The effects of psycho-education and self-help on depressive Surinamese Hindustani

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ObjectiveInventory of the support and willingness of the visitors of the temples to participate. This study should be beneficiary in the development of a preventive program, focusing on depression. The primary outcome of this randomised trial is:...

Ethical review	Not approved
Status	Will not start
Health condition type	Mood disorders and disturbances NEC
Study type	Observational non invasive

Summary

ID

NL-OMON34686

Source
ToetsingOnline

Brief title
The effects of psycho-education and self-help

Condition

- Mood disorders and disturbances NEC

Synonym
Depressive symptoms

Research involving
Human

Sponsors and support

Primary sponsor: Altrecht GGZ (Den Dolder)
Source(s) of monetary or material Support: Fonds Psychische Gezondheid

Intervention

Keyword: Depressive symptoms, Hindustani, Psycho-education, Self-help

Outcome measures

Primary outcome

The primary outcome of this randomised trial is: depressive symptoms. Secondary outcomes include: incidence of depression, suicidal ideation, symptoms of anxiety, use of antidepressants / benzodiazepines, (mental) health care use (including medication), absence of work and quality of life.

Secondary outcome

Secondary outcomes include: incidence of depression, suicidal ideation, symptoms of anxiety, use of antidepressants / benzodiazepines, (mental) health care use (including medication), absence of work and quality of life.

Study description

Background summary

In the Netherlands, there is a large community of Surinamese Hindustani. The prevalence of depression in this group is approximately just as high as that in the autochthon population (12.4%). The impact seems however more severe. The percentage suicides in this group is approximately four times as high as that in the autochthonal population. Moreover this group is underrepresented in the regular psychiatric care. Most of the people seek help in their own group or at the spiritual leader. Given the seriousness of the impact the prevention of depressive disorders in this group deserves a high priority. Finding the right access for preventive interventions in this group, forms thereby the most important challenges.
The assistance is provided at the place where the community mainly looks for support: the temple (part of the cultural organization).
This study will also take place in the Hindu temples. In about 3 temples, a semi-structured interview will be taken of the board and structured questionnaire of the visitors.

In this study we propose the following:
Inventory of the support and willingness of the visitors of the temples to participate. This study should be beneficiary in the development of a preventive program, focusing on depression.

Study objective

Objective
Inventory of the support and willingness of the visitors of the temples to participate. This study should be beneficiary in the development of a preventive program, focusing on depression.
The primary outcome of this randomised trial is: depressive symptoms. Secondary outcomes include: incidence of depression, suicidal ideation, symptoms of anxiety, use of antidepressants / benzodiazepines, (mental) health care use (including medication), absence of work and quality of life.

Problem definition
In the Netherlands, approximately 332,500 people of Surinamese origin are living (CBS, 2006). About 200,000 of them are Hindustani. The Hindustani community can be considered as a collection of smaller groups, dynasties and families (Adhin, from 1998; Van Dijk et al. 1999). It is a very closed community with a we-character, which identify itself as conflict avoiding, demanding, loyal and progressive. The groups have generally a patriarchal structure (Van Dijk et al. 1999). During the upbringing much emphasis is laid on performance, amiability and respect. This even can seems to be very humbly. Hindustani believe in spirits. Gods can also appear as spirits (Van Dijk et al.1999; Rambaran & Koeldiep 2004). These spirits gives support, unless they are evil spirits. They play a role at rituals during birth, sickness and dead, as well as in traditional (religious or spiritual) healing. People who sees good spirits are not considered to have a psychiatric disorder. When it is about evil spirits, a spiritual healing will be done by a Pandit (Hindu priest) or a spiritual healer.
Within these closed community psychiatry is considered a taboo. It has been known from the healthcare authorities that this group seeks very minimal aid through the common way. Most of the Hindustani are a member of a cultural organisation, which manages the Hindu temples. First they seek for help for their problems within this organisation or temple, by a religious or spiritual healing (Gokoel, 2005; Adhin, 1998; Van Dijk, et al., 1999). When they have to visit a general practitioner (GP), they usually are loyal to the doctor. However, it is necessary to some extent that they can find themselves in the explanation (explanatory model) of the doctor (Braakman et al., 2003). It is important to let the patient and the family tell you what the cultural norms are. When this does not happen, then a disagreement can arise, with a poor work relation and therapy non-compliance.
From general population research, it is clear that depression is an important health problem with a high year prevalence, a great burden on personal level, but also on population level and with enormous economic costs (Smit et al.,

2005; Cuijpers et al., 2005). As well as from the perspective of the public health and that of the individual patient, the optimum prevention of a depression deserves the highest priority.
In the Netherlands there are no study known regarding the incidence and prevalence of depression in the Hindustani community. In the international literature estimates are given which varies from 5 to 25% (Fareed Aslam Minas et al, 2000; Mirza and Jenkins, 2004; Raguram et al, 1996; Khan 2002; Tiwari 2000). Therefore it seems that depression occurs as frequent as in the autochthon population and possibly even more often. However, the impact seems to be more severe than in the autochthon population. Research by the GGD in The Hague shows that suicide ideations and suicide attempts in the Hindustani group are four times higher than in the autochthons (GGD The Hague, 2000; Burger, et al. 2005). Research within the Hindustani comunity, who lives in Suriname, has shown approximately the same remarkably high percentage suicide ideations and suicide attempts (Graafsma & Mooij, 2006; Graafsma, et al., 2006). This is confirmed in studies in the Hindustani communities elsewhere in the world, like in United Kingdom, Maleisia, Singapore, the Fiji islands, Guyana and Trinidad (Bhugra 2003; Mahy 1993; Maniam 2003). Social deprivation (poverty), social fragmentation, alcoholism, family problems (especially in women) and psychiatric disorders are considered in these studies to be important risk factors.
For this reason, the prevention of depressive disorders in this group deserves high priority. Finding the precise access for preventive interventions in this closed community, forms thereby the most important challenges.

Relevance
To reach the participants, existing networks are used as much as possible. The temple is therefore the most suitable place, because it has a important role in the Hindustani community and it is the first place where problems are discussed.
There are no figures known of the under represenation of this target group in the regular (mental) health care. In the report "Diversiteit in de participatie in gezondheidsbevordering, een verkennende studie* (diversity in the participation in health promotion, an exploring study) (Vliet et al., 2006) this is appointed as a problem: "Allochthones (immigrants) does not know the rules and possibilities of the health care and prevention and the care workers experience this as a burden. The knowledge concerning participation of immigrants has been fragmented and limited, and the conditions for participation in policy making are not yet present."
There is little information or knowledge available on the specifics of target group participation of immigrants. Immigrants are underrepresented or not involved in policy making, researches (studies), knowledge advancement and care. Target group, community or target group participation (of immigrants) are no unambiguous concepts. Moreover, these concepts get especially interpreted from the point of view of the professionals. It is important to give attention, on by who and how the target group or community is defined, to the diversity within the target group and the different positions the members of the group

takes at the same time. There is almost never a discussion explicitly about the different roles of the professionals and the specific competence necessary to work together with the target group. There is furthermore no health policy especially form the immigrants, and even less the participation of immigrants in health care policy making. The assumption is that participation of immigrants can be significant with a view to improving their health situation and the degree of care usage. Professionals needs specific skills, which is necessary to make a collaboration work. There is a tension between the wishes and interests of the target groups and of the professionals. Intercultural competency and knowledge of different migrant groups, cultures and backgrounds must be promoted to the professionals. Cultural differences, such as the difference in the way health is experienced and the manner of communicating can play a role. Attention is necessary for `conflict or interest*: there are inevitably differences in expectations, wishes and perspective. The professional must have sufficient skills, knowledge and commitment to work with the target group. It stands out that there is never a explicitly discussion about the competency of the professional, which is necessary to work well with the target group, such as skills in intercultural communication. Professionals also must be able to handle several roles: they should be able to anticipate on the wishes of the target group, and use their professionalism to work out and carry out those wishes further (Vliet, et al. 2006).
This is an important reason why the Hindustani, first seeks help in their own group.
In the Netherlands, approximately fifty percent of the depressive disorders are not treated and in about half of the cases it leads to a severe major depression (Spijkers et al., 2002; Bijl et al., 2003). It is proven that subclinical depressive disorders lead to serious sickness burden (Kruijshaar et al., 2003; Cuijpers, 2004), associated with high mortality chance (Cuijpers & Schoevers, 2004) and a risk to develop a major depression (Cuijpers & Smit, 2004).
This makes the necessity for prevention great, also seen the high prevalence of depression and the severe impact and consequences of this.

Knowledge transfer
This project will produce a description of a preventive intervention form Surinamese Hindustani with depressive symptoms. The head applicant of this project is a member of this community and holds a lot of functions in organisations within the community. He has excellent contacts with the Hindoe Raad Nederland (Hindu Council the Netherlands (HRN) and MIKADO, with whom he will work together.
The HRN is a covering body for all the Hindu organisations established in the Netherlands and is considered by the government as a speaking partner for all matters concerning the Hindustani community and Hinduism. The HNR is the advising organ for the government. All Hindu temples are part of the HRN.
MIKADO is the centre for intercultural mental health care.
HRN and MIKADO have offer to support this project and dissemination of the results will also take place by this existing network, among other existing

networks.
Moreover, the results of this research can be use to reach other allochthone community in the Netherlands with the same characteristics as the Surinamese Hindustani. In particular the Moroccan and Turkish community.
These are also closed communities with a clear man/woman role for example. This means, also in these communities the upbringing of the boys are different (freely) than that of the girls and that the brothers feel responsible for their sisters. Problems, in particular psychological or psychiatric, are considered taboo and is not discussed outside the group. The Moroccan and Turkish community also uses the mosque to discuss their problems with the Imam, the elderly or others with an important role in the community (Meekeren, et al., 2002; Borra, et al., 2002).
Some members of the project group participates in the Netherlands Study of Depression and Anxiety (NESDA) in which there is a cooperation of a lot of other institutions, which is responsible for research and policy considering the treatment of anxiety and depression (University of Groningen, University of Leiden, WOK (Centre for Quality of Care Research), NIVEL, Trimbos-institute and a lot of patients' organisations). Also this extended network will be used to disseminate the results of this project. Without doubt, the outcomes of the project will be make known by professional and public media, by means of study days and publications in national and international practically-oriented magazines.

Study design

Study design
Pre - post treatment study
No controle group

Intervention
For this research, about 3 temples are approached and divided into two steps.
Step I
A semi-structured interview will be conducted on the basis of a questionnaire to the board of the temple. One must think of the Pandiet (Hindu priest), chairman, secretary, treasurer.
Questions will be asked about:
their co-cooperation
-the co-operation from the visitors
-the prevention of mood disorders, anxiety disorders, suicidality
-is this a problem
-should the problems adressed and solved by the Hindu community itself or is external help needed
-what could be the causes for these problems
-the feasibility of a study
-will visitors participate in a prevention study (as proposed: 'lichte dagen, donkere dagen')

Step II
A structured interview will be taken from the visitors of the temple. In addition, the CES-D (for depressive symptoms) and suicide risk questionaire will be presented to the visitors. For visitors with a score> 15 on the CES-D, a MINI interview will be taken, by telephone, to establish a depressive disorder. This will give an impression of the prevalence of depressive symptoms and disorder. Questionnaires will also be taken on suicide ideation, anxiety symptoms, use of antidepressants / benzodiazepines, use of health care, absence from work and quality of life.

The degree of participation will help determine the feasibility of a preventive study.

Recruitment of respondents
All respondents will be recruited at the temples.

Inclusion and exclusion criteria
The inclusion criteria are: all visitors to the Hindu temple, who are 18 years and older. In general, all visitors speaks the Dutch language. But this is not crucial for the study, since the principal investigator speaks the Sarnami Hindi and can explain the study. There are no exclusion criteria.

Measuring
CES-D will be use for the screening of depressive symptoms. During the telephone interview participants will be diagnosed for depression, using the MINI International Neuropsychiatric Interview. The MINI is a brief structured interview to diagnose psychiatric disorders, according to the DSM-IV (Sheenan, 1998).
During the interview, we also measured the following: personality (Mastry list), suicide ideation (Beck Scale), anxiety (HADS), quality of life (SF36 and Euroqol), and use of health care (TIC-P).
This choice for these instruments are made, because of their frequent use in national and international surveys.

Planning
The timeline is divided into 3 phases.

Phase I: duration 6 weeks
A semi-structured interview conducted from the board. And once for a temple.

Phase II: duration 16 weeks
Interview and questionaire from the visitors. This will be repeated 4 times a temple as much as possible to recruit respondents.

Phase III: duration 12 weeks
Processing the collected data.

Time frame
The necessary time for this research is estimated at 9 months (34 weeks).
Due to unforeseen circumstances the above schedule may be changed or adjusted.

Study burden and risks

Time investment is required from the participants for the course, ' lichte dagen, donkere dagen'. The course consists of 12 meetings. Each session lasts approximately 2 hours. In total the course takes 24 hours. In addition, the participants have to do some homwork, as part of the course. This is about 1 hours per session (total 12 hours for the course). The total time investment necessary for the entire course is 36 hours.

Contacts

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Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Adults (18-64 years)
Elderly (65 years and older)

Inclusion criteria

18 years and older
CES-D >= 16
MINI for major depression: negatief

Exclusion criteria

Major depression or other disorder
Treatment for a disorder
Cognitive disorder

Study design

Design

Study type: Observational non invasive

Masking:	Open (masking not used)
Control:	Uncontrolled
Primary purpose:	Prevention

Recruitment

NL

Recruitment status:	Will not start
Enrollment:	40
Type:	Anticipated

Ethics review

Not approved

Date:	21-04-2010
Application type:	First submission
Review commission:	METC Universitair Medisch Centrum Utrecht (Utrecht)

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
CCMO	NL29828.041.10