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Solution-Focused Brief Therapy for Depression in an Indian Tribal Community: A Pilot Study

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Abstract

This study aimed to assess the outcome of solution-focused brief therapy (SFBT) in the context of a tribal community in India and to get some insights about the applicability of solution-focused practice in Indian community mental health settings. The tribal community had a low socio economic status and the clients all had a depressive disorder. The team was comprised of a psychiatrist, a clinical psychologist, a psychiatric social worker, a psychiatric nurse, and a pharmacist, who visit rural areas and later, treats psychiatric clients in their neighbourhood. Nine clients with depression received SFBT along with SSRI medication. The Beck Depression Inventory-II (BDI-II) was used to measure the severity of the depressive symptoms before and after the treatment. The European Brief Therapy Associations SFBT-research protocol was applied in all therapy. The Wilcoxon sign-ranked test was used to analyse the data. Results indicate that there was significant decrease in the severity of distress after the treatment, which suggests SFBT was effective in reducing depressive symptoms in the clients.

Keywords: community mental health service (CMHS), solution-focused brief therapy, depression, Indian tribal community

Depressive disorders have been listed among the most prevalent psychiatric issues. They are some of the most common mental illnesses and one of the leading causes of morbidity and mortality in the world today. They place profound economic burdens on society (Greenberg, Kessler, &Birnbaum, 2003; Lynch & Clarke, 2006). The Indian Community Mental Health Service (CMHS) is a decentralized service model of mental health care, designed to supplement and decrease the need for more costly inpatient mental health care delivered in hospitals, and aimed at treating the clients in their own community, bringing them opportunities to get psychiatric rehabilitation. A team comprised of a psychiatrist, a clinical psychologist, a psychiatric social worker, a psychiatric nurse, a pharmacist, and supporting staff visits the community health centers and primary health centers within each village in the district. They identify clients, treats, and distribute medicine, and follow-up at least once per month. Community mental health services may be more accessible and approachable to local needs because they are based in community settings rather than aggregating and isolating clients and providing in-patient care in psychiatric hospitals. The majority of clients' mental health needs could be met with the help of CMHS, which is proven to be effective and less expensive (Krishnakumar, 2010).

The current study was conducted in the northern district of Wayanad in the Kerala state of India. Wayanad is known for its geographical and cultural heritage. It is a high range forest area, where many tribal communities live in their own traditional manners. Incidents of psychiatric problems within these communities are high when compared to non-tribal communities of the same district (Wayanad District Mental Health Program, 2010). Thise may be due to high use of alcohol and other addictive, locally produced, substances, and the fact that people in these communities are reluctant to accept psychiatric treatment. With the help of

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tribal promoters, the community mental health team visits these localities and treats the clients.

Clinical observations during the visits indicated that the clients did get some symptom control when they were on medication; the biological symptoms, especially, improved to a degree. However, the affective and cognitive symptoms did not change much. For example, sleep and appetite were improved, but clients often still lacked interest in work and still experienced low mood. In order to address this issue, clients who attended the community mental health clinic were invited to visit a psychologist who used the solution-focused approach.

The two main objectives of the current study were to assess the outcome of solution-focused brief therapy (SFBT) in the context of the tribal community and to get some insights about the applicability of solution-focused practice in the community mental health settings. Up to date there are no published studies on solution-focused therapy outcome in similar Indian tribal communities and Indian community mental health care services.

There are a number of outcome studies that have documented the general effectiveness of SFBT in different clinical and non clinical settings, and various studies showing that SFBT is an effective treatment for depression. Moreover, the studies suggest that SFBT produces positive results in a relatively short period of time (Estrada &Beyebach, 2007). A comparative study between a single session of SFBT versus interpersonal psychotherapy among 40 college students indicated no significant difference between the two treatments, demonstrating that single session SFBT was effective in reducing depressive mood (Sundstrom, 1993). Studies conducted by Lee, Greene, Mentzer, Pinnell, and Niles (2001) and Hanton (2008) show significant improvement in depressed clients after SFBT. In the case of specific populations, a study conducted by Estrada and Beyebach (2007) demonstrated significant differences in pre-post test scores on the Beck Depression Inventory-II (BDI-II), indicating that the SFBT treatment was effective in reducing the depressive symptoms of people with hearing impairment.

It is important to note that the present study was conducted under very specific conditions and with a specific population. Indeed, the people in these communities are marginalized due to social, cultural, and ethnic differences. It is to be noted that they often are reluctant to take modern medicines; instead they follow traditional treatment methods such as traditional tribal medicines and rituals to treat psychiatric conditions. Thus, the current study was conducted as an adjunctive to pharmacological treatment. The treatment followed the specifications of the European Brief Therapy Association's research protocol for SFBT (Beyebach, 2002). The therapeutic sessions were conducted from therapy rooms of primary health centers and community health centers which are situated close to each tribal area. Initially, the community mental health team visited each tribal community and identified clients, educating them and their family members about the condition and the treatment. They were then escorted to the community health centers and primary health centers with the help of tribal promoters and received medication.

Method

Participants

The sample consisted of clients selected from the community clinics who were diagnosed by a consultant psychiatrist and clinical psychologist as having mild, moderate, or severe depressive episodes; recurrent depressive episodes; or adjustment disorder with brief depressive reaction according to the International Classification of Diseases-10 (ICD-10) criteria. Clients with co-morbid psychiatric conditions or chronic physical illness were excluded from the study. There were 11 participants initially, seven females and four males. There were two dropouts and the final group included six females and three males. The age range was between 24 to 48 years. None of the clients had formal education, and all were of low socioeconomic status, living in a rural locality with no specific occupation except as labourers earning daily wages. All of the participants in the study were on SSRI medication while participating in the study.

Design

A single group pre-post test design was used in the study to examine the outcome of SFBT in regards to reducing symptoms of depression. Figure 1 shows the study design.

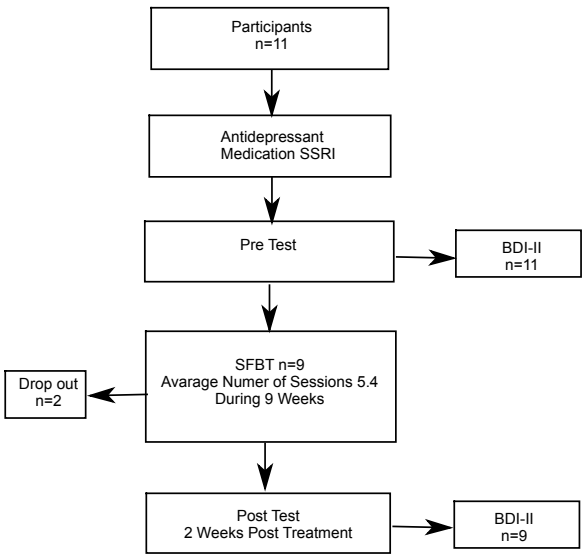

Figure 1. Schematic illustration of the study design.

Materials

Demographic data schedule with diagnostic details and medical information.

Beck Depression Inventory-II (BDI-II): The BDI–II consists of 21 items assessing symptoms of depression experienced

during the previous 2 weeks. Each item contains four statements reflecting varying degrees of symptom severity. Respondents are instructed to circle the number (ranging from zero to three indicating increasing severity) that corresponds with the statement that best describes them. Ratings are summed to calculate a total BDI–II score, which can range from 0 to 63 (see Beck et al., 1996).

Procedure

Step 1. The community mental health team visited the tribal locality and identified potential clients, who then were escorted to community health centres and primary health centres near the tribal area.

Step 2. Clients were examined by a psychiatrist and a clinical psychologist. After diagnostic evaluation, each client received psycho-education about their condition, its treatment, the medication, and its side effects.

Step 3. Clients with depressive episodes who came for follow-up of the psychiatric medical treatment were sent to the clinical psychologist for psychotherapy. Consent was obtained from each client after informing them about the research aims and purpose of the therapy. Eleven clients agreed to continue psychotherapy and all were assessed with BDI-II before the first therapy sessions. The treatment followed the specifications of European Brief Therapy Association's treatment manual for SFBT (Beyebach, 2002). Each session lasted 45 to 60 minutes at a frequency of once per week for first two sessions and then once every two weeks for the rest of the sessions. There were no in-session breaks in any of the sessions as the research description suggests; however, all other SFBT ingredients listed in the research description of SFBT were maintained throughout the sessions.

Step 4. A post-test was done two weeks from the fifth session. By the fifth session, the therapy was terminated and follow-up appointments were held in a month´s time.

Step 5. Analysis of BDI-II pre- and post-treatment scores were analysed using Wilcoxon T statistics.

Step 6. Follow-up sessions were continued for those who required it with no further measures obtained.

Data Analysis

The Wilcoxon signed-rank test was used to analyse the data. The pre-treatment BDI-II scores were compared with post-treatment scores to evaluate the outcome of SFBT. As two participants dropped out, there were a total of nine participants for the post-assessment.

Results

Table 1 show the BDI-II score before and after the treatment along with the sign rank difference for each participant. Results indicate significant differences in the BDI-II scores at pre- to post- treatment ($T = 1.5$; Wilcoxon $T = 3$, $p = 0.01$). This implies that the SFBT was successful in reducing the symptoms of depression in the participants' group.

Table 1.
Participants' Pre- and Post-Scores and Sign Rank Differences

	BDI Score Pre-Test	BDI Score Post-Test	Difference		
			Sign	Size	Rank
1	27	18	+	9	4
2	29	28	+	1	1.5
3	32	17	+	15	8
4	23	14	+	9	4
5	25	26	-	1	1.5
6	22	13	+	9	4
7	29	11	+	18	9
8	25	13	+	12	6
9	24	10	+	14	7

Table 1 also show that one participant had a higher score on the post test BDI-II, indicating no change or worsening in depressive symptoms, which may be due to many external or internal factors. A conclusive comment on the lack of improvement in the state of this particular participant may be impossible, yet qualitative observation indicates that she had poor family support and a lack of cognitive resources when compared to other participants.

On clinical observations, most of the participants initially presented complaints of low mood; lack of interest, especially in work; irritability; difficulties to sleep; and crying spells.

Initially the participants were not motivated or able to go for work, but following the therapeutic sessions, their own goals were to "go for work in the morning". Most of the participant's goals for the therapy were focused on work, sleep, and healthy interaction with others.

Upon close observation of the domains of BDI-II, it was noted that participants showed improvement in domains of affect, work, and satisfaction.

Within the sessions, it was observed that the participants turned their focus from their distress to their desired state, which enabled a shift in affect. At the follow-up session, most of the participants had made successful attempts to go back to work.

An informal survey was made after the therapeutic sessions by asking each participant what they thought was the most beneficial aspect of the sessions. Most of the clients reported that they felt relieved after talking out their problems to someone who understood them and they felt that somebody was there to listen to them.

Discussion

The results of the study suggest that SFBT is a useful therapeutic approach, which can be applied to Indian tribal populations in treating depressive disorders. Findings indicate that, with the exception of one person, the participants in the study experienced improvements. Table 1 demonstrates that most of the clients reported large reductions in BDI-II scores after the treatment; however, a

few clients experienced persistent mild depressive symptoms and they continued to get follow-up treatment after the end of the study. The current findings support earlier studies on depressed clients and demonstrate the effectiveness of SFBT as an adjunctive to treating depressive disorders with pharmacological treatment.

In the course of therapy the clients started to go back to work again, and with that, spending time outside the house and taking part in the daily activities of the family and community. This can be assumed to have added to the positive change of mood reported, and this would also have help strengthen interactions with their families and social network in the community. It was clinically observed that the family members often could have a unsupportive attitude while the clients were not working and not earning an income. But as the treatment progressed and the clients started working and earning daily wages again, this was a great relief for the family and made a change in the attitude of the family members and in the interactions within the family toward creating a more supportive atmosphere. Putting it all together, there was a shift in affect and cognition that was reflected in several domains of the life of the clients.

To come to the clinic took a lot of time and it was difficult for clients to spend the day to come in to the clinic. As mentioned, none of the participants had a specific occupation so all of them worked for daily wages. To miss a day of work would cost them much. The two clients who dropped out of the treatment gave this explanation for not coming to the sessions. Compensation was therefore provided for a few clients to meet the expenses for coming to the clinic.

It was a bit difficult to bring these clients in to the context of therapy and the solution-focused approach they were used to treatments following the logic of the western medical model with the doctor prescribing medications and giving expert advice, or traditional tribal medicine. Most of them had never met a psychologist before, either.

One special observation about the SFBT method was that during the therapeutic sessions, participants had difficulties in comprehending the miracle question as they had a prevailing belief about miracles. According to their beliefs, miracles happen when performing rituals or in the performing of religious ceremonies, and not during sleep. On the other hand, as they believe in miracles, the idea was part of their understanding of the world, and it was therefor easy to elicit a description of the desired future.

Methodological Considerations

This study did not have a control condition, meaning that the data cannot be used to conclude that the changes observed were due to the combined treatment by SSRI and SFBT. Hypothetically, the treatment group could have recovered due to some other uncontrolled factor. This is, however, quite unlikely to be the case in all participants, but may be true for a part of the reported recoveries or be part of an explanation for the changes observed. Also, all participants received SSRI medication while receiving SFBT, so in this study there was no way of separating the effects of the two treatments; one may account for a larger portion of the change than the other. It is also possible that different clients responded more to one of the interventions and others may have responded to the other.

It is important to note that the researcher in this study also did the diagnosing, baseline assessment, post-assessment, and also the therapy. The data were collected as part of the treatment and were not an unrelated set of events only for research purposes. This could, for example, mean that the participants may have had a tendency to give answers on the BDI-II that they thought the therapist expected to hear.

Ongoing Research

This report is part of a larger, currently ongoing research project with four groups in which two are experimental and another two are control. The selection and measurements in this coming study were done with the help of two clinical psychologists other than the therapist who administers SFBT in the study. The pre- and post-measures being used include the BDI-II, the General Health Questionnaire-12, a progress scaling question, the Trail-Making Test, and the Digit Span Test. An evaluation form will also be used to obtain responses from the participants about the therapeutic sessions after the termination of therapy.

Conclusion

As there are no reported studies on SFBT in India, and especially not in tribal communities, the current study made an attempt to explore the outcome and the application of a time-limited, solution-focused therapeutic approach in treating clients with depression. The findings indicate that SFBT is an effective therapeutic approach in treating depression also in this very specific context. The findings also give a scope for further research in SFBT on this and in other populations and also with other psychiatric conditions in India.

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