these two women. They were presented with evidence which suggested contrary and more positive beliefs about them. For example the first woman was challenged on 'not being a good mother' and she was presented with evidence which suggested that she was a good mother. She was given examples which suggested that her behaviour was that of a good mother, such as attending a parenting course to improve her relationship with her two children and to manage child-related stress more effectively. Also the fact that she had, on her own, raised two children for the last six years without any practical, emotional, social or financial support. The women appraised the positive elements of her children and gave her an alternative positive view on how they perceived her as a good mother.

The second woman was also told that her behaviour is not consistent of a person that was 'weak' because the women felt it takes a lot of courage to end a marriage when there is financial insecurity. She was also appraised about her bravery to move on in life and once again she was reminded of the evidence which suggested that she was a strong and wilful person. These are only some of the case examples and a number of other topics were also discussed, such as negative body image, confidence in social settings, and marital problems and the impact they have on self-esteem, and feeling inferior to other people due to financial status.

3.2.4.4. 'Keeping up with the Joneses'

The qualitative interviews showed that some of the participants were striving to go up the social ladder and as a result, feeling a sense of hopelessness and despair from trying to keep up appearances. This session targeted negative feelings and beliefs that may have resulted from individuals comparing themselves to others who were in a better position and re-inventing positive feelings and beliefs about oneself. This also came up in the previous session as a threat to positive self esteem. We went into depth on this matter in this session and some of the reasons the women described that contributed to the struggle of moving up the social ladder were mainly around low self esteem and the social pressure to be 'doing well'. One woman described having financial assets as a message to others that 'we are doing well'. "It signifies survival, which leaves us in the safe zone. If people see us struggling, it gives them room to attack us in different ways, even if it means verbal abuse. It gives them room to talk about us behind our back, and that can cause embarrassment and loss of face in front of others in the community". Therefore, we discussed this concept of keeping 'face' or honour' and talked about the costs and benefits of engaging in such behaviour. The list of costs outweighed the benefits and we encouraged women to contemplate on ways of developing more positive beliefs about what they have rather than what they do not have. Another woman talked about her insecurities in terms of feeling judged by others, which often resulted in her wanting to achieve everything to not feel judged by everyone. The group discussed the impact of other people as a barrier to getting to know yourself better and finding out what pleases you as a person rather than what pleases others. They also talked about the intrinsic benefits of pleasing yourself and the boosting effect of this on mood.

3.2.4.5. Exercise, looking good and ways of building motivation

The link between exercising and feeling better was demonstrated by explaining the physical benefits of exercising such as the production of endorphins in the brain thus reducing stress levels, psychological benefits such as breaking the vicious cycle of negative self image and social benefits such as making new friends. Practical

exercises included identifying ways of incorporating exercise in the women's daily routine as well as building the motivation to exercise. The barriers in the way of maintaining a healthy lifestyle and ways of minimising these barriers were also discussed. Behavioural activation exercises were incorporated in this session as well as some motivational work. The group exercises included in this session were practical activities in the domain of the Pakistani culture. For instance, given the financial and social restrictions in this group, women were asked to make use of things that were readily available to them, such as walking the children to school opposed to going in the car to increase physical activity. Women were also told about some free television channels that featured different types of exercises, ranging from dance workouts, Pilates and Yoga to the more traditional aerobics and toning workouts. This was particularly welcomed by the women due its convenience of a workout in the house and not having to pay any expenses.

3.2.4.6. Religion and spirituality

The concept of depression being a punishment for past sins was discussed in numerous qualitative interviews. This group of women were quite practising in terms of religion and from the interviews it was quite apparent that they held a lot of subjective ideas of depression and religion. This session looked at ways of challenging negative or dysfunctional thoughts using factual information on a religious perspective of depression. What religion identified as depression and the causes of depression. Some of the concepts that were discussed in this session included the religious perspective on abortion, on looking after elderly parents, the role of past sins haunting present life etc.

All of the women agreed that depression was not a form of punishment for them. Conversely, one woman had previously disclosed that her depression resulted as a punishment for her past sin, an abortion. She remained quiet in the group until she found the courage to openly speak about the concept of abortion. The group therapist provided the group with some factual information about the religious

teachings on abortion and left it open for a discussion. Most of the women were positively surprised with the religious teachings and felt empowered by having faith rather than feeling judged.

Some women talked about Salat, the five times a day prayer which is obligatory in Islam. They discussed why they didn't perform their Salat and how it made them feel afterwards. Some of the reasons why they didn't perform their Salat were temptations from Satan, laziness and selfishness. It was important not to discard any religious beliefs, such as the temptations from Satan, as this is one of the reasons described in religious scripture about the nature of Satan and what he does. The women talked about the fact it is important that you perform Salat for yourself, not for others or when you have been told by others to pray, as this defeats the purpose of praying and diminishes the spiritual benefits of praying. One of the women discussed how most people, including herself, only pray when they are in despair or in need but never in periods of happiness. Some women included this on their behavioural activation sheets and decided to re-introduce Salat in their lives, as they acknowledged feeling sinful and only focussing on the negative aspect of not praying, rather than the positive aspects of praying, such as feelings of completing an obligation and thus feeling empowered.

3.2.4.7. Relaxation: "Taking time out"

This session included more behavioural activities than cognitive. Women were taught to manage their time using time sheets to plan their activities or just to take 'time out' to relax. Mindfulness based exercises were taught in this session as well as breathing techniques for anxiety or panic. Discussions on ways of relaxing took place and goals were set in order to incorporate some time to relax. Some of the goals included, going for a walk, making time to have a chat with friends and family over the telephone, watching general television or a favourite movie, gardening, doing meditation such as Dhikr (religious exercise involving the use of repeating religious words and different breathing exercises).

It was acknowledged in the group that this may be a difficult task to achieve, due to the busy family lives. However, looking at the benefits of taking time out, gave women the motivation to engage in this activity.

3.2.4.8. Assertiveness and confidence building & breaking social isolation and building social networks

The two sessions were incorporated into one. Assertiveness in terms of what it is and how to achieve it, and threats to assertiveness were discussed in this session. A group role play exercise was done to demonstrate ways of being assertive. The benefits of being assertive were discussed as well as the costs of not being assertive. The topics that came up had been discussed in previous sessions and we tried to practise some of the techniques or positive behaviours in a role play.

Ways of identifying possible social networks to alleviate the distress caused by social isolation and improving social support was discussed in this session. The women talked about their feelings and behaviours of social isolation and described being alone, trapped, sad, crying, miserable, guilty, not getting out, and staying in bed. When asked about why they didn't want to talk to anyone, women replied it was due to feeling stressed, hormonal, angry, having family problems and tiredness of looking after a baby. Some further barriers to achieving good support found were a lack of trust in friends, family politics, and low self confidence to join new networks of friends. One of the women described this as, "When you are feeling down, you push people away, and I pushed my family away". The women then discussed the physiological elements of feeling isolated, stressed and down, such as pains in knees, heels, back and shoulders. Women were advised to become more socially aware of their environment and look for opportunities and ways of building social networks. The benefits of having good social support was discussed and some of the women suggested that having someone to talk to allows them to release negative emotion, such as 'crying' and 'talking it out' and 'getting rid of loneliness'.

Social confidence was discussed and the threats to becoming socially active were also discussed.

3.2.4.9. Practising CBT and assessing any change

This session was about measuring the positive changes in lifestyle and also identifying a lack of changes and the barriers to making positive changes. It was also used to as an opportunity to practicing CBT skills. The challenges of using CBT skills and techniques and becoming comfortable with practising the techniques used in the intervention were also discussed.

3.2.4.1.0. Talking about relapse prevention plans

A relapse prevention plan was introduced. Participants were asked to identify early signs and symptoms of their depression. They were also informed about the contact points for help and how to manage their depression in the early stages of recurrence.

3.2.4.1.1. Award ceremony for the completion of the programme

Participants were given certificates for completing the Positive Health Programme for depression. This was a more free play type of session where women were asked to talk about what they had learned and how they intended to use these techniques in the future. The group session took place in a social setting where women went out for a bowling game and lunch.

3.3. Results of the acceptability of the intervention

Eight out of the ten women who completed the Positive Health Programme agreed to take part in the semi-structured interview. The remaining two women were not available to take part in this interview. One woman had gone to Pakistan to visit family and the second woman did not participate due to ill health.

3.3.1. Current feelings after the interventions

The semi-structured interview began with the question, "How are you feeling these days?" Almost all of the women (6/8) reported feeling a lot better since attending the PHP. Women reported improvements in their lifestyle by the active changes they had introduced since attending the PHP. These improvements were in building a positive self esteem (1), managing stress more effectively (1), learning to appreciate things more (1), feeling more control in life (2), feeling less stressed (2), adopting a positive view of life (1), exercise (1). Some examples of what the women said when asked this question are;

Example 1

"I feel very good. I didn't feel too bad before, just didn't understand why I felt so low without there being any reason. I had everything in life, but didn't feel satisfied. Now I have learnt to appreciate things more, things that I have and other people really want."

Example 2

"I'm feeling very good thank you. I feel I can manage my stress more effectively. Before, any little thing that happened, I would take it to heart, but now I try and see it from a positive point of view, then things don't seem too bad. You know, it's not the end of the world kind of thing. I also exercise more now because before I thought the only way to exercise is if you go out of the house like to the gym, but when in that session Sobia said that we have all these free ways of exercising, you know that channel on sky that she told us about. I tape the exercise session and then when I have free time, I do the exercise at home. That has really helped me because my weight hasn't gone up either, it's stayed controlled. Yeah, I guess I feel more in control of my life".

Two women reported feeling somewhat low in mood explained that this was due to the social isolation they had experienced since the group finished. They described the group as being a place for social support and since the group finished they

experienced feeling alone again. Both of these women were fairly socially isolated and were going through a separation period with their husbands at the time of the intervention. For example, one of the women said;

Example 1

"I'm ok, but then again you need support around you. When I was in the PHP I felt quite good. You know when you meet other people, you feel much better. You talk to each other and that makes a lot of difference. At the moment I'm just doing housework, running around. You need time for yourself too. I don't do much for myself and I keep positive for the sake of the kids". [When probed on why it was that she stayed positive for the sake of the kids and not herself, she replied], "My separation with my husband makes me feel this way, it gets me down, no matter how positive I try to be it still gets me down. I feel hurt, and being positive doesn't get rid of the pain, it still hurts".

3.3.2. Motivators to participate in the intervention

The second question was about motivators to participation in the PHP. Some of the women expressed it was to learn about mental health problems, in particular depression (4), the need to adopt a positive attitude and build self confidence was also expressed (1) and to be able to share problems and make new friends (4). Below are some examples of the type of responses to this question.

Example 1

"I thought that I needed some kind of therapy. I needed somebody to talk to me. I found that very helpful, when you have someone who can advise you and you can express yourself to them and they understand you. Someone who gives you guidelines, how to improve your health, adopt a positive attitude. So that helped me".

Example 2

"I just wanted to build some self confidence back in myself and experience something different and share my problems with different people and get to know people. Listen to theirs".

Example 3

"To learn about depression, you know what it is and why people have it because you know us Asians don't really know much about depression and don't really see it as an illness, like you see a real illness like cancer".

3.3.3. Barriers to attending the intervention

There were no major hindrances to social group participation in the present study. In the initial qualitative interviews, the women shared concerns about potential resistance from family members, particularly husbands. Therefore measures were

taken to reduce the husband's reluctance to allow the wife in attending the group intervention. One of the women reported time constraints as a barrier to attending the sessions. However, she acknowledged that that the time settings could not be suited to all of the members and she attended where she could and missed the sessions where the timing did not suit her.

A key factor encouraging attendance was the crèche service. All of the women stressed the importance of having a crèche available for mothers with children to attend any type of intervention. The crèche was situated next to the intervention room in order to make access to the children readily available. This reduced the mother's anxieties about being away from her child and also gave her the opportunity to check on the child whenever she felt she needed to. For example the following woman said:

Example 1

"There were no barriers but crèche was very good, it gave me time away from the children, which is very good when you are with them all the time. I guess I work too so I do get time away but I needed time away from work and home, and children".

3.3.4. Encouragement for attending the intervention

Some participants described their initial apprehension about the nature of the groups and the degree of disclosure that would be expected. However, the majority of the participants said they did not need convincing to attend the group. The following are examples of what some of the women said:

Example 1

"I just had to convince myself. I thought it would be better to go there and meet other women you can share your problems with and that did help me a lot because I don't meet anyone. I thought that was very nice."

Example 2

"Yes I did. I guess because you don't know who else would be there, if there was going to be other people there who you knew and then they would talk about you behind our back, but when Sobia said that we were not allowed to discuss what happened in the session, it made me feel more secure. Obviously, you can't stop people from talking, but the way I see it, we were all in the same boat".

3.3.5. Initial expectations of the intervention

The second part of the interview focussed on the process of the intervention. Women described their initial expectations as 'we would be working together to tackle our problems' and 'learn about positive thinking'. Most women enjoyed meeting other women, and particularly liked being in the company of others who shared similar experiences to themselves, For example,

Example 1

"I thought it was gonna be about sharing and understanding each others problems. Working together to tackle problems. Just knowing that other people, how they solved their problems. You do hear a lot of stories about this person had experienced this and that, but for the first time it was nice to see openly women talking about their problems and sharing them. It was a shock to know what the White therapist was saying about women's problems how similar that is to us. It does give you a lot of encouragement and strength when you get home".

Example 2

"I thought it would be helpful, and positive to see other people in similar situations as it helps you to cope with your own situation. My expectations were good."

Example 3

"I expected to feel like a part of a group that people would also want to make friends but they didn't, I felt they couldn't relate to me. I didn't know much about CBT so I wanted to learn about ways of making yourself feel better. But I knew my problem was loneliness and my husband, so I didn't expect much from the group".

3.3.6.1. Views on accessing treatment in a group

Accessing treatment in a group was welcomed by all of the women. Although, some women did express feeling anxious at first but overcoming the anxiety soon after the intervention started. One of the women thought that one-to-one therapy was more for introverted women.

Example 1

"At first it was a bit embarrassing to talk in front of everyone but then I found it good because when you start talking you realise someone has more problems than you. It was something to look forward to."

Example 2

"I liked the way it was all set out in a group. I found a bit insecure to talk about myself in front of others, but the group was genuinely a nice group and I did open up. I guess it was to do with the trust in the group that made me open up, the way people were and their body gestures."

Example 3

"I liked the fact that it was in a group. It gave me a chance to speak to other people other than my kids. It felt like the old days when I lived in my mum's house. I took the company for granted but I felt appreciative of the company I got from the group."

Example 4

"I really enjoyed being part of a group again, like in college when we had a group of friends. They were all very nice women, and I felt good in their company. All had very different personalities, but we were all the same because we had children, and we were married and similar age, so I could relate to most of the women. "

3.3.6.2. Views on format and frequency of group intervention sessions

The women did not seem unhappy about the venue for the intervention or the length of the session; however, a few women suggested that the intervention should take place once a month or something should continue after the sessions have ended. The suggestion was maybe to have the sessions staggered in order to wean the women off the social gathering and prepare them to initiate their own social gatherings, independent of the intervention group. Family pressure against engaging in outside of family and home activities was also insinuated by one of the women and she suggested maybe having the sessions once a month. She also suggested this as she felt meeting every week did not allow her to practise her homework and the techniques she had learnt in the sessions.

The session on self esteem was particularly liked by the women and many of them talked about how they benefitted from the session. The use of case studies to illustrate the debilitating effects of depression was also found very useful by women. The women who were going through marital problems perhaps did not gain as much from the intervention as those women who had more problems with their self, in terms of low self esteem and confidence, negative thinking etc. Some women with marital problems described feeling disconnected to the group due to the differences in their problems; whereas others described their approach to tackling marital problems changed due to practising CBT. Participants engaged in the trial because of the culturally appropriate format and content of the sessions. They felt reassured by the multilingual facilitators who were warm and understanding. The following are some accounts of what the women thought about the sessions;

Example 1

"The length was reasonable, and carried out very good, very informative. Talked about one case study and that was very useful. The case study described their depression, what someone is feeling and how depression affects them. Found the sessions enjoyable, it was depressing to know other people's problems but at the same time we had a great laugh. Just knowing what other people are going through helped me in terms of knowing that other people have problems too and how they managed them. For example, some people actually cried in the sessions, maybe they couldn't cry in front of their families, so the sessions were good in terms of relieving people's problems through crying. My self esteem was low at the time of the session but the session helped because I got a more positive attitude. I think this was a very useful session to have as we need good self esteem all the time being a mum or working or meeting other people, so it teaches people good coping skills. All the sessions were useful. Religion session was very helpful, many people are religious but inside our hearts we don't have the full belief."

Example 2

"The car pool was good, liked the length. It didn't seem too long, time flew because we enjoyed ourselves so much. It was great the way it was set out. It had different aspects or levels of situations people had experiences so it was good to sort it out step by step. I really liked the session on self esteem and religion. To talk about the self esteem first was really good because it made you get out of your shell and then tackle other problems. The CBT really helped me control certain situations. For example there are times when my husband wants me to retaliate back in the worst way but I control myself now, thinking about CBT, and walk away from it just to sort the situation in a much calmer way. Before the whole neighbourhood would've heard us screaming."

Example 3

"I learnt how to control my anger, I realised that there are other ways to handle your emotions and get your point across and get what you want done. You can do things calmly, for example, if I shout at the kids they don't listen to me, I get wound up, but if you ask them calmly they do eventually listen. By being angry I'm only working myself up and getting stressed, I don't benefit, so that is what I have learnt from the sessions. Before I used to get stressed and then let the stress out with anger, now I control the stress to control the anger. I wasn't like that before. I hope I stay this way. I think that people should be taught about CBT. I enjoyed meeting people. Once a week would be difficult but a session once a month would be great."

Example 4

"I think having therapy every week was too much because there isn't enough time, even though I really enjoyed it, I would have preferred it if it was every month. That gives you enough time to do the homework exercises we got and not feel pressured. Also family members can't complain about us going out if it is once a month.

Example 5

Sessions were great. I liked talking about different topics each week because you got a lot of new information, so you didn't get bored. I thought it was a good idea to talk about improving confidence because that's what a lot of us needed. Even confidence about making decisions, because in our culture a lot of the decisions about us are made by other family members, when we hit real life, we don't know how to make decisions. I also liked talking about taking time out that was really good. I never thought you could take time out without feeling guilty, for doing something for yourself, but now I do and I hope I can continue it.

Example 6

I felt like I wasn't really part of the group. I think I had very high expectations of the group, like a magic cure. I didn't feel like I belonged there. They all had husbands, I think one or two didn't, but the rest couldn't understand what it is like to be on your own, with the kids, struggling to make ends meet. I understood what Sobia was trying to tell us about positive thinking, but I just couldn't do it. I tried but I couldn't. I just want a husband who is there for me and good to me, a father to my girls. So even when I tried to think positive about the situation, it didn't change it. Everyone else in the group had, what I didn't have, a complete family. So I felt people's views and opinions were very different to me.

3.3.6. Qualities of the therapist

The women appreciated the therapist's understanding of the sociocultural context and the ability to explain the nature of CBT and depression in very simple terms. The cheerful nature of the therapists was also useful in terms of reducing the anxieties women had and made them feel calm and relaxed about attending the intervention. The women expressed a sense of feeling important and equal to the therapists. To come across as non-judgmental and on a similar level of authority was expressed as an important quality to have in a therapist. It also seems important to show a good level of commitment to the intervention in order for the women to feel that they are participating in something that is valued by the team members such as the therapist.

Example 1

"She [therapist] was amazing, someone who you can feel very comfortable with. Very cheerful. That was very helpful for me as I needed someone who was cheerful as I would be feeling very low before I went to the session but she would cheer me up. If she wasn't good, I wouldn't have gone. Even the way she kept in touch with everybody, was very good. There were occasions when she didn't have to but she still did. There are no qualities that I didn't like."

"I loved her, she was absolutely brilliant. She made you feel so important, just by taking an interest in your life. At first I thought she was a bit snobby, but that was my own fault. I thought what would she understand about my life, she doesn't sit at home and look after kids but when I got to know her, she was very similar to us. Like she knew our boundaries, you know, what is expected of us as women, and wives and daughters. So when she gave us group tasks, she always made sure it was something that we Pakistani's could do. For example, she gave us confidence to make the first move in making new friends not by joining new classes or groups, but just making use of what we already had, like the kids school. I didn't have the confidence to do that before. Even when I went to surestart, I wouldn't engage with the other mums, but now I do."

Example 3

"Oh she was like an angel. Just brilliant. She really knew how to make you feel good and fun. How she made such a sad and emotional topic so fun, I don't know. We need more people like her, with her enthusiasm, who don't treat us like patients in a therapy group, but real people with real problems. She didn't treat the group like a job, instead she treated it like something that she felt very strongly about and gave it her 101%."

The women had no problems with the way they met, which was in a group format. One of the women would have liked to have met her therapist as the first point of contact after her children were born. She felt it may have reduced the chances of her becoming postnatally depressed if she had met a warm and informative midwife instead of the midwife she had met who was rushed and showed no interest in the mothers' mental state after a traumatic caesarean section.

3.3.7. Handouts

The handouts were generally found useful and especially the content on CBT. Some of the women found the handouts a little confusing and hard to understand. The illustration of problems through stories or vignettes was highly appreciated by women as they described the stories as similar to what they have heard or experienced previously. This helped them to connect or relate more to the stories and use it in their learning process for depression and how to deal with depression. Below are some examples of what the women said.

Example 1

"I thought they were a bit confusing at first, but then when I got a moment to look through I did find them useful. I do refer back to the handout when I am very down, then it brings me back on track. They were easy to read, it is consistent with the sessions. I found the case study useful, there was one case study that reminded me of my auntie, which made me a bit emotional, but then again also reminded me that other people have problems too. It makes you want to share your own

problems, it's a good way of getting into your mind emotionally. The leaflets also gave info about exercise activities, which I found very useful."

<u>Example 2</u>

"I find it easy to implement on the things written in the booklet. It tells you how to divert you're problems, how do you deal with it. I used to be very insecure about the future, but now I have made myself more confident and more in control of my life."

<u>Example 3</u>

"I found the booklet useful because it had examples of other women in there, the stories. I really liked the stories because you know people who are also going through similar things, which is why it is meaningful. I learnt through the stories, what bad time women are having, so made me appreciate my life more."

3.3.8. Present mood

In order to find out about the outcome of the intervention, women were asked specifically about how they were feeling in terms of their mood, low mood or depression, functioning (social, occupational, private, leisure, family relationships), and anxiety and stress. A boost in confidence was the most frequently reported change by the women. Changes in more engagement with children such as playing and going out together, were also reported. The examples below indicate the positive change experienced by most of the women who took part in the intervention.

<u>Example 1</u>

"I felt very panicky and very stressed quite often. After the therapy I felt very relaxed and it helped me to calm down. My relationships have been good but with my eldest daughter, it's been hard with her, there's been other family problems that have affected her. But as I said, I am calming down now, so that helps her to calm down she is not reacting as much. I was passing on my problems to her and so she would react to them. I feel socially confident and have controlled my anger, and have a more positive attitude, and feel less stressed and panicky. I plan leisure activities more for myself as well now. I am going to buy some exercise mats from Tesco to do more exercise now."

<u>Example 2</u>

"I feel quite good. I've realised I've got to do things for myself. I make time for the family, but take time out for myself too. It's like most of the time you avoid going out, but with these sessions I really thought this is something I really have to go to, so I would look forward to it and plan it all. My relationship with the kids is ok. Socially, I feel more confident. I used to avoid people and going out, but now I do go out and take the little one. For example there was a children's group down the road, I never went there before but yesterday I did. I liked it, played in the crèche with the little one, and would never have done that before, now I have a confidence boost."

Example 3

"I feel like a roller coaster, because of my own problems but now I think I can manage better. It's bought my confidence back, my self esteem. You can see where you are going in the future. I have actually written in my booklet where I want to be in my future so it really has helped me in that way about planning my life. I react in a different manner than I used to before. My relationship has really improved with my daughter, I am much more involved. Social life is getting there, I used to ignore my friends phone calls, but now I go out for a walk in the park, just getting out of the house. Before I sat at home...for example, if you compare this to the way I was you would be shocked. I would never sit in front of anyone without my face plastered with makeup, but now I have no makeup on in front of you and I feel ok. That's because my self esteem has improved. I have accepted myself the way I am. In some ways my confidence has increased too and I go out more. My relationship has slightly improved with my partner. I talk in a calmer manner. I've controlled my poor eating habits."

Example 4

Pretty much the same. I still have self doubts, but I have stopped crying now. I don't cry as much as I used to. With the CBT, I have got a bit of a wakeup call, and I do make more of an effort now for my children.

Example 5

 "I feel fantastic. I have lost a lot of weight [three stones], and this is one of the things that used to make me feel so bad about myself. I don't second guess what other people think about me because it doesn't really make that much of a difference to me now. I believe people when they are complementing me on my weight loss, before I would never take the credit for anything but now I feel proud of my achievement. I just feel a lot more relaxed. Everyone has noticed these changes in me. My kids play with me now, or let's say I play with them. We go out more and do more things as a family."

3.3.8.1. Managing life

Most of the women reported managing their everyday life more easily than before. One of the women, (who has been previously mentioned with regards to not achieving much from the intervention, due to ongoing marital problems) expressed that she was feeling low since the intervention ended as she benefitted not from the CBT but the social aspect of the intervention.

Example 1

"I'm finding it easier. Before I used to think things will never sort themselves out, will take longer, but now I've been feeling a lot more patient now. I'm waiting for things to happen, more positively, and they are happening. It's also part of our religion, so that is helping now."

Example 2

"Half and half. If I do feel low now, I talk to people or look through my booklet, whereas before I would just hideaway and not face the problem."

 Example 3

"I'm ok. I think I'm managing very well. The thing I find easier to manage now is to control my anger; before if my husband said something which I didn't like, I would always take it negatively. Now I try and think in a more positive way and sort of try and see the opposite side of what he is saying and why. That helps me, because I can get rid of the negative thought and this avoids getting angry."

Example 4

"Much easier since I got rid of the negative thoughts. I can't say I got rid of the thoughts, because they do come back but I have learnt to control it. It was really funny, we had to do a group task where we wrote down one negative we all had all the time, and the person next to you had to say it aloud in a funny voice. It was a way of making fun of the negative voice and not taking it so seriously. That really helped me. I also feel more confident now. I don't hide away from my problems, I move forward and make decisions. I go out more, try and look good, express my feelings more rather than keep them in my heart."

Example 5

A bit harder, now I have no one again. I needed that interaction with other people. So I feel quite down again.

3.3.8.2. Reasons for change

Positive thinking and being part of a group were reported as the most frequent responses to why women were feeling better now than before.

Example 1

I think the positive thinking really helped. I even bought a CBT book which I read a lot, when I am feeling down. I really enjoyed meeting new people, you know other mums who also felt down like me. I mean some of them had a lot more problems than me but still, I understood what they were saying.

3.3.9. Recommendation of the intervention

All of the women said they would recommend this treatment to others. The positive effects of the group on others in the participants' lives were also reported. Therefore, women who were not attending the intervention, such as friends and family members, were also learning about CBT and the topics discussed by the women in the intervention. They were sharing their learning with others and encouraging change in others too.

Example 1

"I would definitely recommend it to my sister and my mum; they even wanted to come then. Even without them going and me just teaching them what I have learnt has really helped them. I think there should definitely be these groups."

Example 3

"I would definitely recommend it to a friend. I even recommended it to the lady at surestart. I told her that there's a Pakistani lady who works with women with depression and CBT and her group was so good and that they should also ask her to work with their service."

3.4. Findings from the brief adapted Veronica Service Satisfaction Scale

At the end of intervention, women were given the short adapted Verona Service with Satisfaction Scale. The results from the scale (in table 19) showed that all of the ten women who completed the intervention were satisfied with the service they were provided. Five out of the ten women said they definitely got the support and treatment they wanted and the remaining five said they generally got the support and treatment they wanted. In terms of the effect of the treatment in helping to relieve their symptoms of depressions, six reported feeling satisfied and four reported being very satisfied. With regards to feeling relieved from other problems, five were very satisfied, four were satisfied and one was not satisfied. The questionnaire output supports what was said in the semi-structured interviews about recommending the treatment to others. All of the women said they would recommend this treatment to others. Seven out of the ten women reported that all of their needs were met by the intervention. Two said almost all of their needs had been met and one said only a few of her needs were met by this intervention.

Table 19: Satisfaction with service

(N = 10)	
Did you get the kind of support and treatment you wanted?	**Yes Generally = 5** **Yes Definitely = 5**
How you feel about the effect of the support and treatment in helping to relieve your symptoms?	Satisfied = 6 Very Satisfied = 4
How you feel about the effect of the support and treatment in helping to relieve your other problems?	Not satisfied = 1 Satisfied = 4 Very Satisfied = 5
If a friend were in need of similar help, would you recommend this support and treatment to her?	Yes I think so = 4 Yes definitely = 6
Have the services you have received helped you to deal more effectively with your problems?	Yes they helped somewhat = 6 Yes they helped a great deal = 4
To what extent has the helped you received met your needs?	Only a few of my needs have been met = 1 Most of my needs have been met = 7 Almost all of my needs have been met = 2

4. Chapter 4: Discussion

This study, to the best of my knowledge, is the first in the UK to specifically explore British Pakistani women's experiences of persistent postnatal depression and the first to design and carry out a feasibility trial of a culturally adapted intervention for persistent postnatal depression. This chapter will begin with discussing the findings from the qualitative study and then moving forward to discuss the results from the feasibility study in terms of the feasibility and acceptability of the intervention.

4.1. Results of the qualitative study

The results from the qualitative study highlighted the role of many psychosocial factors associated with the persistence of postnatal depression and demonstrated the debilitating effects of untreated depression. These accounts show how persistent postnatal depression impacted these women in different areas of life such as relationships, health, and future prospects.

4.1.1. Explanatory model of depression

The results also suggested that depression was described by women as a reaction to negative life events with a psychosocial explanatory model rather than a biomedical model. In stark parallel, a similar finding was found amongst Black and White indigenous groups (Edge 2005; Chew-Graham, Sharp et al. 2009). Furthermore, past studies had also highlighted a certain disposition amongst South Asian to employ such psychosocial explanatory models in part due to the lack of perceived social stigma associated with them (Savarimuthu, Ezhilarasu et al. 2009). However, Oates et al (2004) found that British South Asians also mentioned hormones as a cause of postnatal depression. The perceived causes of distress shared by the women in this study were similar to previous findings of British Pakistani women (Gater, Tomenson et al. 2009; Gask, Aseem et al. 2010) such as low social support, marital difficulties, financial hardship, past stressful life events, and poor physical health (Husain 1997), those reported in Pakistan (Rahman 2003; Husain 2006) and

those reported in the Western culture such as poor marital relationship, social isolation, financial hardship, bereavement (Brown 1987). In addition to the previously mentioned causes, low self esteem was reported for the first time in studies with British Pakistani women, and a divine punishment from God has not been reported elsewhere.

4.1.2. Low self esteem

Low self-esteem has been reported as a risk factor for developing postnatal depression in the West (Villegas, McKay et al. 2010) but not mentioned in studies from the developing countries. One possibility may be that self-esteem is perhaps not identified in women in developing countries such as Pakistan, and may require further exploration. Some of the British Pakistani women in this study attributed their low self-esteem to weight gain. This was also found as a cause of unhappiness in the Oates et al (2004) study but with European women and not the British Asian women. The British Asian women in their study attributed a lack of food and losing weight following birth as a cause of unhappiness, and attributed an adequate supply of food as a source of happiness. The Oates et al (2004) study took place almost a decade ago and based on their findings, the results of this study may indicate a type of cultural shift within British Pakistani women. Most of the women in the current study reflected the unhappiness of the European women in the Oates et al (2004) study with regards to gaining weight.

4.1.3. Support

Around half of the women described suffering from persistent postnatal depression related to lack of social, emotional, and/or practical support following the postnatal period. This was experienced more so after having more than one child. A US based study also reported similar results with White women who continued to be depressed two years after giving birth and were more likely to have less social support (Horowitz and Goodman 2004). This is also in line with findings from

Oates et al (2004), who found loneliness, lack of emotional and practical social support, poor relationships with partners, family conflict and fatigue as commonly recurring themes across nine centre's worldwide. In the Oates et al (2004) study, British Asian women found having too much domestic work within a large extended family as a source of unhappiness. However, a study conducted in Pakistan showed that Pakistani women's depression did not persist due to a lack of practical support such as assistance provided in daily activities, instead the persistence of depression was associated with a lack of a confidant or friend (Rahman and Creed 2007). Nevertheless, the results may be associated with the benefits of living in extended families whilst the Pakistani women in this study lived in a nuclear family system. The authors (Rahman and Creed 2007) further postulate, "It may be that there are qualitative differences in the type of social support that predict a worse outcome of depression, and so studies using better measures of social support may be required". Interestingly, the present study did not find any links between the relationship of mothers with their mother-in-law specifically, whereas this has been previously found across cultures; in particular, Oates et al (2004) found that the British Asian and Japanese women in their study found the mother-in-law as a source of unhappiness following birth.

4.1.4. Marital problems

More than half of the women attributed marital problems as a significant factor for the persistence of their depression. Marital disharmony was associated with different factors such as experiencing regular physical and emotional violence, sometimes a direct consequence of drug and alcohol abuse, and marital infidelity. Oates et al (2004) also found infidelity on the part of the husband as a cause of unhappiness following birth by the British Asian women in their study. Conversely, they also found having a faithful husband as a cause of happiness. Marital disharmony can often lead to suicide in South Asian women (Hicks and Bhugra 2003). Although none of the women reported any suicidal ideation presently, they discussed past suicide attempts. These results warranted attention as South Asian women have a high suicide rate compared to White women living in the UK

(Neeleman, Mak et al. 1997), particularly those with an affective disorder (Hunt, Robinson et al. 2003).

4.1.5. Implications for practice

The lack of studies investigating the views of British Pakistani women regarding the management of postnatal depression, suggest that there is little information available to inform the development of current guidelines for the management of postnatal depression in the UK. Oates et al (2004) found that, although Asian women, in particularly Pakistani women, attributed a medical model to the aetiology of postnatal depression. These women did not regard professional or medical help as appropriate or feel that treatment was needed. The British Pakistani women's conceptualisation of depression in this study was very useful in understanding and developing the current intervention for persistent postnatal depression. The women in the current study showed a preference for treatments for their depression. However, the lack of culturally appropriate interventions raised a question for the appropriateness of existing services for the treatment of persistent postnatal depression. In particular, the women in this study showed a dislike towards antidepressants. Women described their fear of addiction, side effects, and the social stigma attached to mental health problems treatment as contributing factors in their poor adherence to medication. A lack of psychosocial treatments was also emphasised which often stopped these women from seeking help from their GP. This is in line with recent findings on White women with postnatal depression (Chew-Graham, Sharp et al. 2009). Women in the current study viewed depressive symptoms as a legitimate reason for seeking care, but they also felt unable to do this due limited treatment options offered.

4.1.6. Development of a culturally tailored intervention

4.1.6.1. Group based problem solving approach

Findings suggest that there was a need for psychosocial treatments to alleviate persisting symptoms of postnatal depression. Many women expressed treatment should be administered in a group setting to increase the chances of improving social support or reducing social isolation. Therefore a group intervention for British Pakistani women was considered. However, some women's reluctance to join local groups for confidentiality issues was taken account of, in order to understand their fears and to develop more effective strategies of engaging British Pakistani women in group interventions. Counselling services were described as being helpful in that they provided, "someone to talk to". However, women in the current study favoured directive problem solving approaches to the treatment of persistent postnatal depression. These women described a degree of disempowerment and asked about ways of improving their self-esteem and self-confidence. However, there were certain issues to be aware of. Although these women described a liking to become more empowered, they wanted this within the domains of the Pakistani culture. For example, some of the women reported advice from healthcare professionals as being culturally inappropriate. In more than one instance, women experiencing marital problems were asked to leave their husband. This has implications on different levels for these women, both social and financial. Divorce, according to these women, was still regarded as a taboo subject with negative consequences for the woman and her children.

As half of the women in this study were first generation Pakistani immigrants, they faced challenges such as cultural, language and financial barriers. Therefore, considering divorce for these women was not an option most of the time. There is evidence suggesting partners of women experiencing postnatal depression also having a higher chance of experiencing depression themselves (Davey 2006). However, there is no study that has looked at the impact of postnatal depression on

fathers in the Pakistani population. Women who presented with marital problems favoured support for these specific problems over antidepressant medication.

4.1.6.2. Religion and coping

The results highlighted the role of religion reported as a coping mechanism for depression. British Pakistani women mention the need to include religious activities in treatments for postnatal depression. This included behavioural exercises such as practicing ritualised daily prayer as well as regularly reciting portions of the Quran (the Muslim holy book). The role of the therapist within a cultural context was also discussed. The general opinion about health professionals was that they lack knowledge and understanding of the Pakistani culture and did not understand the underlying roots of British Pakistani women's problems. The women suggested that the main therapist should be from the Pakistani culture or should at least have culturally appropriate training before working with British Pakistani women.

4.1.7. Limitations of the qualitative study

The limitations of this qualitative study are acknowledged. This study took place in one geographical area in England so these results may not be generalisable to other populations. The participants were from a Pakistani background so the results may not be applicable to the other South Asian cultures. It is recognised that selection bias may have been introduced as the women who participated were part of a longitudinal cohort and may have felt obliged to take part in the current study. However, three women withdrew from the study which suggests that women felt comfortable enough to decline participation in the study. A major strength of this study is the ability to follow up the same women in their postnatal years and explore the course of their depression in terms of the perceived causes that further prolonged their depression. These women were first approached at six months postnatal and then followed up over two years postnatal. Furthermore, the team approach involving, Senior Psychiatrists, Cognitive behaviour Therapists, and the inclusion of

the service user, provided a robust framework for developing the present study and future interventions and monitoring the research and clinical process.

4.1.8. Conclusions of the qualitative study

To the best of my knowledge, this is one of the first studies to explore in-depth accounts of the course of persistent postnatal depression over two years postnatal, in British Pakistani women. The results highlighted the range of psychosocial factors involved in the maintenance of depression during the childbearing years and the impact these have on British Pakistani women. Furthermore, the results indicated that treatments for British Pakistani women with persistent postnatal depression warrant further consideration in order to provide them with culturally appropriate services. Although these were women with mild to moderate depression, clinical staff should take these experiences seriously because of the persistent nature of their depression, affecting their health, their relationships, and other crucial areas in their lives. Women in this study had not received the type of help they required from mental health services and the effect of their depression on their day-to-day quality of life was highly apparent. It was essential to focus on helping these women and designing a culturally tailored intervention as they belong to one of the largest ethnic groups living in the UK.

4.1.9. Key findings from the qualitative study

- Highlighted the serious effects of persistent postnatal depression on British Pakistani women and their families.
- Identified psychosocial factors that may perpetuate the persistence of postnatal depression.
- Presents the views on the type of treatment British Pakistani women liked for their depression.
- Provided recommendations on developing culturally appropriate interventions for British Pakistani women experiencing persistent postnatal depression.

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4.2. Results of the feasibility of the culturally adapted CBT based group intervention

This is the first feasibility study conducted on British Pakistani women with Persistent Postnatal Depression. The goals of testing a manual and establishing effective recruitment strategies were achieved. The study was also successful in engaging and retaining participants in the group intervention. Feedback from the brief adapted Verona Service Satisfaction questionnaire and the semi-structured questionnaire, demonstrating strongly positive results, indicates that this type of intervention is highly acceptable to British Pakistani women with persistent postnatal depression and that these women benefitted from a culturally adapted CBT based intervention.

4.2.1. Acceptability of the intervention

The drop out rate from the group intervention is similar to that found in a previous study with British Pakistani women with persistent depression (Chaudry et al, 2009). The acceptability of the intervention may have been enhanced by the availability of free childcare provided, which is a well-documented obstacle to treatment for women with young infants. The study did not experience problems arising from the recruitment strategy, as 15 out of a possible 18 women agreed to take part in the intervention. Two-thirds of the sample completed the intervention (10/15) and remained in the study till the end of the intervention. This also provides an estimate in terms of recruitment for future trials that a third of the participants may drop out of such interventions. Nevertheless, the study successfully recruited and engaged with participants from a hard to reach group.

4.2.1.2. Engagement

Several measures were put into place to engage and retain the women in the study. Firstly, in order to engage with the women, I felt it was necessary to identify the barriers and enablers to attending the intervention. This was established in the qualitative study which highlighted factors such as language, cultural knowledge of

the therapist or facilitator, childcare facilities and financial barriers. This was given particular attention especially since in the first session none of the women attended the intervention. This caused particular concern, especially since all the women were sent letters with the dates and times, the address of the venue, and spoken with over the phone a week prior to the intervention starting. All 15 women were followed up and asked if they were facing difficulties in attending the intervention. The reasons varied and some of the women reported feeling anxious about travelling to a new place.

4.2.1.3. Transport

Providing transport has shown to be an important factor in this study. A previous study reported reducing the number of sessions in their intervention in order to reduce the burden and travel costs to the participants (Naeem, Waheed et al. 2011). The volunteers in the current study agreed to bring women who were experiencing difficulties with transportation to the intervention. This was also found as an enabler to group facilitation in a previous study with British Pakistani women, (Gater et al 2010), and lack of transport was found to be a barrier in the Crockett (2008) study where women reported facing obstacles in getting transportation to sessions. According to Gater et al (2010), a key factor encouraging attendance to their intervention group was the taxi service with a female transport facilitator. Chaudry et al (2009) also stated that provision of transport was an absolute necessity in their study as only one woman could drive and others would have found it difficult to attend the sessions using public transport. In addition, Gater et al (2010) reported that it was not only the fact that a transport facilitator was provided in their study but also the qualities of warmth and empathy that the facilitators displayed. In their study, the women reported feeling obliged to attend as the group facilitators had made elaborate arrangements and the participants felt they should not let them down.

4.2.1.4. Engagement with families

Another key factor in engaging and retaining women in the intervention was the engagement with their families. In a previous study with British Pakistani women, Gater et al (2010) reported that a major hindrance to social group participation was resistance from family members, particularly husbands. In their study, the family often did not recognise depression as meriting outside help and lacked faith in the appropriateness of the social intervention. Additionally, women also described their initial apprehension about the nature of the groups and the degree of disclosure that would be expected. In another study with Pakistani women living in Pakistan (Rahman et al 2007), improved engagement to the intervention based on the findings from their pre-intervention focus group. These findings indicated that the intervention should not only include the mother but other members of the family too, in order for the mother to receive support from the family throughout the intervention. This showed to be particularly useful for the participation of women in their intervention. This information was taken into consideration whilst developing the recruitment strategy for the present study. One of the ways in which the intervention was presented to the families of these women was that it aimed to improve the parenting qualities of the mother, ideally producing beneficial outcomes for the child. In the Rahman et al (2007) study, most of the activities in the intervention for infant development were directed towards the mother because the activities may not have been received enthusiastically by the other members of the family, if the woman's depression had been the on the agenda rather than infant development. They also emphasised that interventions targeting postnatal depression in Pakistani women should be sensitive to family preferences. In my intervention, although no activities directly involved children, but the issue of having young children was taken into consideration.

4.2.1.5. Childcare

A free crèche service was provided and the children were in the room situated next to the intervention room, and mothers were free to go and check on their children as they pleased. The Reay et al (2006) pilot intervention study of a group interpersonal

psychotherapy for postnatal depression also reported that free childcare facilities were provided by accredited childcare staff in close proximity to the group facilities. In the current study, the fact that some of the mothers had older children was taken into consideration. Therefore, the intervention took place during the school term to attract mothers with additional school age children and minimise dropouts. This was also done in the previously mentioned study, (Reay et al 2006), and showed to be useful in retaining women in a group intervention.

42.1.6. Group therapist and facilitators

A positive relationship with the group therapist and facilitators also showed to be a vital enabler to participation in the intervention in this study. Women reported feeling accepted and safe in the group and the team, especially the main therapist, having a non judgemental attitude, seems pivotal to the engagement and retaining of British Pakistani women in this intervention. Women also expressed that it is important to show a good level of commitment to the intervention in order for them to feel that they are participating in something that is valued by the team members such as the therapist. The Chaudry et al (2009) study also reported that based on anecdotal feedback from the women in their study; they identified that the relationship developed between the women and facilitators was the most important component to the success of their intervention.

4.2.1.7. Culturally tailored sessions

Another key feature of this study is the cultural acceptability of the intervention. Based on feedback in the semi-structured questionnaires, women in this study reported engaging in this intervention because of the culturally appropriate format and content of the sessions. Women reported feeling comfortable because the multilingual therapist and facilitators were warm and understanding towards them, and written materials were available in their own language. Many women commented that, although the number of sessions were adequate for their needs, in the future, the sessions be spread over a longer period of time; for example, they

explained that weekly sessions be transitioned into monthly sessions as to appease familial pressures. Rahman et al (2007) also stated that the understanding of sociocultural context is very important in culturally adapted interventions. In their study the lady health workers were from the same community as the women, and understood the sociocultural context of the women's problems. This was also expressed by the women in my study.

The study was also successful in reducing depressive symptoms in women with persistent postnatal depression. Persistent depression has been reported as hard to treat because of its longstanding and complex nature (Lynch et al 2012). However, one of the advantages of this study is that the participant's depression rooted in the postnatal period, so the duration of the depression was not difficult to establish. This also made it unique in the sense that it was event specific and related particularly to postnatal experiences.

4.2.2. Practical feasibility of the intervention

The financial implications of such interventions were acknowledged in this study. This was a very small scale study with no funding. However, an 11 week (one session was cancelled) culturally adapted intervention in a surestart centre with free crèche service and transport was carried out, regardless of this limitation. This demonstrates the practical feasibility of this intervention. The surestart children's centre was very supportive of the intervention and stressed the need and importance of culturally adapted and tailored interventions. The room for the intervention was kindly made available and the crèche was booked for the 12 sessions by the Surestart manager. As stated earlier, the women showed some anxiety about getting to the intervention, but they were supported by the volunteer facilitators. Once women felt confident about making their own ways to the intervention, they were encouraged to car share to avoid financial costs. The main therapist, who was an experienced Cognitive Behavioural Therapist (KL), also kindly volunteered to supervise and run half of the sessions. The facilitators were also very supportive

and essential to the running of the intervention. The women in the intervention volunteered to bring food to the sessions and drew up a rota between themselves thus creating a sense of cohesion in the group. This also demonstrates that this intervention can become part of existing services for women and children, such as surestart centres.

4.2.3. Changes in mood

The specific symptoms of postnatal depression identified in the introduction included, feeling emotionally detached from the infant and showing no affection towards family members. It was also reported that some women may feel worthless and isolated due to the physical and emotional stress during delivery and the dilemma in meeting the demands of infant care and other family members. This may perpetuate feelings of inadequacy in mothers, causing them to experience feelings of guilt and embarrassment. Bodily symptoms, such as wound pain, headache and back pain, and ideas about self-harm and suicidal plans were also reported (Lee 2007). Women in this study reported an improvement in mood due to "feeling better" and being part of a group. When asked to report how they felt better, many of the women talked about improvements in their lifestyle that led to improvements in their mood. These lifestyle changes included building a positive view of self and a more positive worldview, managing stress more effectively, and feeling more in control of their lives. These improvements can also be seen as coping strategies.

The women also reported that being part of a group gave them the opportunity to understand other people's problems, which enabled them to share their problems. Although this helped to improve their mood, this did not improve perceived social support. This will be discussed further in the next section. Adopting a more positive view of the self may have helped to reduce some of the above listed symptoms of postnatal depression, such as feelings of worthlessness, emotional detachment, guilt, and embarrassment. Chaudry et al (2009) reported that women in

their study eagerly looked forward to attending the groups and used the terms ''mood became fresh'' and ''forgot their problems'' as ways to describe their positive experience which resulted in a lifting of their self confidence. This was also reflected in the current study where women reported positive thought-related reasons for improvements in mood, such as, "positive thinking really helped me" and "now I try and see things from a positive point of view". They also reported having the opportunity to talk to other women as being therapeutic, and particularly in the last session, women expressed how they had grown to appreciate the group and were sad at its ending. The women also expressed their interests in maintaining contact with group members. Women in the Chaudry et al (2009) study also wanted to continue to maintain the social networks that were formed during this period.

4.2.4. Changes in marital relationships

A significant improvement in marital relationships was also found. Women reported improvements in relationships due to feeling more in control of their anger and applying a more positive attitude. One of the women reported that CBT really helped her in avoiding marital disputes. She gave an example that in the context of a marital dispute, her husband tries to get her to react negatively, but she controls herself by using the CBT based techniques she acquired from the intervention, and adapts a calmer approach than she did previously. Although CBT helped some women with marital problems, others reported minor improvements. There were two women in particular who reported severe marital difficulties. These two women reported feeling somewhat low in mood since the intervention ended as they described the group as being a place for social support. Since completing the intervention, they reported experiencing a sense of loneliness they attributed to social isolation. Both of these women were socially isolated and were undergoing a separation period with their husbands at the time of the intervention. In contrast, all of the women in the Reay et al (2006) study reported better improvements in the quality of their relationships with their partners. One explanation for this may be that IPT may work better for reducing symptoms of depression if they are related to

interpersonal problems as many of the participant treatment goals focus on resolving interpersonal disputes with their partners. In addition, the involvement of partners in a psychoeducational evening class may also have had a positive impact on the outcomes in their study. Reay et al (2006) suggest that postnatal depression has a negative impact on relationships with partners and as depressive symptoms subside, relationships with partners may improve.

4.2.5. Changes in quality of parenting

A significant improvement in the quality of parenting and the home environment were also found. The HOME inventory captures aspects of the quality of parenting and the home environment. This study looked at the verbal and emotional responsivity of mothers, avoidance of restriction and punishment, organisation of the child's physical and temporal environment, maternal involvement with the child, provision of appropriate play materials, and providing opportunities for variety in daily stimulation. The results showed improvements in all six of these aspects. Although the mothers in the current study had above median scores at baseline in terms of responsivity towards the child, they were almost three points below the median scores for acceptance of their child. The responsivity of a mother can be categorised in terms of social, emotional and, physical responses. For example, the physical responsiveness can be measured by observing the mother caress or kiss the child at least once during the interview. Acceptance was measured by looking at physical aspects of punishment or restrictions made to the child, for example, by measuring the number of times the mother shouts at the child during the interview. This is in line with the findings of the qualitative study where women expressed feelings of anger towards their children, resulting in negative behaviour such as shouting at the children. The acceptability questionnaires reported women feeling more in control of their anger and establishing better relationships with their children. For example, one of the women reported feeling calmer resulting in a more relaxed relationship with her daughter as the daughter mostly reacted aggressively to her mother's anger. A drop in learning material provided was observed at three months after the intervention ended. This may reflect the financial

difficulties of providing children toys in the current economic environment and not necessarily the lack of initiative by the mothers in this study. However, the Millennium Cohort study (Hansen & Joshi 2007) reported that British Pakistani children are upto one year behind in cognitive development by the age of three and have amongst the highest rates of behavioural problems. Therefore, interventions should promote the provision of learning materials to children in British Pakistani families.

4.2.6. Changes in perceived health

Significant improvements in women's perceived health were also reported. The findings from the qualitative study showed that some women had gained weight after pregnancy which caused self esteem problems. Weight-loss was expressed as a way of improving self-image and self-esteem. Consequently, it was incorporated into the exercise and living healthily intervention session. Many women reported physical aches and pains in the qualitative study and reported both an increase in physical activity and better physical health at the end of intervention. One of the women reported a three stone loss in weight since taking part in the intervention. She expressed that a positive approach to weight-loss helped her gain confidence in her ability and stopped her from second guessing other peoples views about herself.

4.2.7. Changes in perceived social support

According to Reay et al (2006), participation in a group treatment can help to reduce social isolation for women experiencing postnatal depression. The opportunity for women to share their experiences of adjusting to motherhood, struggling with their relationships, and just generally experiencing the effects of postnatal depression can be seen to have positive benefits for women. In particular, it can be seen to normalise their experiences and reduce feelings of solitude and loneliness (Reay et al, 2006). This was not found in my study or in the Reay et al (2006) study where

they found no significant improvement in social adjustment overall, but there was a trend towards improvement.

However, a group social intervention improved social support in the Gater et al (2010) study. This may be due to the reasons that the activities in that study were focussed more on social aspects, and there was no psychological input. This may have helped women become more social or feel socially supported. Miranda et al (2003) also showed that CBT improved social functioning at six months post intervention; but antidepressant medication showed greater improvements. However, Gater et al (2010) reported a greater increase in social functioning in the social intervention group and the combined treatment group than in the antidepressant group at both three and nine months post intervention, but these improvements were significant only at three months and did not sustain after nine months. This may indicate that social interventions may be good at increasing social support and adjustment immediately after the intervention, but removal from the social intervention may result yet again in experiencing social isolation and low social support. In contrast, the Rahman et al (2007) study demonstrated that one-to-one CBT can improve social functioning, and these effects sustained even after one year post intervention. However, this may be due to the fact that the participants in the Rahman et al (2007) study, who were Pakistani women living in Pakistan, had more social support as 54% of the women in the intervention group lived within joint families. However, none of the British Pakistani women in the current study lived within an extended family network. In the Rahman et al (2007) intervention, the modules covered three areas: mother's mood and personal health, mother-infant relationship, and relationship of mother with significant others. Therefore a third of the intervention focussed on improving relationships with others. This suggests that CBT alone may not be sufficient in improving social support and added attention to interpersonal relationships may show more benefits in interventions for persistent postnatal depression.

4.2.8. Strengths, limitations and future directions

The limitations of this feasibility study are acknowledged. This study took place in one geographical area in England so these results may not be generalisable to other populations. The participants were from a Pakistani background, so the results may not be applicable to the other South Asian cultures. It is recognised that self esteem was not measured. A major strength of this study is the ability to engage the same women from their postnatal period and retain them in the present study all the way to follow-up assessments. These women were first approached at six months postnatal and then followed up over 2 years postnatal; and by the time the women started the intervention, it was almost three years postnatal. Furthermore, the ethnic matching of the team involving Senior Psychiatrists, Cognitive behaviour Therapists, research staff, and intervention facilitators adheres to the framework for cultural adaptation. One of the weaknesses of this study is the cultural inappropriateness of some of the outcome assessment tools.

4.2.8.1. The Dyadic adjustment scale

The Dyadic Adjustment Scale was used to measure marital relationship. One of the difficulties encountered with this tool was the cultural acceptability of sharing personal information about the nature of women's relationships with their husbands. Most of the women in this study held the belief that the intimate nature of a marital relationship should not be discussed outside of the relationship. They found the scale to be too explicit and detailed which made them feel uncomfortable whilst answering the questions. Therefore, some of the women showed a dislike towards this scale and expressed preference towards a more culturally sensitive way of measuring relationships within cultural boundaries.

4.2.8.2. The HOME inventory

The HOME inventory has never been used with British Pakistani population before this study. Although it showed cultural flexibility, some of the items may not be

culturally significant within the Pakistani population. For example, the inventory looked at having pets as a positive aspect of a Childs home environment. However, most of the women reported this as being culturally insignificant. One woman described her child wanting a dog as a family pet but she refused due to a cultural belief that dogs should only be permitted to stay outside of the house and not allowed inside of the house. This is a commonly held practise amongst Pakistani Muslims as the belief behind it is that angels do not enter the house of a Muslim where a dog is present. The caging of birds is also sometimes prohibited to confining birds from their natural environment. To some this may seem bizarre, but it is a culturally held belief and to be culturally sensitive these beliefs need to be identified in order to work within their frameworks. In the future, it may be an idea to replace this item in the inventory with a more culturally relevant or suited item.

Although perceived social support was intended to improve in this intervention by implementing a session on building support and social networks, it did not show improvements in social support. This suggests that improvements in social support may require more transitional work and this should be incorporated in future trials.

4.2.8.3. Self esteem

Another suggestion for future trials is to measure self esteem. This was such an important aspect of the intervention, but due to time constraints in carrying out secondary assessments, a measure for self esteem could not be incorporated in the assessments. In future, the Rosenberg Self-Esteem Scale (1965) could be used as it has been found to be a reliable and valid scale of self-esteem.

4.2.9. Conclusion of the feasibility study

To the best of my knowledge, this is the first study to carryout a feasibility trial of a CBT based intervention with British Pakistani women with persistent postnatal depression. The results highlight the acceptability of this culturally adapted intervention to British Pakistani women. Furthermore, it is evident from this

intervention that culturally appropriate services can reduce postnatal depression that is persistent in nature in British Pakistani women. Interventions targeting postnatal depression in British Pakistani women should pay particular attention to ways of improving social support and marital relationships.

4. 2.10. Key findings from the feasibility study

- Highlights the cultural accessibility of the intervention
- Identifies key factors for engagement into culturally adapted interventions
- Analyses improvements in mood, marital relationship, quality of parenting and home environment, and health
- Explores the views of British Pakistani women in terms of acceptability and service satisfaction
- Recommends areas needing further refinement in the present culturally adapted intervention for British Pakistani women experiencing persistent postnatal depression.

4.3. Overall conclusion

Following the previously discussed MRC complex interventions framework (Craig et al, 2008), the development of a culturally adapted CBT based intervention for persistent postnatal depression has completed three out of the five sequential phases: a selected literature review defined the theoretical basis, qualitative interviews were conducted, and a feasibility trial was carried out. Stages four and five are currently underway in a subsequent pilot trial running a powered RCT and evaluating the real effectiveness of this culturally adapted CBT based intervention for postnatal depression. The current manual is also being used as part of the intervention. This trial has been funded a £250 000 Research for Patient Benefit grant, on the basis of work presented in this thesis, by the National Institute of Health Research.

Research for Patient Benefit (RfPB) was established in 2006 to generate high quality research for the benefit of users of the NHS in England. It funds regionally-derived applied research projects in health services and social care. The main purpose of this grant is to develop evidence-based quality research to improve, expand and strengthen the way that healthcare is delivered for patients, the public and the NHS.

The qualitative findings showed poor experiences of British Pakistani women with inadequate and culturally inappropriate psychological services. British Pakistani women expressed a need for culturally tailored interventions. The persistent nature of their depression also indicated the absence of effective interventions for postnatal depression which resulted in their depression becoming more persistent and ongoing.

This study was successful in engaging participants from a hard to reach group and meeting most of their needs in a group based manualised culturally adapted CBT based intervention. The following diagram displays the process of developing a complex culturally adapted intervention for persistent postnatal depression.

Figure 8: The process of developing a complex culturally adapted intervention for British Pakistani women with persistent postnatal depression

Resources required

- Funding

-Venue acceptable for Group Intervention

- Persistently depressed women willingness to speak about their experiences

- Facilitators for the group intervention

- Crèche facility

- Transport to Group Intervention

↓

Development of Group Intervention

-Theoretical Phase (Literature review)

- Modelling Phase (findings from the qualitative study)

↓

Mode of delivery of the Intervention

- Group format

- Discussions via use of case studies

- Intervention handouts with group and individual exercises

- Group discussion

↓

Change in:

- Knowledge: increased awareness of symptoms

- Skills in terms of handling negative thoughts

- Positive thinking attitudes

↓

Engagement in Group intervention and Improvements in;

- Mood scores

- Marital

- Parenting style and home environment

- Health

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Appendices

Appendix 1 – Letter from Faculty Librarian

Appendix 2 – Ethics Approval letter

Appendix 3 – Participant Consent Form

Appendix 4 – Participant Information Sheet

Appendix 5 – Qualitative Topic Guide

Appendix 6 – Intervention Manual

Appendix 1 – Letter from Faculty Librarian

The University of Manchester

To whom it may concern,

This letter is to certify that **Sobia Khan** has conducted a literature review using a systematic method, to identify the key studies in her area. We conducted an OVID search to find articles in the area of postnatal depression and persistent postnatal depression, searching for articles relating to the impact of postnatal depression, and treatments available.

Kind Regards,

Olivia Walsby.

Faculty Team Librarian for Medicine

Appendix 2 – Ethics Approval letter

North Manchester Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	08/H1006/46	Issue number:	0	Date of issue:	05 September 2008

Chief Investigator:	Ms Sobia Khan

Full title of study:	RCT of a Complex Intervention for Persistent Postnatal Depression in British Mothers of Pakistani origin

This study was given a favourable ethical opinion by North Manchester Research Ethics Committee on 05 September 2008. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes [1]

Approved by the Chair on behalf of the REC:

.... (Signature of ~~Chair~~/Co-ordinator)
(delete as applicable)

.... (Name)

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

An advisory Committee to NHS North West

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MANCHESTER
1824

The University
of Manchester

Appendix 3 – Participant
Consent Form

Medicine

School of Community Based

3rd Floor, University Place, Block 3
University of Manchester
Oxford Road, Manchester
M13 9PL

Study Number:
Patient Identification Number for this study:

CONSENT FORM

Title of Project: **Developing a culturally adapted cognitive behavioural therapy based intervention for British Pakistani mothers with persistent postnatal depression**

Name of Researcher:

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I understand that sections of any of my Hospital/GP medical notes may be looked at by a research worker from the University of Manchester. I give permission for these individuals to have access to my records.

4. I understand that the research worker's will contact my general practitioner in order to inform them about my participation in this study. I give permission for them to contact my GP.

5. I agree to take part in the above study.

Name of Patient	Signature	Date

Name of Person taking consent (If different from researcher)	Signature	Date

Researcher	Signature	Date

1 for patient; 1 for researcher

MANCHESTER
1824

Appendix 4 – Participant Information Sheet

School of Community Based Medicine

3rd Floor, University Place, Block 3, University of Manchester, Oxford Road, Manchester, M13 9PL

Developing a culturally adapted cognitive behavioural therapy based intervention for British Pakistani mothers with persistent postnatal depression

Introduction

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is any thing that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Postnatal Depression is a common and treatable cause of people not being able to lead a normal life. It often occurs 4-6 weeks after the baby is born and last up to four years postnatal. In our previous research, we have found that women of Pakistani-family origin are particularly likely to suffer from depression, which is often persistent. The study we are asking you to take part, aims to find better ways to help women to recover more quickly from depression.

What will I have to do if I take part?

If you agree to take part, you will be asked to complete some questionnaires. This questionnaire asks about your recent health and well-being. You will be able to complete the questionnaire privately, or with the help of the researcher. Those women who complete the questionnaire, will be asked of they will be able to complete a second interview with a female researcher, which would take place at your home, or if you prefer at the University sites or a Surestart Centre. The second interview will take about one and a half hour, and should occur within the next two weeks. All the interviews will be with female interviewers who are fluent in English and Urdu.

Women who complete the interviews will be asked to take part in the intervention to help recover more quickly from depression. We are trying to find the best ways to help and a culturally adapted intervention is being assessed. The treatment we are studying includes attendance at a social group therapy, provision of information about depression and its treatment, and treatment of depression with psychosocial therapies such as CBT.

If you have consented to take part in the intervention, you will be asked to take part in a 12 week positive health programme. This is a group based intervention for postnatal depression. There will be further interviews after the intervention has ended and again at 3 months later. These interviews will be to ask about your health and your satisfaction with the intervention. These interviews can be completed at your home and will be arranged at your convenience.

Are there any possible benefits?

Yes, all the intervention is planned to help speed recovery from persistent postnatal depression and should be enjoyable for those taking part.

What are the possible risks of taking part?

There are no risks with the questionnaires, interviews or the intervention.

Will the information obtained in the study be confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Some of the interviews may be tape recorded with your consent, if so, the tapes will be remain anonymous and identified only by a participant study number. They will be stored and locked in a secure premise. Any information, which will have your name and address, will be removed so that you cannot be recognised from it. The research worker may also access your general practice records, with your consent.

Do I have to take part?

It is up to you whether or not to take part. If you do not wish to, then you need not give any reason at all. We can assure you that your treatment will not be affected if you decide not to take part. If you do start participating in the study and then change your mind at a later date, you will be free to withdraw without it in any way affecting the standard of care that you receive. However, we will use all the data provided by you for our analysis.

What are the alternatives for diagnosis or treatment?

Your general practitioner can diagnose and assess depression, and can prescribe treatment, which is usually antidepressant medication similar to that used in this study or counselling.

What if new information becomes available?

Sometimes during the course of a research project, new information becomes available about the intervention that is being studied. If this happens, we will write to you and you will be able to discuss with a member of the research team whether you want to continue with the study. If you decide to continue in the study you will be asked to sign an updated consent for.

What do I do now?

If you agree to take part you will be given this information sheet and asked to sign a consent form. This is now an ethical requirement for all research studies to ensure that every participant has been provided with information and had the chance to ask questions before agreeing to take part. For this study we have two consent forms. The first is the consent form for a brief questionnaire that you complete today. You will only be asked to complete the second consent form if you agree to a later interview. If you wish, you may take a few days to think about the study or discuss it with someone else, such as your family or friends, before deciding whether you agree to take part and sign the second consent form.

Who is organising and funding the research?

The research is being organised by the University of Manchester as part of a PhD Project. The study is funded by the University of Manchester.

If you have any further questions at this time or during the course of the study then you can contact;

Sobia Khan or Dr Nusrat Husain

3rd Floor, University Place, Block 3, University of Manchester, Oxford Road, Manchester, M13 9PL

Tel: 0161 306 7928 or 7921

Appendix 5 – Qualitative Topic Guide

ID No:
D.O.B:
Date on Interview:

A Topic Guide for the Qualitative Interview

1. **Introduction about the study and the interviewer.**
"Many people have feelings of sadness, stress, and anxiety and for some people these persist over time. I am interested to know if you have ever had persistent feelings of anxiety, stress or sadness?"

2. **Are there any current or ongoing difficulties that the participant has?** If so, probe and ask, *"It would be helpful, if you could give come detail on what these difficulties are?"*

3. **Probe on the participant's belief about the causes of these problems**. Ask, *"Can you please tell me a little bit more about what you think has caused these problems for you?"*
Prompts: *Biological causes* - Birth of the baby, health problems etc.
Psychological causes – Previous depression, trauma, guilt etc.
Social causes – Moved house, isolation.
Relationships – Marital problems, abuse.
Financial/ Housing problems – Poverty, poor living conditions.

4. **Ask about the type of things that maintain the depression**. *"I understand what you think the cause/s of your low mood are, but what do you think keeps the depression or low mood going?*

5. *Ask about any current or past help sought for the depression.* *"Have you sought help in the past?"* Find out the **agency** the participant sought help from. For example, the **GP, Midwife, Health visitor, Voluntary or any other source of help**. *"Do you currently receive any help for your low mood?"*
e.g. Counselling therapies, Medication, Alternative therapies?
If so, has it helped? *"I wonder if you can tell me why you think this treatment has helped you?"* **Probe the actual treatment?**
If not, why not? *"I wonder if you can tell me why you think this treatment has not worked?"*

6. **Enquire about the kind of help the participants currently wants**. Ask, *"What kind of help would help you best"*
Probe: For example,
Group/Individual **Psychosocial** therapy?
Group/Individual **Psychological** therapy?
Medication?
Family Intervention?
Emotional support?

7. **What should the focus of any help for Pakistani women be on**? Ask, *"Do Pakistani women have specific needs when it comes to help for low mood? If so, what should be done?"*
Probe: For example, involving the family?
Involving children?
Religious or cultural practices?

8. **Ask about the barriers for obtaining treatment?** Ask, *"What would make it difficult for you to access this help?"*
Probe: For example, permission from the family?
Chidcare?
Time?
Stigma associated with mood disorders?

9. **Find out about the things that would make it easier for these women to receive help for their low mood.** Ask, *"What would make it easier for you to access help for low mood?"*
Probe: Providing transport?
Childcare?
Flexible timeframe?

10. **Enquire about the type of agency these women would like to receive help from.** Ask, *"Who would you like to provide you with this help?"*
Probe: GP?
Local community groups like Surestart or Neesa Womens wellbeing project?
Hospitals?

11. **The name of the treatment? Ask, "***What should this type of help be called"*. Probe on whether the name should be a medical name or a non-medicalised name? Should it be called treatment or support? Ask about stigma with help for depression?
For example: **Therapy?**
Advice?
Support?

12. **Mention talking therapies.** Ask about the elements that may work. Ask about CBT, have they heard about it? What do they know about it? Could it work with Pakistani women? Does it need to be adjusted to or adapted to the Pakistani Cultural framework?

Positive Health Programme

Instructional Manual

A Cognitive Behavioural Therapy based intervention for Persistent Depression in the Childbearing years of British Mothers of Pakistani Origin

May 2009

Sobia Khan MSc

Dr Nusrat Husain MD

Prof. Karina Lovell

University of Manchester, University Place, Oxford Road, M13 9PL

Session 1: Introduction to the Positive Health Programme

Objectives of session:

- To learn participants expectations from the group
- To emphasise the commonality of problems
- To set some ground rules
- To educate group members about depression and the CBT model and its role in improving their mood
- To find out participants expectations from this programme and establish goals.

Welcome and introductions

F1. *"Hello and welcome to the positive health programme. My name is _____ and I am one of the group facilitators. I am really keen to get to know all of you better over the next 12 weeks that we will be working together. I should tell you something about myself...I am a_____ with _____years experience working in mental health. In the past few months I have been working with you all to try and find out the best way to make you feel even better. I enjoy working with women and helping them to start feeling better and enjoying their life again. I will now pass you onto my colleague Professor Karina Lovell".*

F2. *"And my name is _____ and I will be facilitating the group with _____*

It is pleasing to see you all here today knowing how difficult it can be to set aside time from your busy schedules. We appreciate that it has probably taken a lot for all of you to get here this morning. I am a _____with ___ years experience in mental health. In the past ___ years I have become more interested in working with different ethnic groups and have worked in both research and treatment settings.

➢ **Group Introduction**

The first thing we would like to do is get to know a bit more about each other. What we would like you to do now is turn towards the person sitting next to you and spend a few

minutes each getting to know each other. Then we will get you to introduce your partner to the group."

➤ **Exercise 1:** In pairs each person introduces themselves to a partner, gives brief introduction about themselves, partner then introduces them to rest of group.

➤ Structure of today's session

Write up on whiteboard and discuss:
- **Welcome and introductions**
- **Information about the group: how it works, structure and expectations.**
- **Group agreements**
- **Tea break**
- **Discussion about tensions in women's lives**
- **Cognitive Behavioural therapy and the ABC model**
- **Goal setting**
- **Wrap Up**

Information about the group

"I'm going to talk a bit about the nuts and bolts of the group and to answer any of your questions about the group."

> ➤ **Checklist of things to mention**
> - Why group was developed
> - Length of group
> - Breaks
> - Group structure: check in, body of group and wrap up
> - Phases of group: Goal setting, actively working with individuals, pairs and group as a whole, techniques and strategies, consolidating changes
> - Expectations: commit to all sessions, be on time, actively participate, here and now relationships, express feelings, no extra group contact

Length: *"The positive health programme is specifically developed to address some of the common issues faced by mothers affected by stress. The group will be meeting every week at this time for 2 hours over 12 weeks. Half way through the group we will take a tea break and get back down to business."*

Group structure: *"Each group is divided up into three phases: the check-in, main body of the group and the check out. During the check in each of you will get a few minutes each to talk about how you have been progressing with your goals. During the middle phase of the group the group facilitators will work with you to develop some strategies to deal with the issues that are contributing to your stress. We will*

also read stories about issues affecting women through the use of teen aurtien teen kahaniyan, and collectively draw out some solutions to their problems. At the wrap up you will again have a few minutes to discuss how you have found the session and what plans you have for the following week?

Group Phases: *"The first few sessions will be structured by the group leaders and as you progress group members will gradually take more responsibility for what is discussed. Sometimes we will focus in on one person's issues in detail in order to help all of you generate some insights and ideas for achieving your goals. It will be important that you actively work to discover how this relates to your issues and problems."*

How the group works and expectations: **"**In order to do this work it is important that you are clear about what is expected of you. We ask that during the group that you commit to attending all 12 sessions. You are also likely to get the full benefits of the group if you actively work on your goals each week and use the group to help identify ways that you can reach your goals. We will be helping you to work on your current, here and now problems in life. Whilst the past has a very important influence on how we relate to others, we have found that a focus on current problems is a beneficial approach to alleviating stress. Thus it will be important that you talk about your problems openly with the group, your feelings about the group and how well the group is meeting your needs. In group we will provide opportunities to experiment with new ways of making a positive change to your life; one way of looking at the group is like a "laboratory" in which to experiment with ways of doing this.

Group agreements

Using a whiteboard the group leader brainstorms the group agreements

Example: *"In order to be able to feel comfortable about sharing personal information with the group it will be important to have some rules and agreements with each other. What group agreements would you like to suggest?"*

Examples: *Confidentiality*
                Being on time
                Suspend judgements
                Allow everyone to contribute
                Make positive suggestion but avoid direct advice
                Interruptions: phones/ children/emergencies

Best ways of discussing problems – **Generate a group discussion**

"What do you think is the best way of talking about your problems? For example we can use an anonymous box where everyone can post their comments and so cannot be identified by anyone in the group? We can use stories about other Pakistani women such as the "Teen aurtien teen kahaniyan" from the newspaper or we can use role play to act out commonly occurring scenarios in our lives?

Provide some education about depression in the child bearing years

"What is sadness or low mood? What happens when we feel sad? Can anyone tell us how they think people feel and act when they are sad? An example of someone who is feeling sad is Khalida. I will now read her story to you."

➢ *Read Khalida's story*

"Let's talk about the experience of stress in Khalida's life. I will write your ideas on the board. What are Khalida's main symptoms of sadness and stress? Are there any signs and symptoms you can identify with?"

• **Draw picture of a woman on the whiteboard. Write the women's symptoms on the board and discuss. Facilitate discussion and highlights similarities and differences between group participants.**

--- **Break for tea** ---------------------------------------
----

Cognitive behavioural therapy - *Explain CBT model*

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Cognitive behaviour therapy (CBT) is a treatment which helps people to manage a wide range of difficulties. It was first used to help people who were experiencing depression and anxiety, but over the last few years it has been successfully used in many other areas for example obesity, sleep problems, chronic pain and other medical conditions.

CBT is a 'talking therapy' based on a view that the way we act (behaviour) and our thoughts (cognitions) and our physical sensations (feelings) are all interlinked and change what we do. CBT helps to identify the unhelpful and helpful feelings, behaviour and thinking that you have. It can help you to change the way you think and act and in doing so reduce the impact that a problem has on your life. CBT is about working in partnership with you and together looking at and trying the best solutions. CBT is an umbrella term and there are many interventions that can be used.

Discuss the ABC model of depression

Depression is an emotional disorder. Emotion is made up of 3 interrelated but separate components. (Draw this). Depression has an effect on three different parts of us:
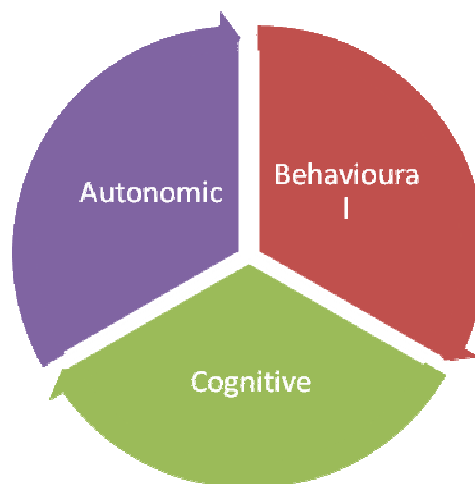
- **Autonomic - Things we feel physically**
- **Behavioural - Things we do or stop doing**
- **Cognitive - Things we think**
- **Autonomic – Things we feel physically** when we are struggling with depression or low mood include not being able to get to sleep and frequent wakening, particularly early in the morning. Other physical symptoms include poor appetite, weight loss, comfort eating, tearfulness, exhaustion and poor concentration.
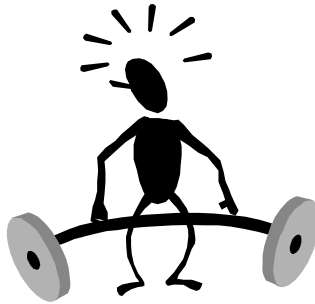
- **Behavioural - Things we do or stop doing** include avoiding things because we feel they might be too difficult or because we have lost interest in them. We end up not doing things that we previously enjoyed. Other symptoms include feeling restless or agitated.
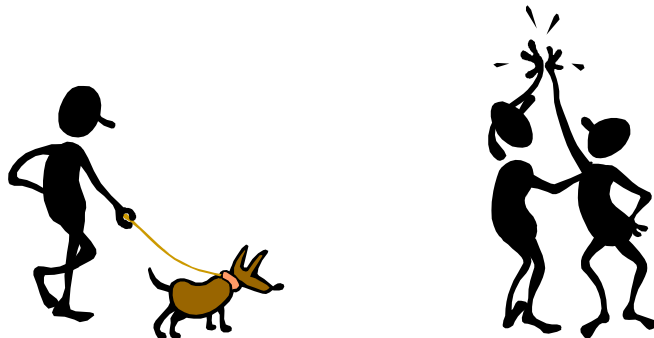
- **Cognitive - Things we think** include guilty or worthless thoughts which make us feel less confident. People might think that everything they do comes out wrong. Some people have thoughts that life is not worth living, whilst others may have definite thoughts of killing themselves.

The 'Vicious Circle' of Depression and Low Mood

Things we feel, do, and think are all related to each other. For example, our physical feelings can lead to changes in the way we do things and the way we think. If we stop doing things we can feel worse physically and have very negative thoughts. Depressed thoughts can mean that we stop doing things and feel physically unwell.

This 'vicious circle' of unhelpful thoughts, changes in behaviour and physical symptoms can keep your mood low. Here is an example:

Thinking
"I cannot do anything right, everything I do goes wrong"

Doing
Avoids doing activities and meeting friends, becomes withdrawn and isolated

Feeling
Aching, stabbing pain, pins and needles, constant fatigue, headaches, poor sleep and poor concentration

Your own personal feelings, behaviours and thoughts

Now let's think about you. What are your feelings, behaviours and thoughts? Below is a copy of a sheet which you can use to write down how your low mood is affecting you. Just jot down the main areas where your physical feeling, the things you do and the way you think they are a problem for you.

It can be quite difficult to write these things down. It is like bringing everything out into the open. This is an area where your self-help coach can help you. Although it might be tough, it is an important first step in recovery. Make sure you talk it through with your coach and, if you want to, with a close friend or family member. Have a go now.

➢ **Exercise 2 -** Now I would like you to take any emotion i.e. sadness and then make the links using the ABC model to explain what is going on– i.e. that our thoughts affect our behaviour, and behaviour affects thoughts and physical feelings.

My own physical feelings

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Things I do or have stopped doing

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My own thoughts

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➢ Now have a look at your lists above. Can you identify how the three areas are linked? Write this in the space below. Once again, your group facilitator can help you with this. Discuss this in the next group session.

My feelings, behaviours and thoughts are linked in the following ways:

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➢ Exercise 3: **Expectations from this Programme and Setting goals**

"I'd like you to begin talking about what brings you here and what you would like to get out of this group. Write down what you think this group can help you with and the goals you want to set for yourself. Spend some time thinking about what you want to start with? We will be using your comments to modify what you would like to achieve in this group. Would anyone like to comment on their goals?"

My healthy living Goals

Today's date…………………………..

Goal number 1

………………………………………………………………………………………………………

………………………………………………………………………………………………………

I can do this now (circle a number):

0	1	2	3	4	5	6

Not at all   **Occasionally**   **Often**   **Anytime**

Goal number 2

………………………………………………………………………………………………………

………………………………………………………………………………………………………

I can do this now (circle a number):

0	1	2	3	4	5	6

Not at all   **Occasionally**   **Often**   **Anytime**

Goal number 3

………………………………………………………………………………………………………

………………………………………………………………………………………………………

I can do this now (circle a number):

0	1	2	3	4	5	6

Not at all   **Occasionally**   **Often**   **Anytime**

Wrap Up: **This may be a useful process for gauging how the group has gone for people and allow them time to gather themselves before leaving.**

"The final task for today is to go around the group giving each of you just a few minutes to say how you found the group today?"

Session 2- Pressures and expectations of being a woman

Objectives of session

- Review of participants expectations from the PHP and their goals
- **What is expected of women, and any cultural differences?**
- **The pressures on women nowadays?**
- **Consequences of these actions**
- Begin to identify the unrealistic expectations people have of them and the stressors in life
- To understand the connection between their symptoms and thoughts as a consequence of these pressures and unrealistic expectations

Housekeeping: Group agreements on the board. Goals to be handed out at the start of the group.

Check in: Members to reintroduce themselves to the group.

"Welcome to the 2nd week of the Positive Health programme. Let's start by finding out how you have been going in your life this week. Also we have handed your goals back to you so have a look at them and let us know if they reflect what you want to achieve in the group or whether any changes need to be made?"

Therapist should reiterate participants' role in the group:

> **Checklist about the group participants' roles:**
- Feel comfortable to raise the important issues about your life
- Express your feelings about your thoughts (positive and negative)
- Express your feelings about the group (positive and negative)
- How the work you are doing is affecting your symptoms

"We'd like to reiterate a few things about your role as group members. It will be important that you feel comfortable to raise the important issues that are going on in your life. We will be active over the weeks in giving the group structure; however it is up to you to decide what the important issues are that you would like to focus on. We will also be encouraging you to focus on the good and the bad things happening in your life. Even what you think about being in the group. We will need to know if you are struggling or having trouble understanding what is said in the group. Whilst we

don't spend a lot of time in the group how being in the group and working on   *talking about symptoms, we are interested in your goals is affecting your symptoms."*

Pressures and Expectations of being a Woman

"For the rest of the session today we are going to be talking about the pressures of being a woman. This is one of the key problem areas that mothers really relate to. We all know there are certain pressures on women, and these can increase in the child bearing years. We also know that women are expected to cope with certain things or behave in certain ways too. This usually occurs at a time of decreased social support. When we enter a transition like marriage or motherhood, it is common to be focused on the many new roles and challenges facing us. We have found it useful to spend some time thinking about and reflecting on these challenges. In particular, the not so good aspects in your life."

"It would be useful to find out how you would like to discuss this issue,

-     *You can work with partners to discuss these issues*
-     *You can write these issues down*
-     *Or you may decide to comment on the following story about the pressures this following woman has in her life*

Case study of Shehla

"Shehla is a 34 year old married woman. She lives with her family in law, husband and her 3 children. She has a very busy life. Her eldest child is 10 and the youngest is 2. Her father in law suffers from severe epilepsy and has had a stroke in the last 6 months. Shehla is the primary caregiver for her father in law as her mother in law also suffers from ill health, severe arthritis. Shehla's sister in law Sara has been recently divorced and is living with them at the moment. Sara does not help with the household chores as she is heavily pregnant. Shehla does not have much support from her husband and is expected to look after the whole family as this is her role as a wife, a daughter in law and a mother. Her husband is a taxi driver and works very long hours. He is the main provider for the family and so feels responsible only for the financial side of the things and feel he does more than his fair share. Shehla works long hours in the house. She keeps the house extremely tidy as this is expected of her from the family, she doesn't get much time to spend with her children, which she feels very guilty about. She misses her prayers, which she also feels guilty about. As a result of this constant hard work over the last 11 years, she now feels unwell, both physically and mentally. She gets tension headaches if her work is incomplete, she doesn't have much time to sit down and eat, so she nibbles all day on sugary foods to give herself some energy. She is neglecting her diet, her sleep and personal hygiene. Her relationship with her husband is suffering too. They often argue about

her being too tired at night to fulfil his manly needs and the fact that she looks a mess! What is Shehla doing? How can she feel better?

"If you want to work with partners then I'd like you to work in pairs, using your partner to explore the issues women face in marriage and motherhood more deeply. Ask questions to prompt each other and we will be available to answer any questions."

➢ Exercise 1: Exploring the pressures and expectations on women
In pairs participants are asked to share with each other the pressures they face and the expectations others have of them in their new role after marriage and motherhood (for ten minutes). After a 10 minute break the therapist should bring the group back together and facilitate discussion about these pressures and expectations, and attend to the consequences of these pressures and expectations.

Therapist uses a grid with boxes on the whiteboard. Facilitates discussion amongst the group about the pressures and expectations of women.

Pressures on women **(The issues)**	**Consequences of these expectations** **(What do you think?)** **(How do you feel?)**
Expectations of women	**Consequences of adhering to these expectations**

Examples of questions to facilitate group discussion

"What are some recent examples of the pressures you face in your life?"

"What are tensions in your life?"

"What is expected of you as a woman?"

"Are there any cultural differences?"

"What are the consequences of these expectations and pressures?

....Tea break..

- ➢ **Exercise 2: Sharing these pressures and expectations**

    Participants are asked to share with the group the pressures and expectation they face in their current life. Therapists should facilitate discussion to help develop a varied perspective of these issues.

    "Pressures and unrealistic expectations can be problematic and burdensome for mothers when some of the negative aspects are not validated or when some of the positive aspects are not apparent. Take a moment to reflect with your partner about the problems these pressures and expectations have caused for you."

    Facilitate group discussion using the whiteboard and the grid. Highlight similarities and differences. Acknowledge the thoughts associated with the feelings.

- ➢ **Therapist summarises the main points raised by the group and during the discussion:**

- On the grid write down feedback from the participants?
- Ask about the pressures and expectations?
- How do they make them feel?
- How do they make them think about themselves?
- The consequences of dealing with these pressures and expectations, day in and day out? On health, children, partners and other family members etc
- Is it healthy to cope with these pressures and expectations?

- ➢ **Exercise 3: Generate a group discussion on Ways of dealing with pressures and unrealistic expectations**

"Now that we have identified some of the pressures you face and the expectations others have of you, I would like you to re-evaluate these pressures and expectations. Are there certain pressures that you can deal with in any other way? Is there an alternative way of thinking and behaving? It will be useful to write these down and we can talk to you individually or in a group to help you with some of these goals." On the whiteboard write the list of the participant's suggestions of positive ways of dealing with pressures and expectations.

On the following grid, write down alternative and positive ways of thinking about these pressures

Pressures on women (The issues)	Consequences of these expectations -What you think? -How you feel?	Positive thought or belief about the pressure or expectation
Expectations of women	Consequences of adhering to these expectations	

Some additional examples are:

- Paying attention to your own feelings and beliefs about what is right and wrong
- Inner strength and self-confidence can help you stand firm
- Walk away and resist doing something which will make you feel under pressure
- When faced with pressure or unrealistic expectations talk to someone you trust
- Don't feel guilty if you've not managed to do everything

"I would now like you go back to the goals you set for yourself in session 1. Can you make any changes to the goals? Are there things which you can remove from your list of goals, as it may increase pressure on yourself or it is an unrealistic expectation? Now, I would like you to write any additional things that you may have realised that you could do to refrain from pressures and unrealistic expectations."

"For example, of one way of dealing with pressures concerning things to is;

You do not feel so well one day, but you are expected to do a lot of things that day. You feel pressured right from when the day starts. So what can you do? Well you can make a priority list. In this list you prioritise the things that are the most important to you (Task A) and things that are of somewhat priority but can wait a day a two (Task B) and things which are not a matter of priority (Task C)." The example is as follows;

A tasks	B tasks	C tasks
Cook dinner	Shopping	Cleaning the oven
Take children to school		

- *Cook dinner for husband as it may avoid him being angry. However, you do not have to cook something which will take a long time to cook. Choose something simple.*
- *Taking children to school: you can ask a friend or a neighbour or a family member to help out. If nobody available, then you can ask your husband. If he cannot either, then that day the children can stay at home.*

If your home is not in the best condition or as ordinarily tidy, and you get a surprise visit from someone. If this person comments negatively on the state of your home, what will you do?

A. *Think, "Oh my God s/he thinks I'm such a lazy person"*
   Or,
B. *Think, "It's ok, everyone's entitled to an opinion, s/he doesn't know the full story that I have not been feeling so well lately".*

Wrap Up

Take time to do a thorough wrap up of the group and check out how people are feeling and managing. Encourage members that feeling uncomfortable in the group is common at this stage and that these feelings will eventually improve as the group begins to get to know and trust each other.

"How did you find the group today? What has it been like for you to discuss the experience of pressures and expectations?"

Session 3 – Understanding and managing self-esteem

Objectives of session:

- Maintain a focus on discussing issues related to low self-esteem
- Understanding the role of our thoughts and feelings on our behaviour in maintaining low self esteem
- Understand other processes involved in maintaining low self-esteem
- To encourage members to implement change in their lives in terms of achieving good self-esteem

> ➢ Housekeeping: Group agreements on board and handouts available.
> ➢ **Check-in statements**

The group therapist summarises the content of last session and the progress that members have been making. Members are then asked to share for 2-3 minutes about their week **in terms of their mood and what progress they are making towards their goals.**

"Hi and welcome to the third week of the positive health programme. I am very pleased to see you all again and hope you have been making progress with your mood. If any of you need to speak to either of us here, please feel free during the break to come and discuss your problems with us. Today we will be discussing a topic most of you here will be able to relate to; low self-esteem. I would like to generate a group discussion on the topics as follows."

What is self-esteem?

Exercise 1– Generate a group discussion about people's understanding of low self-esteem? Ask participants to either say aloud or write down what the term self esteem means to them.

- "The term Self esteem refers to the opinion you have of yourself. High self esteem is a good opinion of yourself and low self esteem is a bad opinion of yourself.

-     Your self esteem depends on many questions:
  - Is your marriage worthwhile? Do others respect what you do? Do you?
  - Do you believe you are successful?
  - How do you see yourself (your self-image)?
  - How do you feel about your strengths and weaknesses?
  - What do you think of your social status?
  - How do you relate to others?
  - Can you make your own decisions? A lack of choices leads to low self esteem.

What causes low self-esteem?

Exercise 2 – In a group generate ideas about what causes low self-esteem?

Some of the issues to discuss may be:

- You are not born with Low Self Esteem
- Low Self Esteem starts at a very early stage in our lives; and can also begin at a later time in our lives
- Low Self Esteem can be the result of our background, or our status as we grow in age
- Our social status, beauty, physique, personality, intelligence etc
- Influences from the media, such as TV, Press, Radio, and the Internet, can also cause you low Self Esteem.
- The over flogged idea of trying to model yourself to suit "the ideal lifestyle, life of the famous and the rich, the superstars" can really destroy your Self Esteem.
- Parents could also cause low Self Esteem. A home where there's no love produces nothing but negativity. A situation where you are not praised by who you are, what achievements you have made cannot encourage you to feel happy about yourself

How is negative self-esteem maintained?

Exercise 3– In a group discuss the factors that maintain low self-esteem

(Write down the ideas on the board)

Discuss the following factors, if not already raised in the discussion:
- Through negative beliefs about ourselves, e.g. stupid, incompetent, unlovable, ugly.
- Through various things that have happened to us and the way we interpret these events.
- Our responses to certain day to day situations
- The way we process information around us
- We pay attention to things we expect to happen
- We interpret things in a way that is consistent with our expectations

Case study – Shazia's story

- How does Shazia feel about herself?
- What has made Shazia feel this way about herself?
- What is maintaining the way she is feeling?
- How could she change the way she is feeling?
- How can you stay mentally healthy within the same environment?

…………………………………….tea break…………………………………………

The ABC of our thoughts and behaviour

"We have discussed the ABC model in the earlier sessions. Let's see if we can apply the ABC model to our self-esteem. Certain things happen in our lives which result in us feeling low or bad about ourselves; For example, having an argument with your husband. The argument may result in you feeling tearful, thinking that you're worthless, avoiding your husband or sulking. A typical thought may be "if he valued me, he wouldn't have said all those awful things to me". So the Autonomic or physical response may be the crying, the behaviour may be avoiding your husband and the cognition may be that you are a worthless person. Getting the hang of ABC format is easier if you break it down into these three steps. This gives you the chance to catch the negative automatic thoughts and helps you understand the relationship

between your thoughts, your behaviour and physical responses. The more negative the meaning you give to an event the more negative you will feel; and so you are more likely to act in a way which maintains that feeling. Can you think of an event, which has led you to feel bad about yourself?"

➢ **Exercise – 4.**
- Think of something that occurred recently, in the past or you anticipate may happen some time in the future. It can be pretty much anything, e.g. something negative someone has said, something that happened which resulted in you feeling negative about yourself.
- In the ABC box write down your autonomic response, your behaviour, and your thoughts.

- **My own physical feelings**
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....
....

- **Things I do or have stopped doing**
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....
....

- **My own thoughts**
....
....
....

"*Changing your thoughts can change your behaviour. Working with the same example, after you have the row with your husband, you could think, "there may be a 1001 reasons for him behaving this way, when he is calm I will discuss this with him or maybe not. Your behaviour may be that you give him his space and continue with the good things in your day to day life, something like playing with your child, or watching your favourite programme on TV, and you may not feel the negative physical reactions.*"

Exercise – 5. "*I would now like you to write down in the following box the old meaning you had with your negative event. How do you feel? Now I would like you*

to write a new meaning to the event. This should be a more positive meaning. How do you feel about yourself now?" **(Discuss these new feelings in detail and emphasise the thoughts and emotions attached to this new meaning).**

Negative event	Old meaning (How did you feel, behave and think after the event)	New meaning (How did you feel, behave and think after the event)

What do you need for good self-esteem?

For example – doing things we value

"I read stories to my 3 year old daughter. That is something that I value. Being a good mother is very important to me and I am always looking for feedback. By reading stories to my daughter I get my feedback about being a good mother."

"Can you maximise in other areas of your life that are working well, rather than focussing on those that aren't working so well?"

Some other examples of achieving good self esteem are;

- **Always try your best and try to be happy with yourself**. Know what you can achieve, and what may be difficult to achieve. Use your skills and do your best. Accept your best as good enough.
- **Enjoy your life for the gift it is**. Experience and give love. Don't drive yourself so hard you no longer enjoy life or see the goal you set yourself. First think about your health and allow yourself time to reflect and quieten down each day.
- **Understand yourself**. Identify what your strengths and weaknesses are. You will find satisfaction when you are doing what you are good at and when you accept your weaknesses. Chances are you will also be more successful this way. Try new things and don't be scared to do so. If you feel the need, then try to improve yourself but don't waste effort and time on those things which are not for you.
- **Faith in God** is very helpful to many of us. Religion teaches us our importance as people but also reminds us we need help from above to achieve anything real. Always hold on to your beliefs and values and don't betray them or you will hurt inside.

- **Don't compete with others** as life is not a race. Set yourself your own standards and try to reach them, but once again, don't be scared to fail and accept your own limitations. Competing with others will only drain you and will take away your good self esteem because there will always be someone better than you. Decide on your own path and stick to it.
- **Don't be too hard on yourself**. You can't do it all. Don't try to. The best you can do is to use your skills and abilities as best you can and trust that everything will work out.
- **Reward yourself for your achievements**. No matter how small these are. Try to achieve more but don't tire yourself out on things which don't truly matter to you. Focus on what is really important for you. When you know what you want to achieve then set goals (small steps) and reward yourself when you achieve each step. It takes time to achieve things that are worthwhile, so never give up and lose hope.
- **Be thankful for all the good things you have**. Think of those who are lesser off than you, and the things you have, which they don't have. Be happy with your life as it is! Look for the things that are right and take satisfaction in those. Try to improve your life yes but be realistic about where you are and where you want to go.
- **Finally, life is too short** and we have to choose what we can achieve and how we want to live. Choose wisely but have faith in others and in anything you believe in.

Wrap up and Review of Goals

Exercise 6 – Group members are given 2-3 minutes each to discuss what new insights they have developed from the group session and what they will be doing in next week to progress towards their goals.

- I would like you to re-evaluate your goals according to how you are feeling about yourself now.
- Is there anything you feel differently about now?
- Is there anything you think you can do now, which you thought you could not do before?

"Thank you for attending today's session. I hope you have found it useful. If there is anything you would like to discuss with us, please feel free to do so. I look forward to seeing you all next week".

Session 4: "Keeping up with the Joneses"

Objectives of session:

- Maintain a focus on discussing issues related to self-esteem
- To unveil feelings of envy and jealousy and learn from others
- Express feelings and reactions to negative life events
- To encourage members to implement change in their lives outside of the group

➤ **Housekeeping**: Group agreements to be put on the board.
➤ **Check-in**: The group therapist summarises the content of last session and the progress that members have been making. Group members are given 2-3 minutes each to discuss the progress they have made since the previous group session.

"Hello everyone. It's nice to see you all again. I'm interested in how you have all been doing with your goals. Are there things you are finding difficult or hard to cope with? If so, please feel free to come to either of us and discuss any problems you have had in the last week. Now you may remember in our earlier session about low self-esteem, we discussed;

- You shouldn't compete with others
- Life is not a race. Set your own standards and try to reach them
- Don't be scared to fail and accept your own limitations
- Competing with others will drain you and will take away your good self esteem because there will always be someone better than you
- Decide on your path and stick to it

These are just some of the things we discussed. But they are relevant to what we will discuss today. We know that the society we live in now pushes us to do well in a lot of aspects of our life but particularly towards material gains. We feel compelled to have the best and not having the best things can also damage our self-esteem.

This phenomenon here in the west is known as "Keeping up with the Joneses" or "Keeping up with the Chaudry's". Has anyone ever seen the Sitcom "keeping up appearances", if not then the Pakistani drama serial "Parosi". Both these drama

serials are about relentless efforts to climb the social ladder within the backdrop of their less-than-classy families. Well this is what keeping up with the Joneses is about. The term in the west refers to striving to match one's neighbour's in spending and social standing. It happens a lot in Pakistan too in neighbourhoods. However, here in the UK we don't live in all Pakistani neighbourhoods. So we tend to compare ourselves with other family members, friends or acquaintances, women who we bump into at our children's schools, at the supermarket etc.

Do you ever compare yourself to other people in terms of material things? The following story is about Aarzoo. See if you can identify some of the negative thought processes going through Aarzoo's mind.

"My name is Aarzoo and I am a single mother with 3 children. Today is Eid day. All my family has gathered at my mum's house. Present in the house are my brother's, my sister's and cousins and their spouses. I'm the only one here without a husband. I know they look at me with pity and think I'm a loser. Since my divorce, I've not been doing so well financially. I can't afford half of the things they all have here. My car broke down yesterday, I felt so embarrassed. I mean who in this age has a banger for a car. I didn't tell anyone, I borrowed my best friend's car today, and I've told everyone that it's mine. Well I'm not going to let them pity me anymore. Nagina, my cousin, her husband just bought her a brand new BMW for her birthday. She's always showing off. I know she purposely tries to make me feel bad, because she's like that. That's why I borrowed my friend's Mercedes today. They all think I've done really well for myself. They are a bit curious though. I mean Nagina works in the bank and has a very good job. I only work in Tesco and part time too! I told them that I've got a new job at the hospital, working in an office. That sounds better than working in Tesco's doesn't it.

The other person who really winds me up is Tahira, my sister. Her husband's a jeweller. Oh I tell you, she has the best jewellery ever. She has a new bangle set every time I see her. I don't even have any jewellery left. Bit by bit, I've had to sell it all. I was something once too you know; when I first got married. He was a very generous man. Although he was constantly having affairs and beating me up. But he did buy me very expensive presents. Now I don't even feel like meeting people who are better off than me, they make me feel very insecure about myself. Now, my kids are beginning to pick up on this and I think they also behave similarly with their cousins. Today I'll be ok though, I bought these fake gold bracelets from Southall, everyone thinks they are real and have really complimented me on them. So now I feel a bit better and can probably get through the day."

➢ **Exercise 1**– In pairs identify:
- A.   Aarzoo's unhelpful thinking patterns?
- B.   What can Aarzoo do to overcome these negative thinking patterns?
- C.   What's good about Aarzoo's life?

➢ **Exercise 2** – Generate a group discussion about Aarzoo. Discuss the following topics in addition to the ones identified by the group and if not already identified by the group.

A

- Aarzoo's insecurity about herself
- Aarzoo's sense of jealousy and envy

B

- Discuss the **pressures** Aarzoo faces in her life, **financial, single parent, only divorced person in the family – What can she do? (Ask the group)**
- Are there any **expectations** of other's from Aarzoo? **What can she do? (Ask the group)**
- Is it **healthy** to compare **yourself to others**?

C

- Aarzoo is physically healthy
- She is independent
- She has 3 bright and healthy children
- She has a job
- She still has family support
- She has a friend

"Sometimes we can all think like Aarzoo. It's almost inevitable in this society for us to feel secure about our lives all the time. Are there things which you feel insecure about?

➢ **Exercise 3**- Write down the issues in a box and we can anonymously discuss these issues in the group.

Write down the issues on the board and discuss with the group

How to overcome these self defeating thoughts

"We have now identified some of the unhealthy pressures we put on ourselves, which form negative beliefs about ourselves. Going back to the ABC model that we have been using in the past sessions, I would now like you to think of a negative event/s and how it affected you in the following ways; your autonomic/physical response, your behaviour and your cognitions or thoughts. (Here is an example). If this is not clear to anyone, please feel free to ask for help and we will go through this with you individually".

Event	*(Autonomic/ Physical response)*	*Behaviour*	*Cognition (thoughts)*
E.g. Neighbour went for a holiday with the family	*Feel sad, cry, can't sleep at night*	*Feel resentful towards husband and neighbour, as a result avoid the neighbour and get into a mood with the husband.*	*"If only my husband took me as well, he doesn't value me enough like her husband does"*

- **My own physical feelings**

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……………………………………………………………………

- **Things I do or have stopped doing**

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………………………………………………………………………

- **My own thoughts**

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………………………………………………………………………

➢ **Exercise 4 –** Compile a list of healthy thoughts and behaviours

Some of the suggestions are:

- Always look at both sides of the story, if someone has more than you in one way, there may be something that you have and they don't.
- Not everyone has everything
- Talk to people you can trust about these issues and see if they have ever felt this way
- Ask people to tell you some of the good things about yourself to boost your self esteem
- Make a list of all the good things you have in life and be thankful for those things
- Put your energy in the good things and make them even better
- Avoid investing your energy in lost causes
- "Tomorrow's another day"

Wrap up

"On this happy note, I would like to thank you all for discussing some very personal issues with us all here today. I know it is not easy to talk about personal issues and I would like you to give yourself a pat on the back for achieving the confidence to complete today's tasks. I hope this session has been useful in further reducing some of the pressures we put on ourselves which come in the way of our happiness. Take care and if anyone needs to speak to us in private, please feel free to approach us at any time. I look forward to seeing you all next week".

Session 5 – Exercise, Looking Good and Building Motivation

Objectives of session:

- Maintain a focus on discussing issues related to good self esteem
- Identify the pressures on women wanting to look good
- To identify negative feelings associated with our body image
- To discuss the consequences of dieting or overeating
- The looking good and feeling good connection
- Exercise as a way of managing good weight
- To encourage members to implement change in their lives outside of the group

➢ **Housekeeping**: Group agreements to be put on the board.

➢ **Check-in**: The group therapist summarises the content of last session and the progress that members have been making. Group members are given 2-3 minutes each to discuss the progress they have made since the previous group session.

"Hi everyone. Welcome to the fifth week of Positive Health programme. It's nice to see you all again. Today's topic is a very touchy one for most of us women, looking good or thin. We are at a stage in our lives when our bodies are changing. We are no longer sweet sixteen. We have had children and as a result our bodies have changed, maybe a lot for some of us and a little for others. But we have all experienced some kind of change. I have met many women who are as thin as a piece of paper but still regard themselves as fat. Even though it's a touchy topic, let's make it a fun one. We don't have to feel bad about ourselves in terms of how we look. You may remember in our last session we talked about everyone not having everything. I mean Angelina Jolie and Aishwariya Rai may be the gold standard portrayed by the media for how a woman should look; we should set our own standard!

We are all different, you may like my nose and I might like your eyes. You may think I have the perfect sized waist, but I may think you have the most flat stomach ever to be seen! I would like everyone to be supportive towards each other and let's break

this vicious and unrealistic cycle of wanting to look good for the wrong reasons. If you need to discuss some matters privately, please feel free to talk to either of us here. Now you may remember in our earlier session about "keeping up with Joneses", we discussed threats to our self esteem in terms of material gains. I would like to keep on the same theme and talk about, yet again another threat to our self esteem, the way we look, in particularly our body image. One of the main causes for having a negative self image is due to comparing ourselves to other women. Whether they are in the media, in our families, social circle etc.

As women, we have much insecurity related to the way we think we look or our body image. Some of the example are, weight, skin colour, height, facial features, hair etc. You can sometimes find yourself thinking about the way you look, 'Am I pretty', 'Am I attractive', 'Do I have a good figure', 'Is my hair silky' and so on. When we don't get any positive feedback from ourselves or the people in our environment, we can sometimes end up comparing ourselves with others in terms of the above mentioned factors."

➢ **Exercise** 1 – Can you think of any other reasons as to why we compare ourselves to other women, in terms of how we look? You can work alone, or work in pairs to generate some ideas.
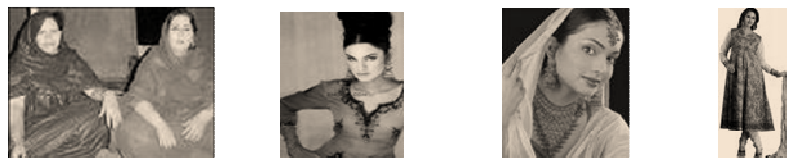
In the format of a discussion, write down the ideas generated by the group on the white board.

"We may feel threatened about the way we look for a number of reasons and in turn compare ourselves to other people as a consequence of this. Our body image is affected positively and negatively by many events. As a woman, the ups and downs of weight are normal; there are times in life when we eat more or less. Events such as an important personal or social event might lead us to slim down temporarily, and a battle to keep this weight off can be difficult. Pregnancy can also cause weight changes that are difficult to reverse. All these variations and events can lead to frustration, especially if you weigh yourself every day."

You may suggest some of the following ideas, if not already mentioned by the group;

- Media - health campaigns more about looking better than feeling better
- Pressure to be thin can come from many areas such as parents, friends, and magazines, TV programmes on diets and weight loss
- We may feel bad about our own body image due to being criticised about the way we look
- We may feel envious and jealous of other people for being negatively compared to other people by members in the family or in the social circle
- Other areas in our lives may not be doing so well so we generalise the negativity to all areas of our lives including the way we look

Some of our experiences which can be a threat to our self esteem

- Getting weighed in a social situation e.g. at the doctors during and after having a baby and realising that we are a lot heavier than before
- Trying on clothes and not fitting into them
- Seeing pictures of yourself from different time points and comparing them
- Spending time with someone much thinner than yourself
- A comment by someone regarding weight gain

➢ **Exercise 2** – Identify in group discussion, some of the dangers of wanting to be thin for the wrong reasons?
Some examples are;

- Continuous dieting can be the start of developing poor body image
- Constant pressure makes many women feel "fat"
- Statistics show that 70 to 80 percent of women feel they need to lose weight!
- One-fourth of college and university age women have some bulimic behaviour!
- Up to 60 percent of girls and women have some components of eating disorders!
- Bad eating habits make it difficult to maintain normal weight and good health!
- Mood can become directly related to weight fluctuations and dieting success or failure!
- Dieting itself can cause you to feel low in mood, difficulty concentrating, frequent illness, pain, poor skin, brittle hair and nails, and irritability!
- These symptoms can cause a rebound effect of even worse body image, leading to further dieting, eating disorders, or overeating!

- Affects other aspects of life, such as not wanting to spend time with others when eating is involved
- Regularly skipping social, family, or work activities to avoid eating
- Cancelling social engagements based on weight

The ABC model for negative body image

Exercise 3 - I would like you to apply the ABC model, which we have used in our previous sessions, to identify some of the unhelpful thinking patterns about your body image.

Negative event	Autonomic response	Behaviour	Cognition	Positive thought
E.g. Family member made a comment in a social gathering about you having put on a lot of weight after the baby's birth	*Heart starts racing, feel weepy, angry at yourself and feel under confident, and jealous of thin women*	*Avoid family gatherings.*	*"I'm so fat and ugly, no wonder they don't think much of me, I'm just not going to come again to another family gathering"*	*"I'm ok with the way I am. As long as I am healthy that's all that matters. If my weight is over the healthy limit, then perhaps I should look at ways to reduce it"*

Evaluating our Body Image

Exercise 4 - *If you have body image concerns, as most women do, review the following statements and allow yourself to consider how positive you feel about your body image. Starred statements suggest a higher risk of eating disorders".*

Statements to Consider When Evaluating Your Body Image

- I seriously worry about my weight on a daily basis.*
- I want to weigh 10 pounds more or less than I do now.
- I have been on more than one diet in the past year.
- I have or have had an eating disorder.
- People tell me I am "too thin," but I always feel fat.*
- Even though I weigh less than I have in the past year, I feel fat.*
- I weigh myself more than once a day.*
- I get anxious if I can't exercise more than one hour each day.
- If I gain more than one pound, I get anxious or depressed.*
- I feel guilty when I eat foods that contain any fat.*
- I would rather eat by myself than with family or friends.*
- I don't talk about my fear of being fat, because everyone tells me I am too thin.*
- I'm afraid I won't be able to stop eating if I start.
- I get very upset when people urge me to eat.
- Sometimes I think that my under eating or overeating is not normal.*

*More serious signs that suggest components of an eating disorder

"Agreeing with many of these statements is a sign that you might need to speak to your GP about your eating habits. Your GP may be able to refer you to a nutritionist or advise you her/himself about a healthy diet and eating habits. Be aware that even women with an overall healthy body image occasionally agree with some of these statements. It takes some discipline to be successful in weight management."

Some of the possible ways of managing weight

- Identifying the danger in letting this get out of control and letting it control you!
- Being able to recognise behaviours consistent with eating disorders, dieting or binge eating.
- Knowing that you need to correct thoughts and actions out of line with positive body image are that these are key to maintaining confidence, happiness, and health.

Some tips for healthy eating:

- Replace fizzy drinks and fruit cordials with water
- Eat plenty of fruits and vegetables
- Cook food in olive oil rather than ghee or butter
- Swap whole milk for semi-skimmed, or semi-skimmed for skimmed.
- Eat less lunch than usual. For example, eat one chapatti rather than two
- Reduce sugar intake in tea and coffee.
- Have smaller portions of the food you enjoy.
- Avoid having a second helping at dinner.
- Cut out unhealthy treats such as confectionary, sugary biscuits and crisps between meals.

Exercise as a healthy means to obtaining good weight and feeling good

Benefits of exercise:

- Helps the circulatory system deliver oxygen and nutrients around the body
- Helps the removal of toxins and waste products from your body
- Improves the condition of your skin
- Reduces the rate of bone loss, the risk of heart disease, hypertension (high blood pressure) and diabetes
- Alleviates feelings of depression and anxiety
- Controls weight
- Builds and maintain strong and healthy bones, muscles and joints.
- Stimulates the production of endorphins - chemical substances produced by the body that make you feel happy and exhilarated. So not only is exercise good for you, but it makes you feel happy too!

How much exercise should you do?

Ideally, you should engage in moderate exercise for 30 minutes every day. Moderate exercise includes taking the children to school, going up and down the stairs, the stairs or going for a walk during the day with a friend, whilst the children are at school etc. You can do the 30 minutes in one go or divide it up into a few manageable blocks of 10 minute sessions.

Ways of increasing levels of exercise

- Walk to the shops instead of driving and carry the shopping bags home to give your arms a good workout. Make sure you balance the bags between your two arms.
- Use weekends to get out and about. Take the children to the park.
- Find a friend to exercise with. This increases your motivation and ensures that you get there and on time.
- Join an exercise class, one in which you feel comfortable and that fits into your week or invest in a workout video to do at home
- Go up and down the stairs for 1o minutes
- Try a walking group or a women's only swimming or aerobics class.
- If you have a garden, mowing the lawn, pruning and weeding are strenuous activities that also give a great sense of accomplishment and wellbeing.
- For something more gentle and controlled, try yoga or Pilates video which you can do at home.

Re-evaluating Goals – "At the start of this session, if any of you here felt you couldn't feel better about the way you look; I would like you to re-evaluate your goals and add this to your goals. If you think you look good, you will feel good, and if you feel good, you will look good. It's a win win situation ladies. So why don't you go ahead and write down all the things which will make you feel good about looking good. If you need any help, then don't hesitate to ask.

Your looking good, feeling good plan

Things I want to achieve	The way I can achieve this	Possible barriers and how to overcome them
e.g. Want to lose weight	Starting a walk with a friend	May not always be possible, so the days I Can't, I will more physical work at home, such as cleaning the windows, mowing the garden, washing all the curtains in the house.
e.g. Better skin	Eat more fresh fruit and vegetables, and drink water. Wash my face after wearing make-up.	Might not get time to do so, or may not have enough money for fruit and fresh vegetable. Then drink plenty of water!

➢ **Exercise 5** – "I would like you to fill in your own looking good and feeling good plan now. If you need any help, just ask anyone of us here and we will help you with the plan.

Take home message – "*Your role in life as a mother, wife, family member, and friend will not be affected by more or less pounds. It will be affected by happiness and self-confidence. Feel good about yourself, and understand that occasionally questioning how you look is normal.*

Finally I would like to thank you all for attending today's session and I hope it has been useful in promoting some healthy ways to look good and feel good, for the right reasons. I hope to see you all next week. If anyone would like to speak to us about matters discussed in this session, we will be more than happy to speak to you."

Session 6 – Religion & Spirituality

Objectives of session:

- Maintain a focus on discussing issues related to faith and spirituality
- Identifying negative beliefs about "Punishment from God"
- To challenge our negative thoughts regarding religion using the ABC model
- Using spirituality as means of increasing inner calm
- To encourage members to implement change in their lives outside of the group

➢ **Housekeeping**: Group agreements to be put on the board.
➢ **Check-in**: The group therapist summarises the content of last session and the progress that members have been making. Group members are given 2-3 minutes each to discuss the progress they have made since the previous group session.

"Welcome back to the 6th week of the Positive Health Programme. We are now half way through the programme and I hope you have started to notice some changes in your health. It doesn't matter how big or small the change is. If you are feeling concerned about any matter related to your health, please take a moment to come and speak to us. Now, today's topic is one which affects most women. As women we have a tendency to feel guilty about anything or everything! We are good at taking the blame for things which aren't even our fault. And if blaming wasn't enough we go one step further and see things as a punishment from God.

I would like to begin this session with Amna's story. This is just an extract of how she is feeling at the moment. I will explain why Amna started feeling this way in more detail after the first exercise"

➢ **Case study of Amna**

"Since June 2007, after my aunt passed away I have felt really down, thinking about life and how I wish I was not here. I know this is wrong and I hope Allah can forgive me for thinking this, but it's the mind that says all the negative things. I also feel I am a bad person, as sometimes if it is prayer time and I am tired, then I'll think, "I will pray tomorrow".

I was a very healthy person, but since June 2007, I have been off work for more than a year because of my constant tiredness. I feel very weak and nauseated. I always think negative thoughts about everything. When I'm happy, my mind will question me by saying "Why are you happy?" or when I make prayers after, my mind says "You're still ill, you will never get better, so there's no point praying to Allah to make you better." Why do I feel like this? I want to be happy, active, full of energy and

motivated. I am so weak that I feel dizzy when I do ablution and I pray sitting down because I feel dizzy and my vision goes blurry. I want to be a good Muslim and perform my duty on this earth which is to obey Allah.

I have a friend who reverted to Islam and I wanted to teach her more about it. I just don't have the strength to help her. The only reason I am still alive is because I feel that it is a big sin to commit suicide and to wish death upon yourself and I think of Allah, that's what stops me. But I really need help. But I have had help from all different doctors and specialists and they all said physically my insides are fine, it's just my mental thinking. I want some piece of mind? I want to have good health, so that I can do all the things I want to do, like pray five times a day. If I don't have the health, how can I?

I cry myself to sleep thinking and praying that I hope I wake up well in the morning. I have even had a couple of job offers come through, but because of me feeling weak (no energy) and dizzy and sick, I cannot get up in the morning. I want full strength in everything I do, and I want to say to all people out there to thank Allah for giving you health, because if you have none of that, you won't have anything. I just want to take negative things out of my head. I get scared when people pass away too. This really puts me down."

➢ **Exercise 1** – In pairs,

(a) Can you identify some of the negative thoughts Amna is having?
(b) Can you identify the consequences of these thoughts?

Some suggestions are: (a) – negative thoughts

- Wants' full strength in everything she does
- My prayers will never be accepted!
- My Mind say's "Why are you happy?"
- I Wanting to help other's but I can't
- Feeling scared about things that are out of her control (i.e. people dying)

(b) Consequences of negative thoughts

- Feels tired
- Feels guilty
- Low in motivation
- Suicidal, no desire to live
- Physically unwell

"Amna's symptoms are not alien to many of us here. We all go through surges of guilt from time to time. Amna was once a very happy girl. She wasn't a very practising Muslim girl but she was a good natured and righteous person. She wanted to marry someone from her own choice. This resulted in great family tension and feuds. As a result she gave into the family pressure and married her cousin from Pakistan.

This man treated her very badly. When her father passed away, he did not let her go to his funeral as they were no longer on talking terms with Amna's family. A few months later, Amna became pregnant for the first time. She felt very happy once again in her life. However, she had a miscarriage in her fifth month. She was cleaning the kitchen window and slipped. Amna can still have children but she is too scared of losing the baby again. She was distraught. She isn't getting much support from her family as they are still not on talking terms. Her husband has become even more hostile towards her. Putting Amna's thoughts in context, can you understand why she became thinking like this?

She is in an awkward position. Her husband's behaviour is unacceptable; however, leaving your husband in the Pakistani culture is not the easiest thing to do. Are there way's she can cope with her life, without leaving the husband?

➢ **Exercise 2**– In pairs, can you come up with any solutions for Amna. What can she do? How can she manage her mood and symptoms of guilt?

Some possible suggestions are:

- Speak to someone about her problems rather than bottling it all up, e.g. a GP, a friend, a trustworthy family member
- Finding a hobby to take her mind off the current problems
- Exploring ways of building energy
- Challenging her unhealthy thinking styles using ABC model

"Sometimes we can also feel like Amna. When something starts to get out of hand, we can sometimes begin to externalise our thoughts and behaviours related to that event. "It's out of my hands", "It's a punishment from God", "I'm getting punished for my sins" etc etc. These sorts of thoughts can make us feel very disempowered about our own life. These are self defeating negative thoughts."

➤ **Exercise 3** – *"If any of you here have had similar thoughts as Amna, then I would like you to write these thoughts on a piece of paper and we will collect your comments and put them all in an anonymous box. One by one, we will discuss your thoughts in the group and work together to come up with more positive ways of thinking".*

Islam and depression

"I have done a little research on the facts in our religion regarding depression or low mood and distress. The following are some useful facts: Islam does not deny the existence of depression, and describes it as the phase of Qabd. In Islam, low mood is due to diseases of the heart or soul. It encourages identifying the ailments that make the heart sick. These ailments include:

1. Arrogance and conceit (al-kibr wa al-ghurur)
2. Ostentation (al-riya)
3. Jealousy or envy, hate and deceit (al-hasad, al-hiqd, al-ghish)
4. Suspicion (su' al-zann)
5. Anger (al-ghadab)
6. Stinginess (al-bukhl)
7. Love of Jah (power, money, position and fame)

So for example, if my depression is because I am dissatisfied with my life and I am envious of other's wealth/relationship etc; taking medication is not going to make it go away. I will have to deal with the root. Depression is the symptom and enviousness is the problem. This is quite similar to what we have already discussed in our previous sessions. Whether we are religious or not, it is quite obvious that the above mentioned factors are not good to have and that they can cause us problems within our individual minds and our social world. Therefore, for any of us here, with religious beliefs, who think their depression is a punishment from God, I would really like to emphasise these findings once again. Life can be a test, sometimes we go through happy times and at other times in our life, and we can go through distress. It is up to us to make sense of these events in a rational manner. It is ok to feel down from time to time. I'm thankful, if I'm happy only half of the time, and the other half passes by too. Never give up hope, we are all humans and make mistakes. Learn from your mistakes and move on. It's not a bad thing to have faith but use it in a positive way".

➤ *Exercise 4* – It might be useful to look back to the goals you want to achieve. Is there anything you did not include because you felt you would not be able to achieve due to irrational thoughts such as being punished by God? If so, I would like you to set yourself some new goals and go easy on yourself. An example is to perform the daily prayers or recite the holy book.

"Thank you for attending today's session. I hope you have found it useful. If there is anything you would like to discuss with us, please feel free to do so. I look forward to seeing you all next week".

Session 7 – Relaxation: "Taking time out"

Objectives of session:

- To identify barriers to relaxation
- The effect of relaxation on mind and body
- Some tips on ways to relax
- To encourage members to implement change in their lives outside of the group

➢ **Housekeeping**: Group agreements to be put on the board.
➢ **Check-in**: The group therapist summarises the content of last session and the progress that members have been making. Group members are given 2-3 minutes each to discuss the progress they have made since the previous group session.

"Hello ladies, welcome to the 7th week of the Positive Health Programme. Being a mother is a full time job. As women, we are good at managing our familial duties. However, these duties often revolve around other members of the family. Today, we will examine just exactly how much "me time" we make or how much we relax in our day-to-day routines".

➢ **Exercise 1 –** Using the Daily activity Schedule, first I would like you to write down your routine on a typical day. Starting from when you wake up to when you fall asleep at night. Now, in pairs discuss how much time you get to relax and how much *relaxing you do* during your day.

Daily Activity Schedule

7-10	10-1	1-4	4-7	7-10	10-1	1-4	4-7

➢ Generate a group discussion about the hassles women face when wanting to have some "me time". What are the barriers to relaxation? Some suggestions could be:

- Lack of time
- Don't feel the need
- Too much to do
- Can't relax even if tried
- Don't think it's necessary to relax
- Feel judged by other people
- Feel guilty when wanting some "me time"

The benefits of "taking time out" to relax

Benefits for our physical health

- Reduces blood pressure, which can lead to heart attack or stroke
- Slows the rate of breathing, which reduces the need for oxygen
- Gives the heart a rest by slowing the heart rate
- Increases blood flow to the muscles
- Decreases muscle tension
- More energy
- Better sleep
- Better immune system
- Less headaches and pain

Benefits for our mental health

- Increased concentration
- Better problem-solving abilities
- Greater efficiency
- Smoother emotions — less anger, crying, anxiety, frustration

➤ **Exercise 2 –** Generate a group discussion about
(a) Can you identify some of the ways you currently relax?
(b) Can you identify some of the possible ways of relaxing in a Pakistani home? What do Pakistani women need to relax, what are the activities which can make a Pakistani woman relax? Some suggestions are:

- Read the Quran or a novel
- Go for a walk with a friend
- Go shopping but not for groceries
- Watch a favourite programme
- Listen or dance to favourite songs
- Do some Yoga or Zikr (recitation of Quranic verses or words)
- Get a facial done or massage
- Go to a "women's morning" at the local leisure centre
- Go to a women's study circle

The following are a number of fun activities, which you may want to choose from and may seem fun for you to do.

Fun Activities Catalogue

1. Soaking in the bathtub
2. Going to a movie
3. Jogging or walking
4. Listening to music
5. Thinking I have done a full day's work
6. Sitting in the sun
7. Laughing
8. Thinking about past trips
9. Listening to others
10. Reading magazines or newspapers
11. Spending an afternoon with good friends
12. Remembering beautiful scenery
13. Card and board games
14. Cooking yourself your favourite dish
15. Repairing things around the house
16. Remembering the words and deeds of loving people
17. Taking care of my plants
18. Going swimming
19. Doodling
20. Exercising
21. Flying kites
22. Having light hearted discussions with friends
23. Having family get-togethers
24. Singing around the house
25. Arranging flowers
26. Thinking I'm an OK person
27. A day with nothing to do
28. Sketching or painting
29. Doing something spontaneously
30. Doing embroidery or cross stitching
31. Sleeping
32. Going to classes (baking, sewing, etc.)
33. Playing musical instruments
34. Doing arts and crafts
35. Making a gift for someone
36. Cooking or baking things you like
37. Writing books (poems, articles)
38. Sewing
39. Buying clothes
40. Discussing books with friends
41. Gardening
42. Going to the beauty salon
43. Watching my children (play)
44. Daydreaming
45. Refurbishing furniture
46. Watching TV or videos
47. Making lists of tasks
48. Walks in the park

Exercise 3: I would like you now to devise a relaxation plan for yourself. Are there things you would like to do but can't make time for? We have already established the barriers. Are there ways of overcoming these barriers?

An example of a relaxation plan is;

Things I'd like to do	When can I fit it in	Barriers	Overcoming barriers
"I'd like to watch my favourite movie"	"After I've dropped the kids to school"	"I have to cook and clean the whole house today"	"I suppose I can cook first and do half the cleaning today and half tomorrow. That gives me time to watch my movie"

Wrap up

"Finally, I thank you all for taking time out of your busy lives to attend this session today. By coming to these sessions, you have already taken the step to do something positive for yourself, SO YOU CAN DO IT! Carry on with the positive changes in your life and if you are having any difficulties, come and discuss these with us. I wish you all a wonderful week ahead."

Session 8: Assertiveness and confidence building

Objectives of session:

- To discuss what it means to be confident and assertive
- Discuss issues related to low self confidence and lack of assertiveness
- To teach ways of becoming assertive and confident
- To encourage members to implement change in their lives outside of the group

➤ **Housekeeping**: Group agreements to be put on the board.
➤ **Check-in**: The group therapist summarises the content of last session and the progress that members have been making. Group members are given 2-3 minutes each to discuss the progress they have made since the previous group session.

"Hello everyone. It's nice to see you all again. I'm interested in how you have all been doing with your goals. If you encountered any difficulties, then please feel free to come to either of us and discuss any problems you have had in the last week. Now you may remember in one of our earlier sessions we talked about self-esteem, which is your opinion about yourself. One of the threats to good self esteem is low self confidence; however, low self esteem can also cause low self confidence. Sometimes as a result of having low self confidence, you may become less assertive and more passive or aggressive. We will begin today's session with a definition confidence."

➤ **Group exercise 1** – Ask the group what their understanding of confidence and assertiveness and then give the following definitions.

- *Confidence* is generally described as being certain, when you know you are correct about something, or the way you have decided to do something is the best or most effective way. **Self confidence** is having confidence in yourself.

- **Assertiveness** is defined as standing up for yourself and expressing your thoughts, feelings and beliefs in a direct, honest and appropriate way without taking away another person's rights. Non-assertiveness is allowing others to take over your rights.

➤ **Exercise 2** – In a group discussion ask the women, "How does low confidence and lack of assertiveness impact on your lives? What are the specific things that you would like to change?
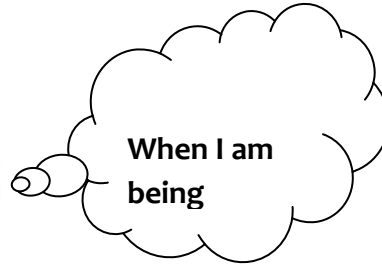
An example of being Assertive

When I am being

"...I express who I am. I tell you what I think, how I feel and what I believe. I do so in a direct and honest way, which is also appropriate. I don't think it is appropriate to tell someone as soon as you meet them that you do not like them but it may be appropriate to tell a friend if they have said something which has upset you. It is also important to be aware that other people have rights too. I like to speak to people in the same way that I would like to be treated or spoken to?" When I am being assertive I express myself in a way that is both nice to myself and to others. I do not like to be put down nor do I try to put anyone else down. Assertion is a win-win situation. I approach a person with respect and I take responsibility for my words and actions too."

What does it mean to be Passive?

Being passive is the opposite of being assertive. It is when you stay quite when you want to say something. Or when you want to do something, but feel you don't have the ability to do so. Why does this happen? Some of us are naturally shy, not saying something is a lot different to not saying something because you feel you can't.

➢ **Exercise 2 –** In a group discussion ask, "Why do people act in a passive manner?"

Some suggestions are

- Lack of willpower: "I know I can't say anything to make a difference, so there's no point in trying in the first place".
- Lack of hope: "Saying something doesn't work. It never has done; it probably won't work now either".
- Lack of encouragement from other people to stick up for yourself: "I can't say anything by myself, and there's nobody there to support me".
- Negativity: "It won't end up well. By saying something, I'd rather not change anything than risk an even worse result".

"Think about the way you tend to act when you're about to ask for something. If there's something that stops you from asking, think about the first negative thought that comes to your mind. What kind of negative thoughts are these? Are these similar thoughts to what we have discussed before?"

➢ **Exercise 3** - In pairs, identify the negative thoughts that come into your head, in situations which require you to be assertive?

An example is:

Situation	Old Thought (Negative)	New Thought (Positive)
You are being asked to cook on Eid a number of dishes that you are not very good at making!	"I can't say no, everyone will think I'm incompetent"	"I don't think it's wise to cook something which I'm not very good at so I think I should tell the truth and suggest I will cook the dishes that I am good at"
How do you feel?	Feel anxious & embarrassed	Feel in control, calm, empowered

Challenging negative thoughts – If you think about the above example, you can see that negative thought generated negative emotions of anxiety and embarrassment. However, if this negative thought is challenged, you can come up with a more positive thought which exert positive emotions. Some of the possible ways challenging negative thoughts are by asking yourself:

- Why do you think or act in a particular way?
- On what belief is this based, how did you come to that decision?
- And if your belief is based on the views or opinions of others, what sort of reasoning is behind their thinking?
- How realistic/true is this thought?
- What is the evidence which supports this thought?
- What is the evidence against this thought?

Some possible ways of developing assertiveness:

- Ask for help if you need to, don't feel embarrassed, and be confident!
- Be more positive about yourself and others and don't always assume the other person has negative intentions!
- Be expressive: practice Speaking up when you have an idea or opinion
- Be consistent: practice standing up for your opinions and stick to them
- Be bold: don't be afraid to ask for what you want
- Be comfortable: practice saying no
- Learn to accept compliments
- Learn to accept constructive criticism

➤ **Exercise 4: Group exercise – In pairs;**

"This is just a little exercise, for those of you who find it hard to say no, and end up saying yes, even when you mean no. In a group let's do this following exercise;
*"Imagine a scenario in the past where you have said **"yes"** but meant **"no".***

- Explain to the group what the situation was, what the outcome was and how you felt.
- Ask the group to ask you the question that you should have said **"no"** to. This needs to be one sentence.
- It shouldn't turn into a debate! We're not looking for the person asking the question to give a convincing argument of why they need a **"yes".**
- As soon as they start to ask the question, interrupt and say clearly and loudly say "NO!"
- If there are several people in the group, get them to form a line. Each person should begin to ask you: **"Can you pick?"** or **"Mum, please can you help me do this so on"**. As soon as you have said **"no"** they must go to the back of the queue.
- With each request your **"no"** has to become more and more determined, blunt and in a confident manner. Whether you're working in pairs or as part of a group, the questions should come thick and fast, in as many ways as you can imagine.
- This exercise can go on for at least 30 **"no's".** Once you've finished, jot down on a piece of paper how you feel. Focus on the positive feelings you're experiencing. Keep this piece of paper with you.
- The next time you feel like **saying "yes"** remember your feelings and how you felt writing down those words. Feel free to **say "no".** Back it up with a short, reasonable explanation if necessary, but if you mean "no" then let it be heard!

Wrap up and Review of Goals

Exercise 5 – Group members are given 2-3 minutes each to discuss what new insights they have developed from the group session and what they will be doing in next week to progress towards their goals.

- I would like you to re-evaluate your goals
- Is there anything you feel differently about now?
- Is there anything you think you can do now, which you thought you could not do before?

"Thank you for attending today's session. I hope you have found it useful. If there is anything you would like to discuss with us, please feel free to do so. I look forward to seeing you all next week".

Session 9: Breaking Social Isolation & Building Social Networks

Objectives of session:

- Maintain a focus on discussing issues related to lack of social support
- Talk about the benefits of social support
- Using social support as protective factor
- To encourage members to implement change in their lives outside of the group

➢ **Housekeeping**: Group agreements to be put on the board.
➢ **Check-in**: The group therapist summarises the content of last session and the progress that members have been making. Group members are given 2-3 minutes each to discuss the progress they have made since the previous group session.

"Hello everyone. It's nice to see you all again. I'm interested in how you have all been doing with your goals. I hope you're all feeling good. If not, please feel free to come to either of us and discuss any problems you have had in the last week. Today we will be exploring different aspects related to social support."

➢ **Exercise 1 –** *Generate a group discussion about social support and ask;*

What is Social support?

An example is:

"A network of family, friends, neighbours, and community members that is available in times of need to give psychological, physical, and financial help".

Why do we need Social support?

Some examples are:

- Need help with managing day-to-day tasks – e.g. too cold to take the baby out, need someone to help mind the baby and you need to go to a doctor's appointment.
- Valuable to emotional health – e.g. good to have someone to talk to when you are feeling down
- People can lift your mood when you are feeling down
- Can make doing some activities more fun e.g. going for a walk
- May need help with English or other formal matters and it may be useful to take someone with you

What happens when we don't have enough social support?

Some examples are:

- Feel lonely
- Feel sad
- Sometimes hard to manage all alone
- Not being able to talk to people, you bottle things up
- Become anti social
- You think too much
- Become paranoid
- Lose confidence

What kind of people should you turn to for social support?

Some examples are

- People you feel good about
- People who are supportive
- People who don't expect reversal of favours
- People who are not antisocial

Avoid people who make you feel bad about yourself

"Some people you meet give off positive energy that makes you feel good, and others give off negative energy which leaves you feeling quite bad about yourself. Sometimes you can have an intuition about people when you first meet them. If you pay attention to those intuitive signals, you'll have a healthier social circle. Here are some questions to ask yourself:

- Do you feel relaxed when talking to this person?
- Does this person truly understand, accept and support you?
- Do you feel you truly understand, accept and support them?
- Do you feel better or worse about yourself when you're with them?
- Do you leave them feeling energized or mildly depressed?
- Do you include them in your life for positive qualities they have, or just to have more people in your life?

You do not have to get on with everyone you meet. If there's someone in your life who makes you feel bad about yourself, who doesn't share any of your beliefs or values, or someone you just don't mix well with, it's perfectly acceptable to stay away from that person, let that relationship fade away, or not develop in the first place. With time, people can change and grow in different directions. That doesn't mean there's something 'wrong' with either of you. But if someone in your life is no longer good for you, it's perfectly acceptable to let them go. You may keep them in your life out of loyalty, that's OK, too. However, it would be beneficial to remember not to count on them for support, if they're not able to give it to you. Only you know if the relationship is worth keeping or not. But it is important to have several people you can count on for support in your life. "

Ways of developing new social networks & increasing social support

"When you are mostly at home, with young children to look after, it is often difficult to make time and meet people. It is especially harder, if all your friends and similar aged women in the family also have young children. This limits the number of activities you can do with or even a chance of a good old chit chat. It may be an idea to make the most of your existing environment and the interactions you have within this environment. This allows you to meet new people and form new social networks."

➢ **Exercise 2**– Think of all the people you meet daily or even a few times a week

Some examples are:

- Women you meet at your children's schools
- Neighbours
- Women you meet in the children's Mosques
- At the local grocery shops
- Friends of the family who come to visit you
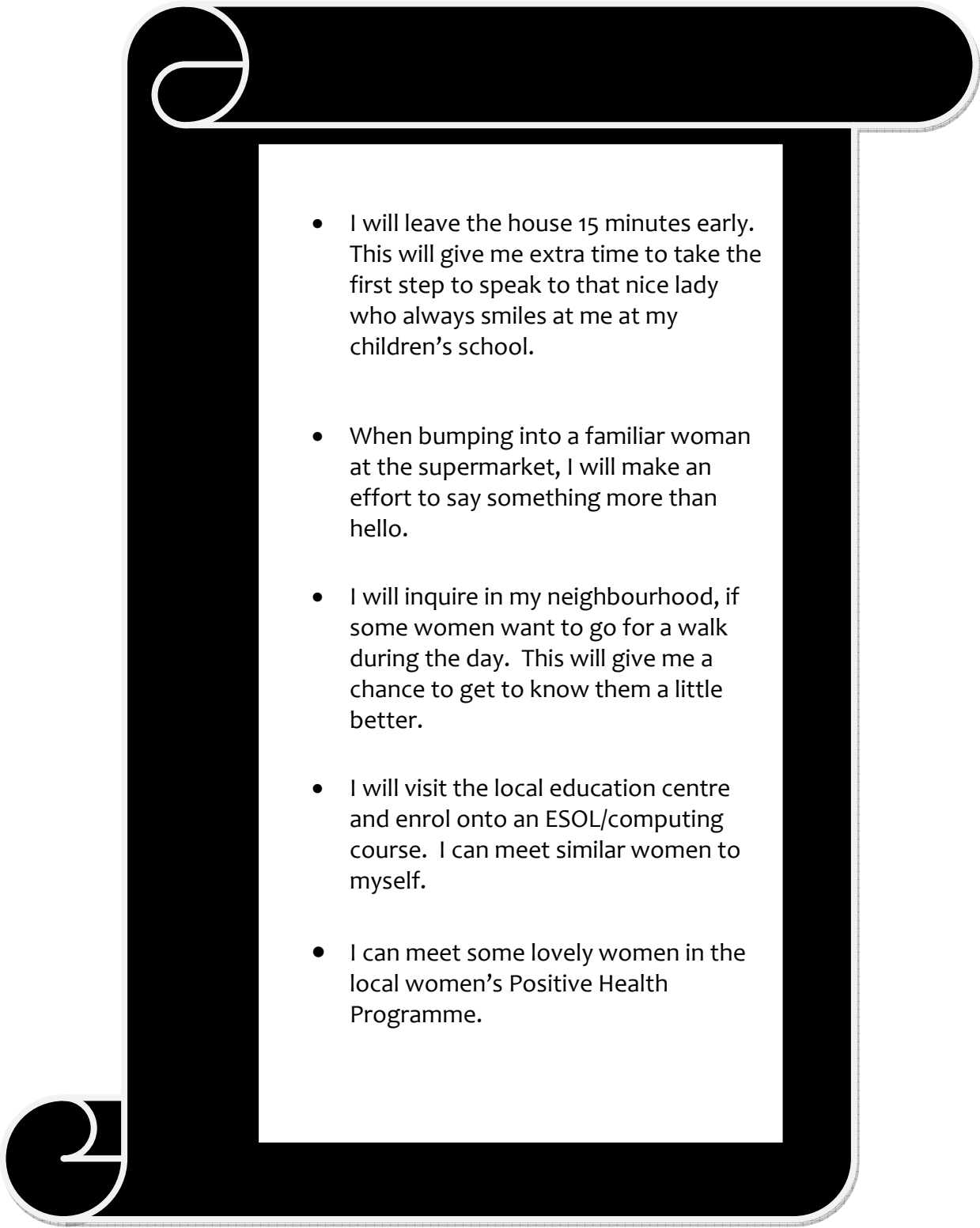- At weddings or other occasions
- Doctors surgery
- Local Parks

How can you become more socially active?

Exercise 3 – In a group, generate ideas of becoming more socially active or looking building new support networks. Some examples are:

- **Have a Party** If you invite all of your current friends and encourage each to bring a friend, you'll have a pool of new people to meet. Plus, you may inspire your friends to throw their own parties, where you'll meet even more new people.

- **Smile!** This one may sound simple, but if you give off an 'approachable vibe', you may find that you're striking up conversations with new people wherever you go. Not all these conversations need to lead to a new friendship, but some might, and just one warm exchange with someone new can brighten up your day (and theirs)!

> **Exercise 3 – Building social networks plan**

e.g.

- I will leave the house 15 minutes early. This will give me extra time to take the first step to speak to that nice lady who always smiles at me at my children's school.

- When bumping into a familiar woman at the supermarket, I will make an effort to say something more than hello.

- I will inquire in my neighbourhood, if some women want to go for a walk during the day. This will give me a chance to get to know them a little better.

- I will visit the local education centre and enrol onto an ESOL/computing course. I can meet similar women to myself.

- I can meet some lovely women in the local women's Positive Health Programme.

"Thank you for attending today's session and see you all next week".

Session 10 and 11 – Chitty Chatty Session

➢ **Housekeeping**: Group agreements to be put on the board.
➢ **Check-in**: The group therapist summarises the content of last session and the progress that members have been making. Group members are given 2-3 minutes each to discuss the progress they have made since the previous group session.

"Hello and welcome to one of the last few sessions of the Positive Health Programme. We have covered some very heavy topics in our previous sessions. Today's session is more light hearted than the previous sessions. I want to have a chance for us all to get to know each other a little better. However, if you feel you need to discuss some of the previous topics in any more detail, I am happy to do this with you. Alternatively, I am happy with you all getting to know each other a little better and talking amongst yourselves. Please feel free to approach us for any help."

Session 12 – Award Ceremony and Party

Objectives:

- **To review progress**
- **Plan for future contingencies**
- **Have a party**
- **To say goodbye**

Check-in: "This is our final group today and no doubt we are all having some feelings about that. Today is a chance to review your progress, remind yourself of the ABC model we used in therapy, look at future difficulties and to say goodbye. Let's start by finding out how have you been feeling in the past week and how you have been doing with your goals?"

Review of progress

An important aspect of the last group is helping group members to acknowledge their own progress and what changes they have witnessed in each other. *"What progress have you made on your goals and what difficulties do you anticipate in the future? What progress have people noticed in each other?"* The therapist facilitates a discussion encouraging members to acknowledge progress towards goals and positive feedback.

Set-backs, relapse, maintaining gains and planning for contingencies

"Slips and setbacks are common in our mental health; regular maintenance is important to ensure continuing good mental health. It is important to spend some time distinguishing a slip from a relapse. I wonder if we can go back to our old goals and see how we managed to stick to our goals, what barriers we faced and the things that made it easy for us to achieve our goals. Discuss these in the group."

Wrap up: "Ball of wool"

"This ball of wool symbolises aspects of motherhood. It is used to keep us warm, for comfort, it is a symbol of creating and giving to others. It has much in common with motherhood. We are going to use this ball of wall to take turns saying goodbye. The idea is that when you are holding the ball of wool you talk about your feelings about the group in general and your feelings about the group ending. When you feel that you are finished you need to toss the ball to someone else, until a matrix forms and the last person is finished. I would like to start and

my colleague would like to say the final words." Facilitator takes first turn expressing their feelings about the group ending and encourages others to express both +ve and –ve feelings. "Do you have any last words to the group, how would you like to say goodbye to the group?"

Ceremony of Awards

Now let's have a party!

Appendices

Appendix 1 - Case studies of Living with Depression

Shazia's story

Ever woke up and wished you hadn't? Wished you could just be swallowed up by the bed and disappear? It doesn't matter how long you lay there... the sun continues to rise and fall and the world outside continues on.

No one tells you it's going to be like this!

Andhairay din (Dark days) are the seconds that turn into minutes, then hours... The days when the darkness isn't going anywhere and neither am I. The irrational thoughts and fears all submerge in my very tired mind!

I stagger in a dopey daze to the toilet - only because if I don't my bladder would surely burst. Occasionally I see sunlight peaking in from behind the venetians. I don't dare to step into another room and look outside and see a person or cars go by, only to find out that the world was continuing on without me.

It is hard when I experience these dark days. I don't want to talk to, or see anyone. Exactly the opposite of what would be good for me. I just hope that with the prayers that I perform, and the right medication, I can get back on track - whenever that may be. At the moment I'm just working on building the desire to live!

Something strange happens to a person when depression takes control. People have started to ask me, "Where's the girl that used to laugh and joke, cook for the whole family in less than an hour, have kids looking tip top?"

Strangely enough when I look in the mirror I see the body I used to live in, but now it's slightly puffed with panda eyes and bad hair. It is as if aliens have visited and replaced me with a shadow of my former self. If it's hard for my family and friends to accept the changes in this once 'the life of the party', 'out there', 'bubbly, happy girl,' imagine how I feel.

I'll be lucky if I can fight my way out more than a few times a week, add a little make up and clothes, I actually am able to appear as a 'sane' or 'stable' human being.

Occasionally I dress up to fool myself and those around me. Upon careful observation you may notice a little lipstick on my face, but you'll know that I don't have a clue about the latest fashion! I may think that I am out fooling everyone and on the road to success, but the depression latches on and I can't yet escape.

I know baby steps are required when planning your escape from this hell. I'm prepared for experiencing moments of frustration. If only I can start to see some light. I so badly want to run straight towards it and to have everything return to normal ASAP! But someone up there is not so forgiving.

People tell me "Simple things start the recovery process such as getting up at roughly the same time each morning, exercising, even if it you can only manage a 15-30 minute walk per day. As the days pass, the time will increase and so your mood will improve!"

As my mum tells me, "Monitor your thoughts Shazia, it's a necessary step for you to escape this darkness you live in!" It is strange to think that I am my own worst enemy. My Dr tells me, "a chemical imbalance, and allowing negative thoughts and worries to build up, leads to feeling down".

Nothing makes sense to me. I no longer have my kids, my husband has left me and in all honesty, the society looks down at me. They pity me. The elders think I'm a weakling!! My Mum tells me it's the environment I was raised in, that she was too soft with me, If only she's given me a real slap after I had Nimrah, my beautiful little girl. I married out of my own choice. My husband was a lovely man. It was me and my pessimism that lead to my divorce. For years and years he tried to make me happy, but gave up in the end. Sometimes I think this is all a punishment from God, I used to neglect my family, my mum in particular, after I got married. I was too obsessed with my own life. My mum had a hip replacement in those days, and I never even went to see her. I guess what goes around, comes around. No I am all alone, my mum pities me. She doesn't say it. I can see it though. My sisters think I'm a liability and my brother is just embarrassed of me. He tells me, "You're a Pakistani girl, so behave like one, not a white girl! What is it like to behave like a Pakistani girl? Is that what my problem is, am I stuck between two cultures? Do Pakistani girls in Pakistan not get depressed?

I cannot get out of this hell, and I hate myself for this. I am fat and ugly; I have no job and no future. That is my life and there is no escape. Why did I become like this? I simply do not know. I lead a normal life, but out of nowhere, things started building up. I didn't do anything about it. And now look where I am. It started with a few negative thoughts, and has ended with only negativity!

Rehana's story

My name is Rehana. I have suffered from chronic depression for more than a decade. I feel sadness most of the time, irritability, anxiety, loss of confidence and motivation, and a withdrawal from society. I spoke to my Dr about coping with depression and dealing with these symptoms in a rational way. Because, I don't know why I am depressed. Just all of a sudden I became very sad and just lost interests in all things.

I'd always felt different when I was a child; I was very sensitive and introverted. I also suffered from insomnia from a very early age, without realising it wasn't normal not to sleep. It's these kinds of things that make me think that my tendency for depression is something that I've inherited, and that it isn't my fault.

I had my first depressive episode when I was 15. My behaviour was erratic. I was constantly upset, and I was preoccupied with thoughts of suicide. I just wanted to end it all. I didn't want to leave the house, I wanted to stay in my room alone all the time. Looking back, I should have sought help then, but I didn't really understand what was going on, and neither did my parents. This first episode lasted for about 6 months.

Since then, I have experienced several severe episodes of depression, some of which I can relate to stressful periods in my life, and others that I cannot explain.

It's unpredictable, which I think helped me understand that it isn't my fault. It's taken me a long time to be able to admit that to myself. What I am really trying to do now is understand it as much as I can, and not let it get the better of me.

Taking that first step to go and try to explain to my doctor how I was feeling was really hard. I felt like it was the last option left to me. I think in the back of my mind I had put off going in case they couldn't help me, and it was a waste of time.

I first spoke to a doctor about her depression when I was 20, and was initially prescribed antidepressants. It seemed like a really big decision to start taking them, it was like I was finally admitting defeat. But I was definitely hitting rock bottom and they couldn't have made me any worse.

I found the daily medication initially helped my depression. The antidepressant first started to work about a month or so after I began taking it, and I really felt that things had changed for me. It was a new experience to wake up in the morning and look forward to the day. I think I finally understood what it was like to be normal.

My initial diagnosis came as a relief after years of wondering what was wrong. It scared me, but at least someone was acknowledging that I had a problem and that it wasn't in my head. The funny thing was, the doctor never actually said the word depression. The first time I saw that was on my medical records; it was a pretty scary moment. After initially being prescribed medication, I stopped taking the medication after about 6 months when my depressive symptoms began to reappear. I acknowledge now this was the wrong way to handle the situation.

I didn't realise then that it was a matter of finding the right medication for you: I thought that if they didn't seem to be working, then what was the point? I was going to be depressed forever. This became one of the lowest periods of my life, as I tried to convince myself I could cope without the medication. There was a part of me that still felt taking the medication made me a failure.

It was another year before I spoke to a doctor about my depression, and I was again prescribed the same antidepressant. After about 3 months with no success, I was prescribed sertraline. I had a bad reaction to this medication, but tried to persist with it. I felt like I wasn't in touch with reality anymore; I was feeling weak and confused all the time.

I have persisted with the medication for about 6 months. I wanted it to work so badly, it was like this was my last chance. I am now prescribed Cipramil, which I continue

to take. I honestly don't know if this is right for me, but I do definitely feel better. Better in the sense that I don't cry as much. I feel a little more relaxed and a little numb.

I know too well how the stigma of mental illness can affect someone with a condition such as depression. I have lost a few friends since I decided to be more open about my depression, but I needed to do it for my own good. Some people don't want to try to understand it, but there are a lot of people who have experienced the same thing and never knew it was depression.

I think there is a perception that you're just lazy, and can't be bothered trying to cope. Some people just can't see that it's not your fault. Even now, I dread my employers ever finding out: I definitely think it would undermine me. I admit I had a lot of preconceptions about mental illness before my diagnosis. Even in my worst times, it had never really occurred to me that I was mentally ill, even after my diagnosis with depression. I think I removed myself from that.

I find it difficult to talk to family members about my problems, fearing that they will see me as weak. But it's reached the point that I have had to tell them or risk alienating myself from the family for good; I didn't really have a choice in the end.

Even my family baulk at using the term 'mental illness'. They all refer to it as a breakdown. I think they are afraid of me, but most family members and friends have been quite positive about it, but really, it's not something we talk about that much. I think it's hard on everyone.

The idea of talking to someone about my depression is daunting. I have dismissed the idea of counselling for many years. I don't really feel comfortable with telling someone I don't even know about how I feet. I don't know how to explain why I am so sad, why I don't want to get out of bed in the morning, and why I seem to be constantly crying. If I can't understand it, how is anyone else going to?

I have days when I don't want to go on. I have to live with depression: it isn't something you deserve, and it isn't something that's going to go away for me. All I want is try to be happy within myself, and not to give up, for the sake of those who love me!

Salma's story

I got married to a wonderful man from Pakistan. He was good looking and had a great future as an electrician. He used to let me do anything that I wanted. I started computer classes at college. He wanted to spend a lot of time with me and never once complained that I did not drive, so he would drop me to college everyday, which was 25 miles each way to pick me up and bring me back home. My husband had been

married before for about a year to his cousin in Bradford. He had been divorced about the same amount of time. When I met him he was 23 and I agreed with him that he had married too young. I know I was young when I got married, but we all always think our situation is different, don't we? This great relationship continued for about a year.

I wanted to study further because I was very intelligent, but my mum and dad told me that I had to get married. I wasn't happy at first, but when I saw his picture, I said ok. But I still wanted a little more freedom. He was quite suffocating. He didn't like me to go out much or meet any friends. Even my own family didn't like visiting me much. So I would always go there.

One day I told him I needed to go to my mum's house and he said that he didn't want me to. I explained to him I had made plans with one of my sisters and needed to go. He came up behind me, pulled my arm behind my back, wrapped my hair around his other hand, and slammed my face into the brick wall that covered the outside of the house. As he whispered in my ear that I wasn't going anywhere until he decided, he was scrapping my face against the brick and leading me back inside. This was more than a shock to me! He had never shown any sign of abuse to me in the year we had been married.

At the age of 19 you have a tendency to believe someone when they cry and tell you they are sorry for what they did and don't know what came over them. That they are under a lot of pressure and it will never happen again. This became a habit after this incidence. I could no longer take it but I was too scared. I ran away and secretly stayed with my auntie's family. Only my middle brother knew where I was. I didn't have much support from anyone else. However, when it was finally accepted that I had left him for good, I came back to live with my parents. He found out and showed up with a gun and tried to make them let him take me. Fortunately for me, my brother did not scare so easily. He had been in the army and was not afraid of him. But a week later he came into a park I was at, and dragged me to his car, and took me to his house, hit me over the head with a statue and tried to drown me. Luckily, my neighbours had heard me screaming and called the police. After that I moved in with my middle brother's sister in law to make sure he couldn't find me.

That February I became sick with headaches so bad that I would hit the floor in agony. I was taken to several doctors. They said it was my nerves or that I was under severe pressure. I had gone from 11 stones to less than 7 stones, (I'm 5'7"). One day my sister-in-law came home and found me wet and naked on the floor. She called my Mum. Mum took me to her house. The next day we went to yet another doctor. He told her to get me straight to the hospital. He had seen a dark spot, I don't know what they call it but it was behind my right eye. Less than 48 hours later I was having brain surgery. They assumed it must be a tumour due to the long period of pain I had been

in but when they operated they found I had a blood clot. The surgeon woke me up while I was in intensive care and told me I need to thank God because people just don't go around with their brain bleeding for 6 months and live to tell about it. He said that God must have something special in mind for me. I agreed at the time but now, somehow, I question this.

Now let's move on, shall we. About 6 months after my surgery I got divorced from my first husband. A year later I was married to my distant cousin from Pakistan. He was 3 years younger than me, so you can imagine his dismay when he found out I was pregnant. I was thrilled, but I was also a littlie older than him (and female). We had a beautiful little girl! We stayed married a total of 2 1/2 years, I just couldn't get to love him. I loved my little girl more than him. When I said I wanted another child, he refused as he thought I was only with him to have children, which was true. It was a very typical loveless marriage. So we decided to get a divorce. The divorce was more or less amicable, due to the fact I told him all I wanted was my little girl. He could have the furniture, house, car, and anything else. The judge also awarded me £75.00 a week. We did fine until the girl he divorced me for, which I found out about later on, decided she needed to become involved in any decisions we made concerning our little girl. You know the type, always stirring up trouble. Now my husband wants full custody of my child. He thinks I am not fit to look after my daughter. Yes I know, I am depressed, but I do look after my little girl to the best of my ability. I can't seem to concentrate much on the good things in life, but who can blame me?

My family doesn't support me much, because they were not in favour of the divorce. My second husband was my mum's nephew. So my aunt's family does not mix with my family anymore. I feel very guilty for all the trouble that I have caused and the shame I have brought on the family.

I know I am depressed, but what can I do? I didn't finish my course at college, so who would give me a job. Plus I'm too scared to leave my daughter at a crèche as my ex husband might kidnap her. My physical health is a wreck, aches and pains all over. Don't get out of the house much. Nowhere to go. Plus people don't want to know you if you've had a divorce. And nobody has the time for you. As a result, I am very overweight now, and don't like looking at myself very much.

I went to see my GP, but he wasn't very helpful. He wants me to take the antidepressants. But I can't. I don't want to. I would kill myself, but it's forbidden and I don't want to leave my girl. I really want to live, but a good life. Right now, I'm living in hell. I have a constant black hole in my heart, it's just getting more and more deeper by the day.

Khalida's Story

I have dealt with depression and anxiety for years. I was doing very well until the pregnancy with my second child. Everything came back full force and then some. Since Abid's birth I have had severe fatigue, pain in my joints: hands, feet, elbows, etc. I can hardly walk at times. I cannot live life the way I need to. My kids are not neglected, but their life is not as full as it could be. I have been tested for Rheumatoid Arthritis (which my mother has severely) and many other things. I am not pleased with this diagnosis. I know that stress has a huge role in my physical well-being, but my life is filled with the utmost of stress right now.

Job losses, having to sell our house because we cannot pay our mortgage, you name it, my mother in laws health, my sister in laws lack of marriage proposals, you name it. Of course, it could be worse. I am so tired of letting my family down by not being able to participate in regular activities. I try to take on new endeavours, but often give up. I do not want to be a failure. I want to be brave and strong, but the fatigue, severe headaches and physical pain wear me out.

In August of 2006 I tried to take my life and was hospitalised for several weeks. My children, although small, were without their primary caretaker for weeks. I have little will power and my energy comes and goes. I was so agitated in bed last night that I had to get out and do something. I know that everything is going to come back to my stress.

How do I move past it and enjoy my life? I pray to God to help learn this skill, to be stronger. I have lost friendships due to my negativity and I guess you could say self-pity. I have already lost one marriage. I must hold on to this one. My children are amazing blessings from God and I do not want to mess them up! Please help with any advice you could give me!

Shahana's Story

I've been in a relationship for 10 years with a man I now realise is abusive to me. He was extremely jealous and I thought it was a sign that he loved me. But now I know that was a warning sign of an abusive partner. He only hit me once when we first got married, and he promised it would never happen again. Our relationship was good until I was pregnant. He became more violent and abusive. He called me fat and stupid, and said no one would want me because I had gained so much weight. After many months of psychological and verbal abuse, I stood up to him. That was when he hit me so hard that I had to go to the hospital. I forgave him for that and for many more times.

Initially, my family and friends were very supportive, but now they do not want to hear about it. It's difficult for them to still tell me to stay with him, despite his

behaviour. I blame myself and feel totally depressed. I feel sad and frustrated and have spent many years feeling that no one will love me, and I do not want to be alone. He is nice sometimes and that is why I am still with him.

As the years are passing, I do know that the bad times are increasing, but I don't want to admit it. I am now starting to wonder how the abuse is affecting my kids. As the violence gets worse, I realise something has to change. I've admitted to friends and family about what is happening and they have given me the same advice, "Stick with him for the sake of your children".

I'm scared of course, because I know that if the kids and I left him he would come after us and maybe try to take the kids away. I need to keep my children with me but I don't feel safe. Plus, where would I go and what would I do. I can't support myself, never mind my children. Sometimes I wonder if I can run away to Pakistan with the children but then reality kicks in and I realise that it could never happen.

I often think about how my life used to be. I was such a happy person. A good person, I prayed a lot, never did a bad thing to anyone. So why is this happening to me? I feel so empty, like life has been drained out of me. I'm very very tired now. The same routine every day, the same fear and depression that lives with me now. I look in the mirror and I hate what I see. How did I become this way, so timid and fearful? I hate everything in life, no colour looks its colour, and no food has its taste, no season to look forward to... just more misery coming my way.

My husband blames me for the violence. He say's I've always been a miserable woman. I drove him to this, my negativity, lack of drive in life, my personality. I think he has another woman in life, we don't even share the same bed. God knows when we did the last time. I live to cook for him, look after his children, and that is it. What can I do? Who can help me? Is there an escape from this living hell?

Amna's Story

Salaam. Since June 2007, after my aunt passed away I have felt really down, thinking about life and how I wish I was not here. I know this is wrong and insha-Allah (With the will of God) I hope Allah can forgive me for thinking this, but it's the mind that says all the negative things. I also feel I am a bad person, as sometimes if it is salat (prayer) time and I am tired, I will say "I will pray tomorrow".

I was Masha-Allah a very healthy person, but since June 2007, I have been off work more than a year because I feel tired, very weak, and nauseated. I always think negative about everything. When I am happy, my mind will then be saying "Why are you happy?" or when I make du'a (prayer) after my salat, my mind says "You're still ill, you will never get better, so there's no point making du'a to Allah to make you better." Why do I feel this. I want to be happy, active, full of energy, and motivated. I am so weak that I feel dizzy when I do wudu (ablution) and I pray sitting down

because I feel dizzy and my vision goes blurry. I am so happy I am a Muslim. I want to be a good Muslim insha-Allah and do my duty on this earth which is to obey Allah.

I even have a friend who reverted to Islam and I wanted to teach her more about it. I just don't have the strength to help her. The reason I am still going on is because I feel that it is a big sin to commit suicide and to wish death upon yourself and I think of Allah, that's what stops me. But I really need your help. I have had help from all different doctors and specialists and they said physically my insides are fine...it's just my mental thinking. I want something to pray, some kind of du'a to pray? I want to have good health insha-Allah, so that I can do all the things I want to do...like pray five times a day. If I don't have the health, how can I?

I cry myself to sleep thinking and praying that I hope I wake up well in the morning. I have even had a couple of job offers come through, but because of me feeling weak (no energy), and dizzy and sick I cannot get up in the morning. I want full strength in everything I do, and I want to say to all people out there to thank Allah for giving you health, because if you have none of that, you won't have nothing...meaning you can't pray, you can't work.

Can you please, please, please help. Give me du'a for my depression and a du'a that will give me strength and will power and energy. Something that will take negative things out of my head. I get scared when people pass away too. This really puts me down.