Group CBT for Depression and Anxiety in South Asian women: Description and Preliminary Evaluation through a Small Case Series.

Thomas Richardson

Trainee Clinical Psychologist, University of Southampton

Dr. Katherine Bradbury

Chartered Clinical Psychologist, Adult Community Mental Health Team, Southampton, Southern Health NHS Trust.

**Summary**

This paper describes the development of a Cognitive Behaviour Therapy (CBT) group aimed at South Asian women with depression and anxiety. A small case series demonstrated little overall improvement, highlighting the complexity of work with this population.

**Introduction**

The largest Black and Minority Ethnic (BME) group in the UK is South Asian (primarily Indian, Bangladeshi and Pakistani), representing 4% of the population and more than 2.3 million people (Office for National Statistics, 2001). South Asian women have significantly more mental health problems than Caucasian women (Gater et al., 2009), and higher levels of depression (Bhui, Bhugra, Goldberg, Sauer, & Tylee, 2004; Gater, et al., 2009) and anxiety (Gater, et al., 2009; Weich et al., 2004). However South Asian women underuse available services, and many see cultural, language and religious differences as a barrier to treatment (Tabassum, Macaskill, & Ahmad, 2000). Many are also reluctant to seek help due to shame, stigma and concerns over family reputation and confidentiality (Wynaden et al., 2005). In addition referrals to mental health services are less likely (Bhui et al., 2003).

Cognitive Behaviour Therapy (CBT) is recommended as an intervention for both depression and anxiety (NICE, 2009, 2011). Research suggests that the cognitive model of depression may fit immigrants from non-western cultures (Oei & Kohn, 2007). However there may be differences as assumptions, thoughts and beliefs which are often challenged by CBT may be different in different cultures (Padesky & Greenberger, 1995). Thus therapy interventions may need to be flexible, and take account of cultural norms. This has been referred to as ‘Cultural Sensitivity’. There is little research examining whether such adapted CBT is more effective, though Kohn, Oden, Munoz, Robinson and Leavitt (2002) found that adapting group CBT for African American women led to greater improvements in depression than standard CBT. Culturally sensitive CBT has been shown to reduce depression and anxiety when used in Pakistan (Naeem, Waheed, Gobbi, Ayub, & Kingdon, 2010; Rahman, Malik, Sikander, Roberts, & Creed, 2008). However, there is little research examining whether culturally sensitive CBT is effective for South Asian women living in the U.K.

**Method**

**Participants**

Participants were recruited from the caseload of a Community Mental Health Team. The group was aimed primarily at first generation South Asian women. However, some from other BME communities were invited, as were those who were connected to the community through family or religion. Participants had to have clinical levels of depression and/or anxiety, and not currently be undergoing any other psychological therapy. Current psychotic symptoms or serious self-harm or suicidal ideation also excluded participants.

**Assessments**

Participants completed pre-assessments at the start of the first session, and post-assessments were administered to completers at the end of the final group, or at their next routine appointment. Participants completed the Hospital Anxiety and Depression Scale (HAD, Zigmond & Snaith, 1983), Clinical Outcomes Routine Evaluation (CORE, Evans et al., 2000), and Rosenberg Self-Esteem Scale (RSES, Rosenberg, 1965). A brief feedback questionnaire was also designed for the purposes of the research.

**Intervention**

The group was based on CBT and consisted of seven sessions lasting 90 minutes. This was led by a Trainee Clinical Psychologist, and a Social Worker and Support Worker who worked with the South Asian community. A number of culturally sensitive adaptations were made e.g., pictures were used in handouts and in session to aid understanding for those with poor English. Verbal translation during sessions was also provided where possible. This was more appropriate than developing written translations as this may have been too literal, which can cause problems (Naeem et al., 2010a). All concepts had a story to illustrate them. Where possible these were provided from culturally relevant stories and folk tales.

The word ‘sad’ was used instead of the word ‘depressed’ as it was believed this would have led to stigma. The group was referred to as the ‘Hope and Happiness Group’ for this reason. An emphasis was placed on the physical side of emotions, in line with previous culturally adapted CBT (Naeem et al., 2010b). The term ‘negative thoughts’ was not used as this may suggest evil thoughts in Asian communities (Naeem et al., 2010a), so the terms ‘unhelpful thoughts’ and ‘thinking traps’ were used. A section on the effects of being from a different culture on mental health was included. Aside from these changes the content of the intervention was largely similar to standard CBT for depression and anxiety. For example the idea of safety behaviours and graded exposure were covered, as was behavioural activation and thinking errors.

**Procedure**

A small case series was used. This research represented a service audit, and the relevant National Health Service (NHS) Research and Development Department was informed.

**Results**

**Uptake and completion**

A total of 15 service users were invited to take part and ten attended an initial session. Five participants completed the group (two or more sessions) of whom four complete standardised measure pre and post.

**Participant characteristics**

Of the ten participants who attended an initial session, ages ranged from 27 to 67 with a mean of 45 years (*SD* = 13.6). All but one participant was born outside of the UK. Ethnicities were six ‘Asian or Asian British- Indian’, one ‘White British’, one ‘Black of Black British- African’, one ‘Iranian’ and one ‘Asian or Asian British- Pakistani’. In terms of religious beliefs, two were Sikh, four were Muslim, one was Catholic and two did not report their religious beliefs. First languages spoken were Punjabi by four, English by two, Farsi by one, Urdu for one and data was unavailable for two participants. An interpreter was formally required by two of the participants. All participants were diagnosed with depression or an anxiety disorder, and all had comorbidity.

**Overall pre-post changes**

A series of one-tailed paired samples t-test with Bonferonni correction were used to compare changes in those with complete pre and post data (*n* = 4). These showed no statistically significant changes on any of the subscale scores (*p* > .05).

**Reliable and clinically significant changes**

Due to small sample size the paired samples t-tests above may have been underpowered. Thus changes in the proportion of participants above the cut off were used to determine any clinically significant changes. Prior to the group one participant scored below the cut-off point on the RSES suggesting low self-esteem, this had increased to two after the group. Those above the HAD Depression cut off changed from four pre group to three post group, with the same pattern being observed for the HAD Anxiety score. All participants were above the cut off for the total CORE score pre and post.

The reliable change index was also calculated using the standard deviation from the pre scores of the current sample. Any changes beyond 1.96 were deemed reliable. On the RSES one participant did not change, one improved, and one deteriorated. For the HAD Depression scale, three participants did not change, and one deteriorated. For the HAD Anxiety scale, one participant did not change, one improved, and two deteriorated. On the CORE total two did not change, one improved, and one deteriorated. On the CORE Well-Being subscale three did not change and one deteriorated. On the CORE Risk subscale two did not change and two deteriorated. On the CORE Functioning subscale two did not change, one improved and one deteriorated. Finally on the CORE Problems scale three did not change and one improved.

**Feedback**

Table 1 displays the median, lowest and highest rating for the seven likert scale items of the feedback questionnaire. Ratings were high, with the highest rating for recommending the group to others, and the lowest for finding it helpful meeting other Asian women with problems. When asked if there was anything about the group they did not like responses were “I wish more people could have attended”, and “Sometimes hearing other people’s problems”. Parts of the group which participants found especially helpful were “Meeting new happy people”, “Parts of the group that focused on anxiety” and “I can tell my feelings and thoughts”. Improvements which were suggested were “Make sure everybody came” and “To have a longer term group”. Other comments included “Start this group again”, “Have a continuous group so we could talk about things every week”.

**Table 1**

*Feedback ratings*

|  |  |
| --- | --- |
| **Question** | **Median rating****(Lowest, Highest)** |
| Did you enjoy the group? (1-9)*1=not at all, 5=a bit, 9= a lot* | 7 (5, 9) |
| Did the group help you to understand your unhappiness, worried and problems? (1-9)*1=not at all, 5=a bit, 9= a lot* | 8 (7, 8) |
| Had the group helped you find new ways to cope with your unhappiness, worries or problems? (1-9)*1=none, 5=a few, 9= lots* | 8 (5, 8) |
| Has the group helped you with your unhappiness and worries? (1-9)*1=not at all, 5=a bit, 9= a lot* | 7 (5, 8) |
| Did you find it helped to meet other Asian women who may be having problems? (1-9)*1=not at all, 5=somewhat, 9=very much so* | 5 (5, 8) |
| Would you recommend the group to someone who was having problems with their mood, worries or unhappiness?(*1=definitely no, 5=maybe, 9=definitely yes*) | 9 (5, 9) |
| Overall did you find what we talked about in the group...(*1=too difficult, 5=just right, 9=too easy)* | 5 (1, 6) |

**Discussion**

Whilst the initial uptake of the group was satisfactory, half dropped out after just one session. Reasons for drop-out were not formally recorded, though anecdotally some found it hard to get to the group, and one participant found the group complicated due to her poor English.

The sample used here was heterogenous with a range of ages, religions and ethnicities. Indeed some of those included were from a non-Asian background and one was British born. A range of comorbidities were common which may have influenced the effectiveness of the intervention. Pre-group scores on the standardised measures suggest poor mental health, so the group was meeting a need within the CMHT. However Asian women are underrepresented in mental health services (Bhui et al., 2003), thus this intervention may have only reached a small proportion of those with poor mental health.

In terms of changes post-group, t-tests failed to find any changes, against previous findings of improvements when CBT is used in Pakistan (Naeem et al., 2010b; Rahman et al., 2008). However the low sample size may have reduced statistical power. Examining changes in those scoring above cut-off points, it appears that a proportion of the sample improved in self-esteem, depression and anxiety. Results from the reliable change index were varied, with some having no change, some improving and some having higher scores post group. However it is important to note that the two participants who deteriorated completed the post assessment up to eight weeks post-group. Group CBT is recommended for depression and anxiety (NICE, 2009, 2011), but this study suggests that the effectiveness of providing such interventions for Asian women is uncertain.

The feedback questionnaire demonstrated moderate to high group satisfaction, with high scores on questions about enjoying the group, and it helping to understand and cope with unhappiness and worries. This is important given that many Asian women see cultural and religious differences as a barrier to the treatment of depression (Tabassum et al., 2000). Though ratings for difficulty were that it is was generally about right, one found it too difficult, highlighting the complexity of conducting CBT at the right level in this population. Qualitative responses suggest many wished the group had run for longer, thus additional sessions may have improved satisfaction.

Future research will help determine how best to work this population who have poor mental health, but poor levels of access to psychological interventions.

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