STRATEGIES PAKISTANI WOMEN USE TO SELF-MANAGE RECURRENT DEPRESSION

by

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS ii

LIST OF FIGURES x

LIST OF APPENDICES xi

ABSTRACT xii

Chapter I Introduction 1

Statement of the Problem 1

Rationale for Conducting Research 5

Need for conducting research on Pakistani women with recurrent depression. 5

Need for conducting research on Pakistani women's strategies. 7

Purpose of the Study 9

Significance of the Study 10

Summary 11

Chapter II Literature Review 13

Depression in Pakistani Women 14

Cross-cultural differences in the presentation of depression. 15

Cross-cultural differences in the diagnosis of depression. 17

Influencing Factors 18

Personal factors. 18

Illness factors. 20

Provider factors. 21
Societal factors. 23
Interpersonal factors. 24
Cultural factors. 25
Religious/spiritual factors. 26
Self-management Strategies 27
What research has been done so far on self-management strategies. 27
Why not consider other concepts. 32
What is known and what is not known about the concept of self-management strategies in depression. 34
Summary 38
Chapter III Method 39
The Researcher 39
Research Design 41
Sample 41
Measures 42
Procedure 43
Human Subject Protection 46
Minority/Gender/Children 49
Data Analysis 50
Summary 54
Chapter IV Results 55
Sample Description 55

Findings 56
Women's experience of depression. 56
Perspectives of depression. 56
Contributors to depression. 57
Depression as an insidious and hidden illness. 58
Depression impacted self and beyond. 58
Experience of depression created positive insights. 59
Symptoms of depression. 59
Factors influencing strategies. 60
Personal factors. 61
Gender. 61
Socioeconomic status. 61
Education. 62
Age. 62
Personal goals. 63
Illness factors. 64
Impaired functional ability. 64
Number of previous episodes of depression. 64
Knowledge of, understanding of, and attitude towards depression. 65
Knowledge of medication. 67
Provider factors. 67
Professional providers performing limited versus comprehensive roles. 67
Societal factors. 69

Social hurdles affecting seeking treatment. 69
No or limited health insurance. 70
Interpersonal factors. 70
Family living in the household played supportive versus non supportive roles. 71
Family living outside the household played supportive versus non supportive roles. 72
Non-professional persons from outside the family played supportive versus non supportive roles. 74
Cultural factors. 75
Stigma attached to mental illness. 75
Stigma attached to seeking help from medical- and non-medical health care providers. 76
Desire for a female psychiatrist. 77
Religious/spiritual factors. 77
Faith in God, an influence. 77
Self-management strategies. 78
Perspectives on self-management strategies. 78
Self-management strategies were learnt from a variety of sources. 79
Self-management strategy use required a conducive milieu. 80
Self-management strategy use involved decision making. 81
Specific self-management strategies and their perceived effectiveness. 84
Religious/spiritual. 85
Help-seeking. 90
Medication management. 94

Self-help. 98

Keeping busy. 100

Cognitive strategies. 106

Symptom redirection. 108

Unhealthy to healthy path, a transition. 110

Striving to meet self-needs. 112

Summary 115

Chapter V Discussion 117

Women's Experience of Depression 117

Perspectives of depression. 117

Symptoms of depression. 118

Factors Influencing Strategies 119

Personal factors. 120

Illness factors. 123

Provider factors. 126

Societal factors. 127

Interpersonal factors. 129

Cultural factors. 131

Religious/spiritual. 133

Self-management Strategies 133

Perspectives on self-management strategies. 134

Specific self-management strategies and their perceived effectiveness. 136

Implications for Research 155

Implications for Practice 157

Implication for Nursing Education 161

Study Strengths and Limitations 161

Summary 163

Appendices 165

References 185

LIST OF FIGURES

Figure 1: Graphic Representation of the Three Major Topics Studied 13

Figure 2: Women's Experience of Depression 56

Figure 3: Factors Influencing Strategies 61

Figure 4: Self-management Strategies 78

Figure 5: Perspectives on Self-management Strategies 78

Figure 6: Specific Self-management Strategies and their Perceived Effectiveness 84

Figure 7: Religious/Spiritual 85

Figure 8: Help-seeking 90

Figure 9: Medication Management 94

Figure 10: Self-help 98

Figure 11: Keeping Busy 101

Figure 12: Cognitive Strategies 107

Figure 13: Symptom Redirection 108

Figure 14: Unhealthy to Healthy Path, a Transition 110

Figure 15: Striving to Meet Self-needs 113

Figure 16: Graphic Representation of Research Findings 116

LIST OF APPENDICES

Appendix A Self-management model for recurrent depression of Hagerty, Williams, Greden, and Lynch Sauer, 2002. 165

Appendix B Participant Information Sheet (Handout p.1) 166

Appendix B Interview Questions (Handout p.2) 168

Appendix C The English-Urdu Version of Flyer Describing the Study 172

Appendix D Checklist of Inclusion and Exclusion Criteria (Handout p.1) 173

Appendix D The English-Urdu Written Proof of Interest in Participating in the Study (Handout p.2) 175

Appendix E Proof of Payment Form 176

Appendix F Confidentiality Form for Translator 177

Appendix G Consent Form 178

Appendix H Set of Borrowed Categories and Sub-categories 184

ABSTRACT

Major depression is a concern for Pakistani women. Considering its recurrent nature and the socio-economic,-cultural, and-health care issues Pakistani women confront, it is imperative to understand strategies they use to self-manage it.

The purpose of this qualitative study was to describe Pakistani women's perspectives on strategies to self-manage their recurrent depression. With a purposive sample of 10 Pakistani women, 27 semi-structured interviews were conducted and analyzed using content analysis.

The findings generated three categories: (1) women's experience of depression (2) factors influencing strategies, and (3) self-management strategies.

Women's experiences comprised of their perspectives and symptoms of depression. Their perspectives were captured under four themes: (a) contributors to depression, (b) depression as an insidious and hidden illness, (c) depression impacted self and beyond, and (d) experience of depression created positive insights. Women's symptoms of depression were grouped under three themes (a) physical symptoms, (b) emotional symptoms, and (c) cognitive symptoms; physical symptoms were the most common.

Seven influencing factors were personal, illness, provider, societal, interpersonal, cultural, and religious/spiritual. All seven factors contributed to the selection or use of strategies and were uniquely interrelated depending on women's life circumstances.

Self-management strategies comprised of perspectives on self-management strategies and specific strategies and their perceived effectiveness. Three themes regarding perspectives on

self-management strategies were: (a) strategies were learnt from a variety of sources; (b) strategy use required a conducive milieu; and (c) strategy use involved decision making.

Specific strategies and their perceived effectiveness comprised nine themes: (a) religious/spiritual, (b) help-seeking, (c) medication management, (d) self-help, (e) keeping busy, (f) cognitive strategies, (g) symptoms redirection, (h) unhealthy to healthy path, a transition, and (i) striving to meet self needs. Not all strategies were healthy and safe. Frequency of strategy use varied. Perceived effectiveness was not a constant; rather, it evolved over time and could change from being helpful to not helpful and vice versa.

This research provides groundwork for future cross-cultural research and has the potential to broaden the roles and responsibilities of advanced nurses by promoting collaboration and partnerships within a patient-provider care framework.

Keywords: Major depression, Pakistani women, experience of depression, influencing factors, self-management strategies, qualitative study

Chapter I

Introduction

Statement of the Problem

The Islamic Republic of Pakistan has an estimated population of nearly 150 million (Syed, Hussein, & Yousafzai, 2007). Pakistan is divided into four provinces, Sindh, Punjab, Baluchistan, and the North Western Frontier Province (NWFP) (Mubbashar & Saeed, 2001). According to 2012 estimates, the ratio of Pakistani males to Pakistani females is 1.06 males/1.0 female. Hence, there are more men than women in Pakistan. The population is 36% urban and 64% live in rural areas. The Pakistani population is Muslims (95%); and Christians, Hindus, and others (5%) (Central Intelligence Agency (CIA)-The World Fact Book, 2012).

Pakistani people in general and Pakistani women in particular face various, serious socio-cultural, mental health and health care services issues such as early marriage, high fertility; low employment; low literacy; poverty; limited budget allocation for health, particularly for mental health, few mental health care service providers; stigma associated with mental illness; and accessing mental health care services.

The average age of marriage for Pakistani women has increased (Sathar & Zaidi, 2011). In 1951 the average age of marriage for women was 16.9 years; in 2005 the average was 22.5 years ("Women in Pakistan", 2012). For Pakistani men it was around 27 years (Sathar & Zaidi, 2011). Although there has been an increase in the average age of marriage for women, it is still lower than for men. Pakistani women's estimated fertility rate (children born live per 1000

women) for 2011 was 3.17 (CIA-The World Fact Book, 2012), such procreation with the combination of a variety of complex socio-cultural issues compromises Pakistani women's physical and mental health.

The rate of women's unemployment reported in 2011 indicated an encouraging trend. Job opportunities for women and people living in rural areas rose compared to opportunities for men and people living in Pakistan's urban areas. Unemployed Pakistani women decreased from 1.21 million to 1.18 million; whereas unemployed Pakistani men increased from 1.19 million to 2.22 million. This decrease in women's unemployment is significant as Pakistan is known for its bias against women in the workforce (Rana, 2011) and being financially independent. This lowering trend though encouraging is still quite alarming.

In Pakistan, a literate person is an individual aged 10 and above who can read and write. Pakistani women's low literacy has been a consistent pattern from the past to the present. According to the Pakistan Social and Living Standards Measurement Survey of 2008-2009, the overall literacy rate for Pakistani people age 10 and above was 57% (69% of Pakistani men and 45% of Pakistani women). Literacy is higher in Pakistan's urban areas and in men than in Pakistan's rural areas and women. Compared to the literacy rate reported in the 2007-2008 survey findings, the literacy rate increased one percent overall, and one percent for women's literacy ("Pakistan Social And Living Standards Measurement Survey (Pslm) 2008-09 Provincial/District"). Though these survey findings show an upward trend in literacy for Pakistani women, these figures are still a concern because a low level of literacy limits Pakistani women's possibilities of getting formal employment which makes them financially dependent on husbands or in-laws and parents. In short, Pakistani women have no or limited economic power, and, therefore, experience relative inequality compared to Pakistani men.

Pakistan is one of the poorest countries in the world. Of Pakistan's population, 23% live below the international poverty line of US $1.25/day (Human Development Report, 2011). Pakistani women in particular suffer from poverty of financial opportunity, which poses serious threats to their physical and psychological wellbeing.

In Pakistan, one of the major mental health related concerns is the prevalence of mental illness. An estimated 10-16% of Pakistan's general population suffers from mild to moderate mental illness and 1% suffers from severe mental illness (Mubbashar & Saeed, 2001). This problem is further disheartening when the budget allocated to health in general and to mental health care services in particular is woefully inadequate to meet the health care concerns in general and mental health care in particular. For example, Pakistan allocated only 1% of the 2010-2011 annual budget to health (Ali, 2011), and less than 0.4% of the health budget was allocated to mental health (Gadit, 2012; 2007). The private sector is one of the most widely used health care services in Pakistan but is expensive. People who access mental health services from the private sector have to pay a fee-for-services (Gadit, 2012). Although Pakistani people can access free consultation services from the public sector, they have to pay for medications since the state does not sponsor health care (Gadit, 2004).

Compared to the estimated prevalence of a variety of mental health related concerns there are grossly inadequate mental health care services to provide for the population's mental health needs. For example, in Pakistan there are four government mental health hospitals with a bed capacity of a total of 3000. In addition, there are about 4000 psychiatric beds available in the private psychiatric hospitals (Indo-Asian News Service, 2011). Most mental health facilities are in the urban sectors of Pakistan and a large majority of the rural population does not have access to such facilities due to geographic, financial, and cultural reasons (Karim, Saeed, Rana,

Mubbashar, & Jenkins, 2004). Naeem, Ali, Iqbal, Mubeen, and Gul (2004) reported that not every Pakistani woman has access to health care.

There are very few human resources currently available in Pakistan to provide formal mental health services (Afridi, 2008; Ahmad, 2007; Syed et al., 2007). There are about 400 psychiatrists and around 50 psychiatric nurses in the country providing mental health care services mostly in the urban areas. Another problem is that psychiatry is neither taught nor examined as an essential subject in basic medical education (Naqvi, 2010), and many medical students do not have proper postgraduate qualifications in psychiatry (Ahmad, 2007). Hence, health care providers have a limited understanding about mental illnesses and their treatments. There are no data available on the number of psychiatric social workers and occupational therapists.

In Pakistan, not every woman with depression seeks formal health care services not only because it is neither available nor accessible but also because there is a stigma attached to depression and seeking treatment for it. The reason behind such stigma is a combination of various socially rooted causes in Pakistani society such as "illiteracy, indifference, intolerance, and ignorance" (Syed et al., 2007, p. 121). Due to such rooted causes, seeking mental health care services is not the first or immediate option. Therefore, for many Pakistani women, the initial and a more favorable alternative to seeking psychological treatment is to seek help from religious leaders and faith healers (Syed et al., 2007).

In conclusion, Pakistani women encounter challenges associated with an extremely intricate combination of socio-cultural values and inadequate health care services that not only contribute to their risks for depression but also prevent them from getting treatments to manage and prevent it. Some of the challenges that Pakistani women encounter in their day-to-day lives

include a high fertility rate, low employment, low literacy rate, poverty, high prevalence of mental health care related concerns and inaccessibility and unavailability of health care services in general and mental health care services in particular, and stigma attached to depression and seeking formal health care for it.

Rationale for Conducting Research

The rationale for conducting research on depression in Pakistani women first relates to the need to understand Pakistani women's experience of recurrent depression, and secondly to the need to explore the strategies they use to manage and prevent it.

Need for conducting research on Pakistani women with recurrent depression.

Major depression is a serious public health concern in the world today and is projected to increase from 10% now and to contribute 15% to the mortality index of the Global Burden of Disease (GBD). Based on the World Health Organization's (WHO) projection, by the year 2020 depression will rank as the second cause of "disease burden" in the world if improvements in prevention, management, and treatment are not made (Murray & Lopez, 1996).

Depression with its distressing physical, emotional and cognitive symptoms impairs the quality of life of individuals and families (Worley, 2006), yet it is one of the most under-diagnosed and under-treated illnesses in the health care system. For those who are fortunate to receive treatment, there is inadequate emphasis on the nature of depression as chronic and recurrent. The fact is that 85% of those diagnosed with one episode of major depression will have recurrences. In addition, subsequent depressive episodes tend to occur close together and with increased duration or severity (Greden, 2001).

In the developing world, the prevalence of depression is on the rise. The prevalence of depression in the developing world is expected to continue to rise not only because more attention is given to it and there are better assessment and diagnostic tools but also because of the rapid increase in population growth, urbanization, and adverse environmental and social factors (Blue & Harpham, 1996; Holden, 2000; Murray & Lopez, 1996). In Pakistan, depression is now considered a serious public health concern, particularly for women. However, as Gadit (2007) mentioned:

> There are hardly any organized national studies on mental health morbidity, the information management system is deficient and there is no compulsion on hospitals to send vital statistical information to the central bureau of statistics and hence figures about mental diseases are not always easily available. The current figures which are frequently quoted are because of the efforts of few devoted researchers. (p. 461)

Although there are no available data on the nation-wide prevalence of depression in Pakistani people, research conducted with men and women have shown a consistent and distinct pattern that it is more common in women than in men regardless of whether the sample was from the general population (Mumford, Saeed, Ahmad, Latif, & Mubbashar, 1997; Mumford, Nazir, Jilani, & Baig, 1996), a primary care setting (Ali & Amanullah, 2000), or patients using traditional or faith healers' services (Saeed, Gater, Hussain, & Mubbashar, 2000).

The preponderance of depression in Pakistani women has been associated with a number of unique issues including poverty (Ali, Rahbar, Naeem, Tareen, Gul, & Samad, 2002; Mirza & Jenkins, 2004); low levels of education (Husain, Gater, Tomenson, & Creed, 2004); unemployment (Ali et al., 2002; Patel & Kleinman, 2003); and chronic difficulty with having basic amenities including housing (Husain, Creed, & Tomenson, 2000), early marriage (Dodani

& Zuberi, 2000; Khan & Reza, 1998); early motherhood (Dodani & Zuberi, 2000); large number of children (Husain et al., 2000); living in an extended family (Karim et al., 2004; Dodani & Zuberi, 2000), argument with and abuse by spouse (Naeem et al., 2004), argument with and abuse by in-laws (Rabbani & Raja, 2000), expensive (Gadit, 2004) and inaccessible mental health care services (Karim et al., 2004). Despite the high rate of depression among Pakistani women, there have been few studies on what Pakistan women do for their depression and what factors influence their ways of managing depression in their daily lives.

Need for conducting research on Pakistani women's strategies.

There are several rationales for conducting research on strategies Pakistani women use to manage their recurrent depression, they are as follows. First, depression is common in Pakistani women. Evidence suggests that depression is more common in Pakistani women than in men because of unique personal, interpersonal, socio-cultural, and health care services issues that women commonly face which increases their developing and worsening depression.

Second, little is known about what Pakistani women do to manage their depression. In relation to recurrent depression, no knowledge exists on what strategies Pakistani women use to self-manage it and what factors influence their use of strategies. Hence, there are knowledge gaps in understanding Pakistani women's use of self-management strategies and the factors influencing those strategies.

Third, since depression is a recurrent and chronic illness, treating an episode of depression may not address the challenge of living a life with depression until women with depression, learn to: (a) manage depression on a day to day basis, (b) detect depressive episodes

early, and (c) prevent future episodes. These goals of managing depression on a daily basis, detecting an early episode and preventing future episodes cannot be achieved unless knowledge is developed and disseminated.

Fourth, Pakistani women's mental health and wellbeing are important, and knowledge that enhances understanding of how Pakistani women live their day-to-day lives with recurrent depression and understanding their perspectives on the strategies they use and their effectiveness to self-manage their recurrent depression is imperative and timely.

Finally, a review of Pakistani literature related to strategies (Gater et al., 2010; Rafique, 2010) revealed that they were not studied from the perspective of self-management. In addition, considering how little is known about strategies in general, there is certainly a need to develop more knowledge about the strategies Pakistani women use to self-manage their recurrent depression, how frequently they use each of the specified strategies, how they make decisions as to which strategy they can or cannot use, whether they use similar or different strategies to manage various symptoms of depression, and what factors influence their use of strategies. Finally, nothing is known about what strategies they find effective or not effective to manage their acute depressive episodes and prevent future ones. Hence, there are theoretical and empirical gaps in the knowledge about self-management strategies, factors influencing those strategies, and their effectiveness which need to be explored. Since little knowledge exists, the best methodology to use in developing understanding and knowledge about the strategies Pakistani women use for recurrent depression is a qualitative methodology.

Purpose of the Study

The purpose of this study was to describe Pakistani women's perspectives on strategies in the self-management of their recurrent depression. Consequently, this study described (1) Pakistani women's experience of depression (2) factors that influence self-management strategies, and (3) self-management strategies and their perceived effectiveness. This study had three specific aims. To achieve each specific aim specific research questions were developed.

1. To describe Pakistani women's experience of depression.
   (a) What is Pakistani women's experience of depression?
2. To describe factors that influence Pakistani women's selection and use of self-management strategies.
   (a) What factors (such as personal, illness, provider, societal, interpersonal, cultural, and religious/spiritual related) influence Pakistani women's selection of self-management strategies?
3. To describe Pakistani women's use of strategies and their effectiveness to self-manage their recurrent depression.
   (a) What types of strategies do Pakistani women use to self-manage their recurrent depression?
   (b) What are the similarities and differences in the types of strategies Pakistani women use for managing acute depressive episodes and preventing future depressive episodes?
   (c) How often do Pakistani women use strategies to self-manage their recurrent depression?
   (d) Do Pakistani women use different strategies to manage different symptoms of depression?

(e) How do they make decisions as to which strategy they can or cannot use to self-manage their recurrent depression?

(f) What strategies do Pakistani women find helpful or not helpful to manage and prevent future depressive episodes?

Significance of the Study

Current knowledge suggests that depression is more common in women than in men; for many, it is a recurrent and chronic illness. Learning and understanding strategies women use to self-manage their depression, what factors influence their use of self-management strategies, and the effectiveness of self-management strategies have particular relevance to nursing, particularly to psychiatric-mental health nursing.

Little is known about depression in Pakistani women, especially the self-management strategies they use to manage their depression. The findings of this study will generate knowledge about how Pakistani women self-manage their recurrent depression. This knowledge is essential for developing a knowledge base for relevant educational, clinical, and interventional programs to help Pakistani women living with depression. Nurses can use this knowledge to enhance their ability to treat clients' current depressive episodes and prevent future episodes. For example, Pakistani nurses will be able to better assess the factors which assist and prevent Pakistani women's use of self-management strategies. In addition, Pakistani nurses will be able to discuss possible strategies and ways to incorporate self-management strategies on an on-going basis considering each woman's context of personal and family characteristics, the availability and accessibility to health care, culture, and religion.

The findings of this study are expected to help Pakistani nurses develop evidenced-based, innovative clinical practice models for women with depression such as encouraging Pakistani women with depression who have limited access to health care services to take an active role in their illness by using certain self-management strategies.

Considering the differences in the sociocultural factors between the developing world and the developed world, it is plausible that the strategies used by women in the developing world will differ from those of women in the developed world. For example, a woman with depression from the developed world may choose jogging as an important strategy to combat her depression; whereas, a Pakistani woman may not choose jogging outside her home as a strategy due to cultural constraints. In addition, the reasons for selecting strategies might differ between Pakistani and western women.

This study will generate knowledge which will help develop an understanding necessary to construct self-management models useful in providing cross-culturally relevant nursing care to depressed patients. In addition, the findings of this study will create avenues for future cross-cultural nursing research on self-management strategies.

Summary

Major depression is a recurrent and chronic mental health condition. It is a concern for Pakistani women as research indicates that the prevalence of depression in women is more than twice that of men. Considering its recurrent nature and the socio-economic,-cultural-, and health care issues Pakistani women confront, it is imperative to understand how they manage depression.

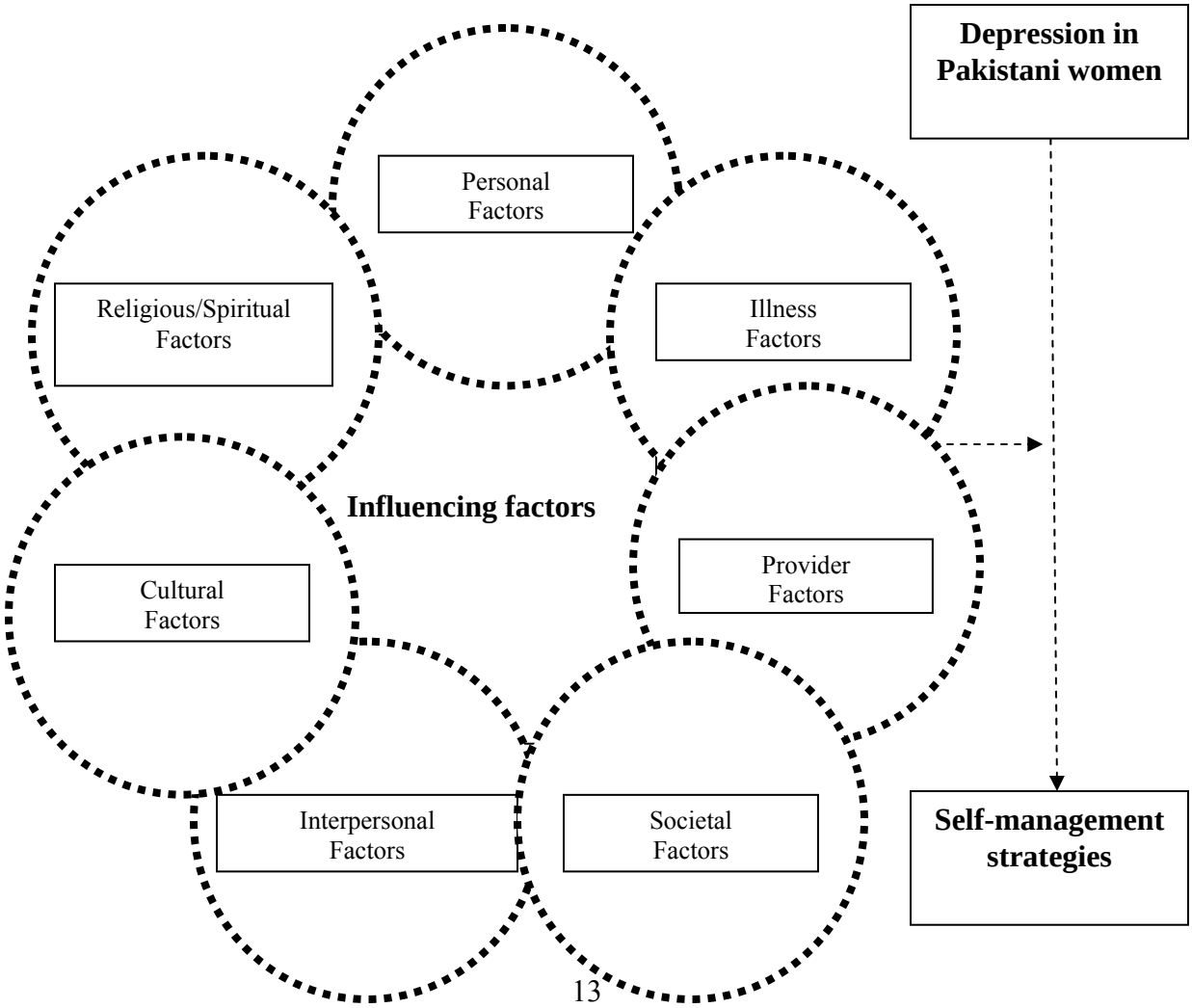
The significance of this study's findings relate to its potential for generating knowledge about how Pakistani women self-manage their recurrent depression in order to develop a knowledge base for relevant educational, clinical, and interventional programs to help Pakistani women living with recurrent depression.

Chapter II

Literature Review

A review of the literature surveyed three major topics: (a) depression in Pakistani women, (b) influencing factors, and (c) self-management strategies which are graphically organized in Figure 1.

Figure 1: Graphic Representation of the Three Major Topics Studied



Depression in Pakistani Women

The term depression (see Figure 1) is used in multiple ways such as a symptom, sign, and clinical disorder. In this study, depression and recurrent depression are defined by the Diagnostic and Statistical Manual IV-TR (APA, 2000). Clinical depression includes: (1) depressed mood; and/or (2) loss of interest or pleasure; (3) weight loss or gain; (4) sleep disturbance; (5) psychomotor agitation or retardation; (6) fatigue; (7) feelings of worthlessness or guilt; (8) difficulty concentrating; (9) recurrent thought of death or suicide. To be diagnosed with Major Depressive Disorder, the person must exhibit at least five of these symptoms, including 1 or 2, over at least a "2-week period and represent a change from previous functioning" (p. 356).

Depression affects physiological, behavioral, emotional, and cognitive functions. It is an episodic, recurrent, and chronic illness which often requires management over a lifetime. Recurrent depression includes the "presence of two or more Major Depressive Episodes" (APA, 2000, p. 376). Over time, depressive episodes tend to occur closer together and become increasingly more severe and frequent (Greden, 2001). Research on brain function and structure in people with recurrent depression shows that if not treated, it can damage the brain (Sapolsky, 2001). In addition, depression is linked to high mortality rates because people with severe depression are at risk for committing suicide (Harwitz & Ravizza, 2000).

Depression is the most common psychiatric disorder. The lifetime prevalence of major depressive disorder in American women and men is 16.2% (Kessler et al., 2003). Epidemiological studies in the United States of America indicate that depression is twice as common among women as men (Kessler et al., 1994; Weissman & Klerman, 1977). Similarly,

studies conducted in Pakistan revealed a more than double the prevalence of depression in women compared to men (Ali et al., 2002).

Cross-cultural differences in the presentation of depression.

According to a study by Furnham and Malik (1994), the perception of the cause and symptoms of depression and anti-depressive behavior are transmitted in an individual's cultural values and beliefs. Hence, an individual's ability to recognize, report, and seek help for depression is affected by their values and beliefs.

Rack (1980) illustrated one among many cultural differences in the presentation of depression between an English woman and a Pakistani woman. An English woman may go to a clinic and report that she is depressed and respond affirmatively to other symptoms of depression such as loss of interest, concentration and memory, feelings of guilt and self-blame and so forth. On the other hand, "a Pakistani woman of the same age, who also looks depressed, complains of pain and weakness" (p. 20). The pain and weakness may be localized in the chest or abdomen or diffused throughout the body, and is usually referred to as "body-ache". On inquiry, a Pakistani woman may report insomnia, anorexia, and loss of interest, and coping ability. In addition, she may admit that she is depressed. Based on this scenario, it can be concluded that both women have the same depression syndrome but their presentation differs significantly. For a Pakistani woman, the somatic symptoms precede a depressed mood; whereas an English woman expressed feelings of a depressed mood. This is one cultural variation in the presentation of depression.

Reza and Khan (2003) presented a similar view; however, they reported that Pakistani patients in general, not specifically women, did not present a depressed mood as a complaint. It is quite possible that depressed mood may not be a part of a Pakistani patient's presentation of

complaints. In addition, they asserted that Pakistani patients more commonly reported difficulties in coping with day-to-day activities and complaints such as feeling tired, unable to cope with work, and difficulty sleeping. Somatizing depression may be due to stigma attached to mental illness in Pakistan (Karim et al., 2004; Naqvi & Khan, 2005; Schuyler, 2000; Suhail, 2005; Syed et al., 2007). Therefore, somatic complaints are more acceptable to family and society than emotional and psychological complaints. Hence, when somatic complaints are explored in detail evidence of depression emerges (Reza & Khan, 2003).

Somatizing depression has been reported in various cross-cultural epidemiological studies as a common phenomenon in non-Western societies (Jablensky, Sartorius, Gulbinat, & Ernberg, 1981). For example, in India, depressed patients also present with somatic complaints and Indian researchers pay special attention to them (Gada, 1982). Similarly, Cheung, Lau, and Waldmann (1981) reported that the majority of depressed Chinese patients complained primarily about somatic symptoms. They suggested that somatic complaints among depressed Chinese patients may very well be explained by the stigma attached to mental illness in Chinese culture. Hence, somatizing depression is a common cross-cultural variation in the representation of depression.

Generally, Asians such as Pakistanis give priority to structural relations in society, that is, how they fit into defined roles and functions. Hence, their criteria of health are more related to their ability to function in society than to their internal mood states (Rack, 1980). The following is an example of an interaction between a psychiatrist and a husband (who was the interpreter for his wife who recovered from depression) which supports to the above hypothesis (Rack, 1980):

Psychiatrist 'How is your wife now?

Husband 'She is very well, doctor. She is able to do the housework, look after the children, do the cooking…'

Psychiatrist 'Good. But does she feel well in herself? Is she at all depressed?'

(Brief conversation between husband and wife)

Husband 'She is quite well now. She is looking after the children, doing the cooking. I have gone back to work…'

Psychiatrist 'Yes, yes but is she feeling well? How are her spirits? Is she happy?'

Husband (After more conversation with wife, both somewhat perplexed) 'she says she is now very happy doctor because she is able to do the housework, look after the children, do the cooking…she is cured'. (p. 21)

This interaction demonstrates that the woman considers her ability to function and fulfill her day-to-day responsibilities to be more indicative of her health status than her mood state.

Cross-cultural differences in the diagnosis of depression.

Despite the cultural differences in the manifestation of depression, the DSM-IV or ICD-10 is used to diagnose depression in women in the United States of America as well as in Pakistan. Pakistani psychiatrists, however, are expected to translate the signs and symptoms of depression listed in the DSM-IV or ICD-10 into appropriate Urdu or other regional languages and cultural equivalents and are expected to describe as completely as possible the core features of depression while conversing with patients in assessment interviews. However, some symptoms such as loss of energy or lack of sexual desire may still go unnoticed as both doctor

and patient may feel too shy to talk about them (Reza & Khan, 2003). Hence, a criterion such as loss of libido may not be valid for diagnosing depression in Pakistani women as doctors do not usually discuss this symptom with patients or vice versa. Reza and Khan (2003) asserted that if doctors were conversant with the symptoms stated in the DSM-IV and ICD-10, they could elicit depression in a fairly short interview; otherwise it is highly unlikely that a Pakistani woman would talk about them. Since there are differences in the manifestation of depression in Pakistani women, Reza and Khan (2003) acknowledged that health care providers are faced with a difficult challenge to correctly diagnose and properly treat depression in Pakistani women.

Influencing Factors

Based on an understanding of the literature on Pakistan, depression, and clinical experience with Pakistani women with depression seven, overlapping factors have been identified: (1) personal, (2) illness, (3) provider, (4) societal, (5) interpersonal, (6) cultural, and (7) religious/spiritual (Figure 1). Examples will be provided on how a particular factor identified in Pakistanis, particularly Pakistani women with depression, might influence their self-management strategies. It is important to note that these factors have been derived theoretically and from clinical practice.

Personal factors.

Participants' personal factors such as demographic characteristics and personal attributes were investigated to determine their influence on self-management strategies for recurrent depression.

Demographic characteristics included: (i) female gender (Ali & Amanullah, 2000; Husain et al., 2000); (ii) age (Mumford, Minhas, Akhtar, Akhtar, & Mubbashar, 2000; Rahman et al.,

2008); (iii) education (Dodani & Zuberi, 2000; Husain et al., 2004); (iv) socioeconomic status (Mumford et al., 2000;); (v) ethnicity (Clark & Nothwehr, 1997); and (vi) marital status (Husain et al., 2000).

With respect to gender, Clark et al. (1997) found that there were gender differences in the effectiveness of self-management educational programs and suggested that interventions needed to be tailored differently for women. In their study only men in the intervention group experienced improvement in their physical functioning, particularly in their ability to ambulate, compared to males in the control group. However, women participants did not experience improvements in physical functioning. Clark and colleagues (1997) suggested that interventions need to be tailored differently for women.

In Pakistani, patriarchal society (T. S. Ali et al., 2011) women are viewed as socially, economically, and culturally dependent (Fikree & Pasha, 2004). Many Pakistani women are not given a chance equal to men to get an education; this limits women's choices of accessing information about depression from various sources such as newspapers, books, hospital pamphlets and so forth. Nowadays, more articles are published in Pakistani newspapers and magazines about depression; however, Pakistani women may not benefit from them. Suhail (2005) argued that improved general literacy improves mental health literacy. In addition, lack of education also limits Pakistani women's self-esteem and self-efficacy in managing illness (Dodani & Zuberi, 2000). Both are important aspects of learning how to deal with chronic and recurrent depression.

Besides demographic factors, personal attributes such as knowledge of and perceptions and attitudes about depression may be related to what strategies Pakistani women select to manage their recurrent depression. Patients described the importance of acquiring information

about their illness (Clark & Starr-Schneidkraut, 1994). However, the relationship between having information about an illness and changing behaviors has not been strong (Becker, 1995). Giving Pakistani women information about their recurrent depression and ways to manage it may be an important consideration. However, to change a woman's behavior, a health care provider needs to pay attention to other factors such as Pakistani women's perceptions and attitudes about depression and its management. For example, if a Pakistani woman suffers from recurrent depression and she or her family believes that the condition is due to either spirit possession, black magic, or testing by God as punishment for one's sins (Karim et al., 2004), prescribing Western medications may not be appropriate or sufficient.

Illness factors.

Illness factors that were considered included illness history and illness identity. Illness history includes: (1) age of first onset, (2) number of previous episodes, (3) frequency of depressive episodes, (4) number of hospital days, and (5) disability, and (6) onset of current episode, severity, and length (Karp, 1996).

Understanding Pakistani women's history and course of their depression may be critical for understanding how they manage current and future episodes of depression. For example, a Pakistani woman with recurrent depression may have learned over several episodes that strategies which were helpful in an earlier episode may not be helpful anymore.

Individuals establish illness identity as they encounter each new episode and by how they understand and label their illness and its characteristics. Karp (1996) identified four phases that people move through in the illness identity process: inability to label their experience as depression, conclusion that something is wrong with them, crisis interventions with experts and

family, and coming to grips with depression as a component of their identity. Within the context of the self-management of illness, the role of illness identity could be a valuable area to understand.

Provider factors.

Provider factors include: types of health care providers, roles various health care providers perform, and the stigma associated with using mental health care providers.

Health care providers in Pakistan include: local religious healers and traditional, alternative or complementary healers; and formal health care providers such as general practitioners and mental health care providers in Government and private health sectors (Karim et al., 2004).

The roles various health care providers perform include: (a) communication, (b) diagnostic, (c) advisor, (d) service provider, and (e) information and emotional support (Clark & Nothwehr, 1997). Health care providers' roles in patients' self-management of depression is important and may ultimately influence patients' health outcomes. Clark and Nothwehr (1997) reviewed 18 adult self-management program evaluations and then conducted a qualitative study on patient and clinician relationships with 29 asthmatic patients. Patients reported concerns about the competence of their clinicians who failed to diagnose and treat their illnesses. Patients described their desire to have clinicians listen to them, value their experiences, and use that information in treatment decisions. Patients also expressed a desire for mutual respect and understanding, continuity of care, adequate symptom management, and higher clinician expectations that their illness could impact their lives less severely. Clark and Nothwehr (1997)

also noted the importance of communication between patients and clinicians and that they provide professional advice, services, and informational and emotional support.

It has been observed and reported that often women who are depressed have been to various health care providers (Suhail, 2005) including spiritual or religious healers, homeopathic doctors, and a variety of allopathic doctors seeking help for somatic symptoms of depression before going to mental health care providers. Hence, seeking specialist mental health care services is usually not their first choice. This is understandable within the context of low literacy, unemployment (Rana, 2011), high cost of mental health treatment (Gadit, 2012) where people are expected to pay out of their pocket (Gadit 2012) and in the absence of any form of health insurance (Abrejo & Shaikh, 2008; Jooma & Jalal, 2012; Naqvi & Khan, 2005), unavailability and inaccessibility of mental health care services (Karim et al., 2004) particularly when struggling with poverty (Tinker, Finn, & Epp, 2000), faith in local healers, and importantly the stigma of mental illness and seeking care from mental health care facilities. Although Pakistani women are faced with barriers to seeking mental health care services, they still seek treatment from mental health care facilities as evidenced by research on depression in Pakistani women in both rural (Dodani & Zuberi, 2000) and urban (Gadit, 2004) areas by various Pakistani researchers on depression in women.

Within Pakistan's mental health care context, it is extremely important that health care providers in both primary and secondary health care settings as well as local healers identify depression early. If they do not, Pakistani women with depression may not be adequately treated within their own family, community, and available health care contexts. Similarly, in order to help Pakistani women self-manage their illness, Pakistani nurses need to play a stronger role in treating depression. Unfortunately in Pakistan, many psychiatric facilities use the medical model

rather than the behavioral model of psychiatric practice; hence, nurses primarily focus on following treatment orders and administering medications. This current practice needs to change so that Pakistani women are helped to learn, monitor, and evaluate self-management strategies to manage and prevent future episodes of depression.

Societal factors.

Pakistani women's perspectives on which and how various societal factors affected their self-management strategies for recurrent depression were explored. They included: (a) poverty (Ali et al., 2002), (b) unemployment (Ali et al., 2002), (c) overcrowding (Ali, et al., 2002), (d) poor civic amenities (Ali et al., 2002), (e) unavailability of mental health care services (Karim et al., 2004), f) expensive mental health care services (Gadit, 2004), and (g) health insurance (Abrejo & Shaikh, 2008; Jooma & Jalal, 2012).

To demonstrate how societal factor could influence women's use of self-management strategies two examples are presented based on clinical experience. A Pakistani woman with depression may want to use mental health care services; however, she may be financially dependent on her husband or in-laws and cannot afford their high cost. This is likely because Pakistani women are expected to be housewives and are not required to be earners in the family. They do not have the option to seek professional mental health care for their depression, even though they recognize that they could benefit from the treatment. Similarly, a patient's health insurance may influence how recurrent depression is managed. A patient's health insurance may not only limit his/her choice of health care provider(s) but may also limit health care providers from using the best available treatments.

Interpersonal factors.

Interpersonal factors affect the identification, employment, and abandonment of self-management strategies for recurrent depression. They consist of: (a) family reactions to depression (Karim et al., 2004; Khan & Reza, 1998); (b) family involvement in deciding the management of depression; (c) lack of autonomy (Rabbani & Raja, 2000); (d) arguments with and abuse by spouse (Rabbani & Raja, 2000; Naeem et al., 2004) or in-laws (Rabbani & Raja, 2000; Rabbani, 1999); (e) social support from spouse and other family members, friends, health care providers, and religious leaders (Rabbani, 1999); (f) financial support from family members; and (g) family members as role models (Clark, Gong, & Kaciroti, 2001).

Dealing with symptoms of illness and its impact on daily functioning requires interpersonal support (Rehm, 1982; Kanfer & Gaelick-Buys, 1999). The role of family and friends, therefore, must be considered in the process of self-management of depression (Yeung, Feldman, & Fava, 2010). Hence, it is possible that Pakistani women's self-management of depression occurs within an interpersonal context where behavior is influenced by interpersonal relationships. There is empirical evidence demonstrating that people self-manage their chronic illness within their family context (Grey, Knafl, & McCorkle, 2006) and use self-management strategies to manage and prevent their illness episodes (Walker, Bamps, Burdett, Rothkopf, & Dilorio, 2012).

A review of the literature on Pakistan and depression clearly indicated that significant others participated in illness management. Families play a crucial role in Pakistani women's decisions about what needs to be done for their illness. For example, they decide where a woman should receive treatment for her illness. It is important to recognize that the family's or significant others' input may or may not support a woman's attempts to manage depression.

Pakistani women use strategies such as talking with husbands, health care providers, friends, or religious healers. Similarly, factors such as lack of autonomy, arguments and spousal and in-law abuse (Naeem et al., 2004; Rabbani & Raja, 2000) may limit Pakistani women's ability to implement strategies which they and their health care providers know would be helpful in managing current and preventing future episodes of depression. A patient's attempts to live with and manage chronic illness can generate conflict with others. Clark and Nothwehr (1997) found that patients with asthma experienced conflicts with significant others around their illness experience. Recurrent depression is particularly difficult for families, colleagues, and employers as a patient's problems to function create tensions, embarrassment, stigma and blame. In addition, research by Clark et al. (2001) demonstrated the importance of significant others as role models and financial resources on a person's ability to self-manage their illness. This may very well apply to Pakistani women as most are dependent on their families to support them financially (Sebghati & Särnholm, 2010). For example, a combination of costly medications and lack of finances can hamper Pakistani women's strategy to continue to take medications for their depression.

Cultural factors.

Cultural factors comprised of: (a) early marriage (Dodani & Zuberi, 2000; Khan & Reza, 1998; Sathar & Ahmed, 1992); (b) being a housewife (B. Ali et al., 1993); (c) living in an extended family (Karim et al., 2004; Dodani & Zuberi, 2000); (d) early motherhood (Dodani & Zuberi, 2000); (e) repeated pregnancy (Dodani & Zuberi, 2000); (f) high number of children (Husain et al., 2000); (g) stigma attached to mental illness (Afridi, 2008; Naqvi & Khan, 2005; Schuyler, 2000; Suhail, 2005; Syed et al., 2007) and stigma attached to seeking formal mental

health care services (Cheung et al., 1981; Karim et al., 2004; Knapp et al., 2006: Khan & Reza, 1998; Weatherhead & Diaches, 2010); and (h) seeking health care from non-medical mental health care providers for mental illness (Karim et al., 2004). Pakistani women are expected to marry and procreate at an early age and raise a family. If they face harsh family circumstances where husband and in-laws are not supportive and influence women's health care seeking related decisions, it is highly likely that these cultural components contribute to what Pakistani women do to manage and prevent depression.

Religious/spiritual factors.

Religious/spiritual factors comprised the following: (a) faith in Allah (b) prayers; (c) use of Taveez (amulet); and (d) use of religious healers and faith healers.

Faith in Allah (Gadit, 2007; Naeem et al., 2004; Syed et al., 2007), prayers (Hawley & Irurita, 1998; Lo, 2003; Naeem et al., 2004), and faith in the Quran play an important part in the life of Muslim women. Prayer is an important aspect of spiritual life and allows people to express themselves in crisis and emotional turmoil. In addition, prayer is a source of personal strength during difficult times in life. Particularly, prayer helps reduce the anxiety associated with illness (Lo, 2003).

Ghouri (2004) reported that Pakistani people use amulet (the recited or written verses of the holy Quran) for healing. It is documented that Pakistani people usually use faith healers (Saeed et al., 2000; Syed et al., 2007) and religious healers (Karim et al., 2004; Qidwi, Azam, Ali, & Ayub, 2002) to treat their illnesses, as it avoids the stigma associated with mental illness and accessing mental health care services.

Self-management Strategies

The last and most critical component is self-management strategies (Figure 1). A review of the literature on the self-management strategies women use to manage and prevent depression prompted the following questions which will be discussed in this section. What research has been done on self-management strategies? Why not consider other concepts such as coping strategies, self-help, help-seeking, or self-care? What is known and what is not known about self-management strategies in depression? Throughout this discussion the gap in theoretical and empirical knowledge will be addressed.

What research has been done so far on self-management strategies.

A few studies conducted in the West and in Pakistan support further investigation into the concept of self-management strategies in depression.

Self-management has been studied in a variety of physical and mental illnesses. Recently, self-management has focused on identifying strategies to manage depression and has become an area for further investigation (Yeung et al., 2010). An important question is whether the self-management strategies patients use in other illnesses can be used by patients with recurrent depression. Pollack (1996) stated that there may be some common strategies that people with chronic illnesses use. However, there may be some self-management strategies that are unique to a particular disorder; each may require systematic investigation. Several research studies (Murphy & Moller, 1993; Pollack, 1996; Taylor, 1999; and Hagerty, Williams, and Lynch-Sauer, 2002) emphasized the value of understanding the concept of self-management strategies in managing illness.

Taylor (1999) studied the self-management strategies of women with menstrual syndrome and found that those who used a combination of self-management strategies had more success in managing their symptoms than those who used only one behavior. Taylor's conclusion supports the conceptualization proposed in this study that women with recurrent depression use a combination of strategies.

Murphy and Moller (1993) interviewed clients who had schizophrenia (n = 76), bipolar disorders (n = 7), and major depression (n = 12). They asked 95 psychiatric patients about their psychiatric symptoms, physical symptoms, interpersonal relationships, activities of daily living, medication management and current symptom management techniques. They summarized their findings into six categories: 1) distraction, 2) fighting back, 3) help-seeking, 4) attempts to feel better, 5) isolation, and 6) escape-oriented. They reported that the symptom management techniques listed under the first four categories were action-oriented, enlisted help from others, and enhanced clients' stability and led to clients' wellness. Whereas, symptom management techniques listed under the fifth category (i.e. isolation) were passive in nature and reflected an attitude in clients that there was nothing they could do and that they could only maintain their stability which did not lead them to wellness. Murphy and Moller (1993) stated that "the use of neurotoxic substances to self-medicate symptoms counteracts the positive effect of medications and interferes with symptom management techniques used in the other five categories" (p. 232-233). Pollack (1996) interviewed 33 participants, (20 women and 13 men), who were hospitalized for bipolar disorder. Their study interviews focused on 1) understanding bipolar disorder, 2) managing daily life, 3) living in society, 4) relating to others, 5) relating to self, and 6) self-management. Pollack conceptualized self-management as encompassing the first five aspects of the interviews mentioned above. The findings on patient-initiated self-management

interventions which included behavioral and attitudinal strategies were presented under the following categories: overall management, management of daily life, life in society, relation to others, and relation to self. Contrary to the interventions mentioned in the category of relation to self, Pollack (1996) reported that if the patient initiated an intervention "hide feelings", it could be potentially destructive. Both Murphy and Moller (1993) and Pollack (1996) supported the findings of Clark et al., (2001) that clients may use strategies that are either effective or ineffective to manage their chronic illness. This finding supports the concept of self-management strategies used in this study.

As mentioned earlier there is a dearth of literature on self-management strategies for recurrent depression. However, Hagerty et al., (2002) conducted a qualitative study using a focus group technique with persons with recurrent depression. One aim of their study was to "identify strategies patients use that are helpful in preventing and minimizing their depressive episodes" (p. 40). Through a content analysis of three focus group interviews, they identified a variety of strategies that participants used to manage recurrent depression. They grouped self-management strategies under six broad categories: 1) adherence to clinician advice/recommendations, 2) contact with clinician, 3) personal life modification, 4) stress management, 5) social environment, and 6) affective and cognitive strategies.

Adhering to clinician's advice/recommendations included following clinician's recommendation and changing medication or dosage without telling the clinician. Contact with clinician included changing clinician and not telling the clinician when symptoms were worse. Personal life modification included changing diet and setting goals. Stress management included meditation and guided or visual imagery. Social environment included seeking support from family, friends, employer, and coworkers, and scheduling interaction time. Affective and

cognitive strategies included purposefully adding more structure/routine to the day and trying to think more positively (Hagerty et al., 2002). It is important to recognize that the data from Hagerty et al.'s (2002) qualitative study have provided an important understanding of the self-management strategies people with recurrent depression use.

Wilson (1992) supports the fact that besides research on the use of antidepressants and certain forms of psychotherapy, little research has been conducted on the "development and evaluation of psychological relapse prevention strategies in depression" (p. 139). This is especially true for strategies that involve social, cultural, interpersonal, and religious/spiritual engagement and demand treatment partnerships involving the patient, family or significant others, and health care providers. Hagerty et al. (2002) added to Wilson's (1992) idea that more research needs to be done on self-management strategies in depression by proposing that research on strategies in depression needs to go beyond the context of cognitive-behavioral therapies as specified in Rehm's (1977) self-control model of depression.

However, Pakistani women are faced with unique issues related to culture, socioeconomics, and health care services. Therefore, it is plausible that the strategies Pakistani women use, the reasons for selecting strategies, and their views about their effectiveness may differ from women in the West who are not faced with these issues.

A few studies that indicated what Pakistani women do for depression lacked a self-management strategies conceptual or theoretical framework and were mainly studied from the perspective of coping or help-seeking related strategies (Gater et al., 2010; Naeem, et al., 2004; Rafique, 2010; Suhail, 2005).

For example, Rafique (2010) published findings in which Pakistani women living in the UK were interviewed about their experiences of depression and coping. The findings included

women's use of a variety of coping strategies such as talking to someone, being strong for the children, keeping busy, religious coping, positive self-talking, downward comparing, and using antidepressants. Though this study provided some information on coping activities Pakistani women did for their depression, they were not queried from the perspective of self-management strategies and the women were not residing in Pakistan.

Gater et al. (2010) shared the findings of a randomized trial in which women in one group combined social interventions with antidepressants were compared to women in an only antidepressant group. The women in the combined treatment group demonstrated greater improvement in depression. This finding confirms that to combat depression, women need to do more than just take medications.

Suhail (2005) reported in a survey research finding a variety of help-seeking options Pakistani women used to manage depression. These options included seeking help from general practitioners, psychiatrists, psychologists, and magical and religious healers. There is further support that women sought help from religious and faith healers. For example, Mubbashar and Saeed (2001) reported that Pakistani people usually seek help from religious leaders and faith healers as the first line of action for their mental illness. Suhail's (2005) findings endorsed that Pakistani women over time might end up seeking mental health care from religious healers because seeking help from them was congruent with their lack of knowledge of the existence of mental illness, and the societal stigma attached to depression as being mentally ill. Syed et al. (2007) confirmed that seeking help from religious healers matched the usual health beliefs about mental illness.

Using a focus group discussion method, Naeem, et al. (2004) studied perceived vulnerabilities, strengths, and resources that play an important role in the recovery of Pakistani

women (n = 7) from depression. The women were from a lower middle class, semi-urban community of Karachi. They reported unemployment, poverty, abuse, and ongoing difficulty in daily life as causes of poor mental health (vulnerability factors). Strengths and resources (restitution factors) included a reliable social support system, a positive thinking approach, faith and prayers, and a turning point event. Each woman reported that they had someone to whom they could turn to when they were distressed. They may be relatives, friends, and neighbors. "… if we go to someone else and share our problems, it reduces our tension. If we stay quiet the tension builds up." (p. 50)

Why not consider other concepts.

There are similarities between coping strategies and self-management strategies. The reason for the similarity is that both are expressed in terms of an individual's actions/activities such as taking medications, walking, relaxing, praying, not doing anything, and so forth. However, there are some important differences between the two concepts.

According to Lazarus (1993) coping is an individual's primary mechanism to adapt to illness and aims at neutralizing a threatening situation effectively (Miller, 1980). According to Lazarus and Folkman (1984) an individual uses two modes of coping strategies in response to stressor(s): problem- and emotion-focused coping strategies. Problem-focused strategies aim to alter the original source of stressor(s) through changing behaviors or environmental conditions. Emotion-focused strategies aim to control stress-related emotions by either avoiding or cognitively reconstructing the context of a stressful situation.

The major difference between self-management and coping strategies is that self-management includes self-regulation. The idea of self-management is based on a paradigm in

which patients are the primary participants in their care. The focus is on what patients themselves can do to manage their illness rather than primarily relying on a provider's prescriptive recommendations such as medication or some type of psychotherapy. Hence, patients play a central role and take responsibility to manage their illness (depression); providers play the role of a coach or a facilitator in the patients' self-management process (Hagerty, Williams, Greden, & Lynch-Sauer, 2003). In addition, self-management focuses on self-regulation which involves an ongoing assessment of illness and personal state regardless of whether the individual is in an acute episode of an illness or not. On the other hand, coping strategies are used when an individual experiences stressor(s); but may or may not continue to use coping strategies once the stressor(s) is absent and may not use them to self-regulate illness on an ongoing basis. Self-management strategies, therefore, is a useful concept to explore when an individual has to live with chronic and recurrent depression.

Similarly, there may be a concern that self-help, help-seeking behaviors, or self-care are not adequate concepts when studying recurrent depression in Pakistani women. This is because they are not broad enough to capture all the strategies Pakistani women may use to self-manage their recurrent depression.

Likewise, the concept of self-care focuses primarily on issues related to maintaining health habits while recovering from illness such as mobility or elimination problems (Nakagawa-Kogan & Betrus, 1984). It also includes actions that an individual takes to sustain a desired level of health irrespective of their interaction with health professionals (Clark, 2003). According to Clark (1993), self-care may not be a suitable term to explore within the context of chronic disease management because most chronic conditions require the involvement of health care professionals, and patients have to follow a particular therapeutic regimen as part of the

treatment process. In addition, the holistic perspective includes preventive or therapeutic health care related activities which address problems related to but not limited to physiological processes, cognition, behavioral habits, and emotions (Nakagawa-Kogan & Betrus, 1984). Self-care, though considered a part of self-management strategies, does not capture the holistic perspective for dealing with chronic illness. Hence, the concept of self-management strategies allows freedom to explore a much deeper and broader understanding of how Pakistani women self-manage their recurrent depression.

What is known and what is not known about the concept of self-management strategies in depression.

The concept of self-management strategies is a combination of two critical components, self-management and strategies. Self-management and self-management strategies have been discussed in the literature in a variety of ways. A few views about the concept that are relevant to this research will be presented.

Clark, Becker, Janz, Lorig, Rakowski, and Anderson (1991) defined self-management as an individual's daily performance of activities to control or minimize the impact of illness on their health status. Fuchs and Rehm (1977) studied self-management strategies with respect to the self-control model within the context of cognitive-behavioral therapy. Clark and colleagues and Hagerty and colleagues conceptualized self-management strategies from a self-regulation perspective. Clark and Northwehr (1997) conceptualized self-management strategies as an individual's conscious effort to use self-management strategies to manipulate their chronic illness to "enhance daily life" (p. S10) and to minimize the impact of illness on daily life. An individual with chronic illness learns which self-management strategies are effective through

self-regulation. Similarly, Hagerty et al. (2002) based their work on that of Clark and colleagues and defined self-management as a "patient's conscious use of strategies or activities on a daily basis to manage the symptoms of their illness, maintain optimum health, and decrease the impact of the illness experience on daily life and functioning" (p. 3) and to achieve personal goals. The patient initiates or maintains self-management effort through self-regulation.

It is important to note that although personal goals play a considerable role in the self-management of other recurrent and chronic illnesses (Clark & Partridge, 2002) including depression (Dickson, Moberly, & Kinderman, 2011), the motivating role in their use is yet to be fully understood.

Self-regulation is defined as a continuous and sequential process (Clark et al., 2001). Clark and Starr-Schneidkraut (1994) and Clark et al. (2001) added that self-management strategies which are learned through self-regulation aim to manage a current episode of an illness and/or prevent future episodes. The use of self-management strategies to manage and/or prevent an illness episode can assist an individual to: meet his/her personal goals, have a better quality of life, have improved health status as desired by his/her health care providers, and use health care services appropriately. Hagerty et al. (2002) delineated the process of self-regulation as individuals monitoring their illness symptoms and environmental triggers, making judgments about the status of their illness, selecting and trying out specific strategies, and evaluating their outcome (see Appendix A).

Regarding the use of self-management strategies within the context of chronic illness, Hagerty et al. (2002) have conceptualized self-management strategies for recurrent depression using Clark's and colleagues' work on self-management. Self-management efforts encompass a variety of strategies. Persons with chronic illness develop a repertoire of strategies to manage

their illness. These strategies can be quite different in content and number, and patients may use one or more strategies for any given situation. In addition, Hagerty and colleagues asserted that over time an individual develops a repertoire of strategies to draw from when experiencing depression. Clark and colleagues and Hagerty and colleagues pointed out that since there is no standard formula for controlling the symptoms of illness, both an individual with chronic illness and his/her family make decisions on what strategies to use to manage the symptoms (Clark & Nothwehr, 1997). The strategies that an individual uses might or might not be consistent with what a health care professional would recommend. In addition, the strategies that an individual uses might or might not be effective in managing illness (Clark et al., 2001). The concept of self-management strategies has been discussed in relation to the self-control model (Fuchs & Rehm, 1977) or the concept of self-management or self-regulation (Clark et al., 2001; Clark & Nothwehr, 1997; Clark & Starr-Schneidkraut, 1994). The concept of self-management strategies is not fully conceptualized as a discrete concept.

The concept of self-management strategies and their perceived effectiveness among Pakistani women with recurrent depression incorporates Clark and colleagues' and Hagerty and colleagues' work on self-management strategies and adds some unique perspectives. First, self-management strategies are the actions/activities a woman uses to manage her symptoms of recurrent depressive illness. Second, a woman with depression may select, try out, and continue to use one or more strategies that she perceives effective in managing or preventing a depressive episode. However, not all strategies actually may be helpful such as using drugs or alcohol and or self-harming activities. According to Clark et al. (2001), the strategies an individual uses to self-manage his/her chronic illness may or may not be effective. Hence, it is worthwhile to explore participants' perceived effectiveness about the strategies they employed to manage

and/or prevent future episodes of depression. Perceived effectiveness is viewed as participants' perceptions of whether or not the strategies they use are helpful in self-managing and preventing their depressive episodes. Third, collectivism, a Pakistani societal value of the importance of family and other significant members in a women's life, could play a critical role in identifying and implementing strategies to manage and prevent a depressive episode. Fourth, the focus of the research is on self-management strategies and not on delineating the five steps of self-regulation Hagerty and colleagues identified. However, monitoring, judging, selecting strategies, trying out strategies and evaluating outcomes could be viewed as action/activities Pakistani women might take to manage or prevent depression. This conceptualization of self-regulation is unique and allows freedom to explore a much broader understanding of the concept of self-management strategies among Pakistani women with recurrent depression.

Considering how little is known about strategies, there is certainly a need to develop more knowledge about the strategies Pakistani women use to self-manage their depression. There is a need for knowledge particularly from Pakistani women's perspectives on the strategies they use to manage their chronic and recurrent illness, depression. So far, there is no knowledge about the range of strategies Pakistani women use for recurrent depression, how frequently they use each of the specified strategies, how they make decisions as to which strategy they can or cannot use, whether they use similar or different strategies to manage various symptoms of depression, and what factors influence their use of strategies. Finally, nothing is known about what strategies they find effective or not in managing their acute depressive episodes and in preventing future ones. Hence, there are theoretical and empirical gaps in the knowledge about Pakistani women's self-management strategies, factors influencing those strategies, and their effectiveness which need to be explored.

Summary

In this chapter, three major components were graphically presented in Figure 1: depression in Pakistani women, influencing factors, and self-management strategies.

First the literature review on depression was presented which included depression as a clinical diagnosis using the DSM-IV-TR (2000) criteria followed by a description of cross-cultural differences in the presentation and diagnosis of depression in Pakistani women with exemplars.

Second, the discussion of seven influencing factors which have been derived theoretically from the literature and from clinical practice with relevant exemplars was presented. These influencing factors were: (1) personal, (2) illness, (3) provider, (4) societal, (5) interpersonal, (6) cultural, and (7) religious/spiritual. It is likely that each of these influencing factors, independently and in a complex combination with other influencing factors, influence the self-management strategies Pakistani women with recurrent depression use. It is possible that there might be other factors which have not yet been identified but warrant an in-depth exploration which influence the self-management strategies of Pakistani women.

Finally, in the section of the self-management strategies, why the concept of self-management strategies is used rather than other concepts such as coping strategies, self-help, help-seeking, or self-care was discussed. The unique features of the concept of self-management strategies were described.

Chapter III

Method

The purpose of this study was to describe self-management strategies of Pakistani women with recurrent depression. This chapter describes the methodology used for the study and consists of eight sections: (a) the researcher, (b) research design, (c) sample, (d) measures, (e) procedure, (f) human subject protection, (g) minority/gender/children, and (h) data analysis.

The Researcher

In qualitative research, the investigator is a "research instrument" (Janesick, 2000, p. 386**)** who, before initiating research, puts forth personal beliefs, assumptions, biases or judgments (Munhall, 1998) that could potentially influence the research process. Hence, the investigator took rigorous measures to promote transparency in the research process.

The investigator is a Muslim, South Asian woman who was born and raised in Pakistan. She was educated, trained, and worked as a mental health nurse both in a hospital and in community settings using the western medical model of disease management and prevention. Throughout the practice experience one observation that kept repeating itself was that although Pakistani people in general and Pakistani women in particular sought medical help for their mental health problems, it was not always the first or only treatment they used. For example, during clinical practice, a variety of clients were heard to say that they sought help from God and alternative healers, became regular in their religious practices, talked with others, and used many other ways they perceived to be helpful to recover from their condition. In addition, they

struggled with seeking and following medical treatment due to stigma and lack of family and financial support which contributed to their lack or limited use of mental health services. In short, as a mental health nurse, the investigator pondered about what strategies women used to do to manage their mental illnesses, whether or not they found them effective, and what contributed to their selection and use.

The investigator sharing the same culture as the participants both assisted and limited the data collection and analysis process. Many participants wondered initially about the value of this research and viewed the investigator as a doctor as they had never heard of nurses performing research. Sharing the same culture and being a female interacting with female participants from a similar culture assisted in relating and connecting with them and communicating the value of their involvement in the project. In addition, conversing and understanding their language helped ease their sharing personal struggles and ways they approached their depressive illness. It was instrumental in obtaining rich descriptions about the strategies they used to self-manage their recurrent depression.

On the other hand, the investigator realized that an insider's perspective and personal meanings and biases could influence the interpretation of the data and potentially threaten the validity and reliability of the data analysis. Hence, the investigator was not only aware of introducing such threats but also made diligent efforts to ensure that such threats were avoided by consciously reminding and clarifying personal assumptions throughout the data analysis about what was heard and understood from the data. Since the investigator conducted all the interviews mainly in Urdu, they needed to be translated into English then back translated into Urdu. The investigator besides translating all the interviews into English back translated three randomly selected interviews as well. To avoid biased interpretations, two independent bilingual

Pakistani colleagues currently residing abroad translated one interview and all the key terms into English. In addition, throughout the data analysis, views, opinions and interpretations of the data were discussed and cross checked with the dissertation chair.

Research Design

This descriptive study used content analysis to describe Pakistani women's experience of depression, factors influencing strategies, and self-management strategies in their recurrent depression. Content analysis is a qualitative analysis procedure for methodically making sense of the transcriptions of open-ended interviews using three basic techniques: (a) deciding on the unit of analysis, (b) borrowing or developing a set of categories, and (c) developing the rationale and illustrations to guide the coding of data into categories (Wilson, 1989).

Sample

In this qualitative study, purposive sampling was used to select Pakistani women who were considered to be "information-rich" (Patton, 1990, p. 169) about strategies they used to self-manage their recurrent depression. Women who met the following inclusion criteria were included in the study: (a) born in Pakistan; (b) 18 years of age or older; (c) diagnosed with two or more episodes of major depression; (d) follow-up patient in the outpatient psychiatric clinic of the Aga Khan University Hospital (AKUH); (e) aware that she had depression; (f) spoke Urdu and/or English; (g) gave permission to access medical files to validate diagnosis and history of two or more depressive episodes; to validate the absence of bipolar disorder or current substance abuse; and (h) was willing to participate in the study. The exclusion criteria for a Pakistani woman with depression were: (a) a diagnosis of bipolar disorder, (b) currently abusing a substance, and c) currently admitted to the in-patient psychiatric unit of the AKUH.

A total of 10 women participated in the study and with them a total of 27 interviews were conducted. "Adequacy of sample size in qualitative research is relative, a matter of judging a sample neither small nor large per se, but rather too small or too large…." (p. 179). A sample size of 10 could be sufficient based on the specific purpose of the sampling and the desired outcome of the qualitative study (Sandelowski, 1995). In addition, a sample size goal is not to include a specific number of subjects or interviews, rather the subjects' enrollment or interviews are continued until saturation in the data is achieved. Saturation primarily refers to the point in the data collection process where the key themes are consistently repeated and no new significantly relevant information is added (Streubert & Carpenter, 1999).

Measures

The measure used in this study was an interview using an interview guide (see Appendix B p.1-2). The interview elicited information from the participants about their experience of depression, factors influencing strategies, and self-management strategies of their recurrent depression. The interview was semi-structured so as not to limit the scope of inquiry i.e., self-management strategies, and would allow the investigator to ask and sequence open-ended questions to respond to individual differences (Waltz, Strickland, & Lenz, 1991).

The interview guide consisted of a participant information sheet and interview questions. The participant information sheet included: (a) participant code number, (b) participant interview number, (c) gender, (d) place of birth, (e) age, (f) years of formal schooling, (g) marital status, (h) numbers of years married, (i) number and type of relation with people living in their household, (j) number of children, (k) ethnicity (l) religion, (m) employment status, (n) monthly

household income, (o) age of onset of initial depressive episode, and (p) number of previous major depressive episodes.

Interview questions helped the investigator generate data to understand phenomena identified in the research questions (Maxwell, 1998). In this study, the interview questions were purposefully open-ended. Open-ended questions permitted participants to answer questions in a way they wanted (Patton, 1990). Before data collection, both Urdu and English versions of the interview questions were evaluated by two non-depressed Pakistani women to get feedback to ensure the clarity, understandability, meaning, usefulness, and simplicity of the interview questions.

The broad overarching interview question was "let us talk about your experience of depression". A specific interview question was "what is a depressive episode like for you?" Samples of the broad interview questions that addressed some of the research questions were as follows. An interview question ascertaining self-management strategies was "what kinds of things do you do for your symptoms of depression?" An interview question ascertaining influencing factors was "what makes you use (name of the particular strategy) it?" An interview question ascertaining perceived effectiveness of self-management strategies was "how does it (name of the particular strategy) work for you?" In addition to the broad open-ended interview questions, the investigator developed a list of specific interview questions, probes, and clarifying questions which were used as needed during the interview.

Procedure

Following the approval of the IRB review board at the University of Michigan and the Ethical Review Committee of the Aga Khan University (AKU), permission to conduct the study

was obtained from the Director of the AKUH and the Dean of the Aga Khan University School of Nursing (AKUSON). A meeting was arranged with the head of the psychiatric department and the psychiatric clinicians (psychiatrists and psychologists) of the AKUH to explain the study and to ask for their cooperation in identifying potential participants for the study. Next, the head nurse of the outpatient department, charge nurse and other nurses working in the psychiatric outpatient clinics of AKUH were educated about the study and were asked for their cooperation to facilitate potential participants' contact with the investigator and identify a room for conducting interviews.

Two approaches were used to recruit participants. First, a flyer in English and Urdu describing the study was posted in the outpatient psychiatric clinic of AKUH to recruit self-referred participants (see Appendix C). Also posted were copies of a handout with a checklist of inclusion and exclusion criteria (see Appendix D, p.1) and a written proof of interest in participating in the study (see Appendix D, p. 2).

Second, all the participants were referred directly by psychiatrists to recruit potential participants. On outpatient psychiatric clinic days at AKUH, the psychiatrists were given a two page handout that had both a checklist of inclusion and exclusion criteria (see Appendix D, p.1) and a written proof of interest in participating in the study (see Appendix D, p.2). The psychiatrists first approached their patients and briefly introduced the study and assessed their eligibility by using the checklist of inclusion and exclusion criteria. They verbally provided information to potential participants who were eligible to participate in the study and personally introduced them to the investigator. All the study participants were referred directly by psychiatric clinicians.

Once referred, the investigator completed the checklist of inclusion or exclusion criteria ensuring they met the criteria and were asked to put a check mark on the written proof of interest section of the handout to demonstrate their permission to participate in the study. For those who met the inclusion and exclusion criteria and were willing to participate, an interview date, time and venue (interview room in the outpatient psychiatric clinic at AKUH) were arranged. They had a choice of interview dates for any week day or at their next outpatient clinic appointment date. Special attention was given to those who preferred to be interviewed in the clinic on the day they had an appointment with their psychiatric clinicians so that the interview time did not clash with their appointment time. Moreover, enough time (1-1 1/2 hours) was given for each interview so that the investigator and the participant did not feel rushed to complete the interview. For those who wanted to be interviewed soon after their first meeting with the investigator, the same study procedures and human subject protection protocols were used; they are explained below. On any given day no more than two subjects were interviewed.

On the day of the interview, the investigator explained the study purpose and the study procedure again. In the briefing about the study procedure, they were specifically informed that the interviews would be audio taped. In addition, they were informed that the investigator would also take some notes during the interview. They were asked to sign the consent form to participate in the study. Although all of them received a written consent form, most did not feel comfortable signing their name on the consent form. In such situations when they said that they wanted to participate in the study, their verbal acceptance was documented by the investigator on the consent form and this was considered their consent.

The interview was conducted using the interview guide. During the interview, participants were given the choice to speak in Urdu or English or both which they did. They

were offered the choice of a break at any time if they felt fatigued; however, no one took a break for that purpose. Following the completion of each interview, their contributions to the study were acknowledged. Since this study had a time commitment, participants were paid 300 Pakistani Rupees, approximately US $5.0 (US $1 = 58 Pakistani Rupees, in the year 2006-2007), only at the end of the first interview for their involvement and contribution to the study.

Study participants were requested to acknowledge the receipt of money by signing a proof of payment form and/or making a check mark on a proof of payment form (see Appendix E) which was immediately co-signed and dated by the investigator. Depending on how much was accomplished in the first interview, participants were asked to participate in 2nd and 3rd follow-up interviews. Those study participants with whom follow-up interview(s) were conducted were verbally thanked for their time both at the beginning and end of the interview(s). There was no monetary compensation for study participants who participated in the follow-up interviews. In other words, every study participant got a maximum of 300 Pakistani Rupees (approximately US $5.0) for their participation in the study. Data collection took five months to complete in November, December of 2006 and January, February and March of 2007.

Human Subject Protection

Besides obtaining the approval of both the IRB review boards at the University of Michigan and the Ethical Review Committee of the AKU, participants were informed through both written and verbal descriptions about what they could expect as participants. First, they were told that their participation in the study was voluntary and that they had a right to refuse or withdraw from the study at any time in the data collection process. They could ask any questions they might have about the study or procedures related to the study. Second, they were told that

the study might not be of any specific direct benefit to them; but that it would create a chance for them to reflect on how they managed their depression. In addition, they had a choice to ask for a one-page summary of the research findings either in Urdu or English which the investigator would provide after the completion of writing up the research findings. For this the participants had to provide their complete home or work mailing address. However, none of them provided the given data to mail a summary of the results. In addition, for some, the 300 Rupees might cover part of their cost of a psychiatric outpatient clinic visit or travel cost. They were informed that the study would generate important information to help health care providers in Pakistan to better understand what the depression experience was like for some Pakistani women. Moreover, knowledge generated on the strategies might help health care providers incorporate them in their care for other Pakistani women with depression, and might help some Pakistani women self-manage their depression. This would assist Pakistani women with depression to improve their day to day functioning, minimize the effects of depression in their lives, and reduce the risks of future episodes of depression.

Third, study participants were informed that there were no identified risks or harm for participating in this study; however, the discussion of their experiences of depression and its management might result in some emotional response. The investigator was an experienced psychiatric nurse who had worked with women with depression, and would make clinical judgments about whether or not it would be appropriate to continue the interview.

Fourth, they were told how their confidentiality would be maintained throughout the data collection and reporting. The investigator would not inform any psychiatric clinician about whether their patients opted or opted out from participating in the study. The investigator would place a code number and not their names on the information sheets. Similarly, before starting the

interview, they would be given a choice of whether they would like the investigator to use an alias or their real names during the interview; however, no one chose to use an alias. In addition, the notes taken during the interview would also be given the same code number as the information sheet. In addition, the interview data would be coded so that data were not linked to their names. All study data would be collected by the investigator and would be stored in a secure place (i.e., locked cabinet in the investigator's home). Only the investigator would have access to the locked cabinet. Data would be shared only with the translator(s) for translating the interviews into English and with the faculty on the investigator's dissertation committee. The translator(s) would sign a form of confidentiality (see Appendix F) prior to translating the interviews into English. Both audio taped and written data would be destroyed at study completion.

However, they were informed that confidentiality would not be maintained if they were at risk of harming themselves or others. If they exhibited behavior that indicated suicidal ideation or increased suicidal ideation, or suicide planning, the investigator who had experience in psychiatric nursing care would conduct a suicide assessment with the participant. If there was: (a) increased frequency, duration or severity of suicidal ideation with no plan or imminent intent, the participant would be asked to contact her psychiatric clinician before leaving for home; (b) indication of suicidal planning, intent, and substance use, the investigator would, with the participant, contact her psychiatric clinician, family member, or friend; and (c) an imminent suicide intent, the investigator would ensure that the psychiatric clinician at the psychiatric outpatient clinic of the AKUH was informed immediately for a complete psychiatric evaluation, including suicide intent. The participant would bear the cost of the psychiatric evaluation.

However, throughout the data collection period none of the participants needed a psychiatric evaluation related to suicide intent.

Fifth, the role of researcher versus clinician was clarified. For example, as a researcher, the investigator was interested in understanding their perspectives of what they did to manage their depression. Information provided would not be recorded in their medical files; hence, it would not be used for treatment purposes. As a researcher, the investigator was not responsible for changing or modifying any treatment plans such as prescribing medications or changing the dose of current medications if any.

Finally, they were asked if they had any questions about the study or procedures related to the study. Data were only collected once and written or verbal consent including making a check mark on the consent form was obtained (see Appendix G).

Minority/Gender/Children

The focus of the study was to understand Pakistani women's perspectives on the strategies they used for recurrent depression; it required the inclusion of women, and, therefore, it excluded men. After learning more about strategies women use to self-manage their recurrent depression, research could later be extended to study strategies men use to self-manage their recurrent depression. The reason children were not included in the study was that this study focused on strategies that were used in recurrent depression. In order to qualify as having recurrent depression, an individual had to have two or more episodes of major depression; this made it difficult for children to qualify. In addition, the depth and the complexity of data the investigator was interested in obtaining were not likely to be provided by children. The aim of the qualitative research was to achieve analytic generalizability which could only be achieved if

participants were experts about the phenomenon under investigation. So any Pakistani woman who belonged to any ethnic group and who met the inclusion criteria was able to participate in the study.

Data Analysis

The investigator listened to the audio taped interviews soon after each interview. Since the interviews were mostly conducted in Urdu, the investigator transcribed all the interviews (n=27). One of the transcribed interviews was then given to an expert in both Urdu and English to translate into English. The rest of the interviews including the one given to the expert to translate were translated into English and three of the interviews were randomly selected which were back translated by the investigator. The investigator checked the translated version of the interview to identify any discrepancies between the Urdu and English versions of the interview and between the translation done by the expert and by the investigator.

Once all the interviews were translated, the study data were then analyzed using content analysis (Bernard, 1988). The goal was to understand and describe Pakistani women's experience of depression, factors influencing strategies, and self-management strategies of their recurrent depression. The text used for content analysis was the transcribed audio taped interviews.

Wilson (1989) established three basic elements of content analysis: (1) deciding on the unit of analysis, (2) borrowing or developing the set of categories, and (3) developing the rationale and illustrations to guide coding of data into categories. Deciding on the unit of analysis means that a decision needs to be made about whether the whole response or a breakdown of responses into separate words, phrases, or sentences will be used (Wilson, 1989).

In this study the unit of analysis was sentences derived by breaking down the responses to the interview questions.

Borrowing the set of categories means that a set of categories can be developed before data collection; if the concepts are borrowed from existing theory, then data can be coded using the pre-identified categories. Developing the set of categories means that a set of categories are developed based on themes emerging from the data (Wilson, 1989). In this study, the set of categories for the content analysis were both borrowed (see Appendix H) and developed directly from the themes appearing in the responses to the open-ended interview questions. It is important to clarify that the research questions guided the development of categories and sub-categories, and the interview questions yielded the developing categories. For example, the interview question was "What makes you use (name of the particular strategy) it?" The label for this question is “influencing factors”. Sub-categories which emerged were personal factors, provider factors, social factors and so forth. Developing the rationale and illustrations to guide coding the data into categories means that in order to code data into categories, the investigator has to “make a judgment on the right category for every response or unit of analysis” (Wilson, 1989, p. 470). The rationale to guide coding the data into specific categories was based on understanding: (a) Pakistani women’s experience of recurrent depression (b) factors which influence self-management strategies, and (c) self-management strategies. Once all the text data were organized into categories and sub-categories, a descriptive summary for each category was written. ATLAS.ti, a qualitative data analysis and research software, was used to organize, manage, and qualitatively and thematically code and analyze a large body of textual data such as the transcribed interview data in this study.

Content analysis is a rigorous procedure; yet measures are needed to ensure its validity and reliability. In quantitative research, validity refers to what is being measured and how well it is measured (Mishel, 1998). In qualitative research, in contrast, validity refers to "gaining knowledge and understanding of the true nature, essence, meanings, attributes, and characteristics of a particular phenomenon under study. Measurement is not the goal; rather, knowing and understanding the phenomenon is the goal." (Leininger, 1985, p. 68). In other words, validity in qualitative research refers to whether the investigator understands what she was trying to get or what she thought she was getting. In qualitative research there are several ways to prevent threats to validity such as searching for discrepant evidence and negative cases, triangulation, feedback, member checks and rich data (Maxwell, 1998). In this study, the validity of the findings was derived from the data collection process including collection of rich data and from feedback from an expert to increase the credibility of the findings. "Soliciting feedback from others is an extremely useful strategy for identifying validity threats, your own biases and assumptions, and flaws in your logic or methods…." (Maxwell, 1998, p. 26). Hence, in this study, feedback was solicited and discussions of the findings were done throughout the analysis process with an expert in self-management strategies, investigator's dissertation chair and committee, and faculty at the School of Nursing, University of Michigan.

In quantitative research, reliability refers to repeatedly obtaining the same results (Mishel, 1998). In qualitative research, reliability "focuses on identifying and documenting recurrent, accurate, and consistent (homogeneous) or inconsistent (heterogeneous) features, as patterns, themes, values, world views, experiences, and other phenomenon confirmed in similar or different context" (Leininger, 1985, p. 69). In this study, two PhD prepared independent reviewers with a nursing and education background respectively reviewed the same one

interview and coded it using the given code list which were later compared with the investigator's coding. In addition, the investigator paid special attention to the reliability of the coding process such as ensuring that the emergent categories were mutually exclusive and that the categories were separate and independent.

Besides mutual exclusiveness, the investigator ensured that other necessary criteria of the emergent categories were met such as homogeneity, inclusiveness, usefulness, clarity and specificity (Wilson, 1989). Homogeneity means that the identified categories are a variation of the same phenomenon under study and have the same level of abstraction. For example, the category "self-management strategies" which addresses the research question "what types of strategies do Pakistani women use to self-manage their recurrent depression" had all the sub-categories as a variation of types of strategies and were expressed at the same level of abstraction. Analysis of the data revealed nine specific groups of strategies which had the same level of abstraction.

Inclusiveness means that the identified categories had every possible aspect of the phenomenon under study, and that there were no categories such as mixed or miscellaneous. Usefulness means that each category served a purpose and that it related to a specific research question. Clarity and specificity means that the identified categories were stated in clear, direct and understandable terms (Wilson, 1989). The investigator made every effort throughout the data analysis process to ensure inclusiveness, usefulness, and clarity and specificity related criteria. Finally, the credibility of the findings was established from systematic data analysis steps.

Summary

This descriptive study used content analysis to describe Pakistani women's experience of depression, factors influencing strategies, and self-management strategies of their recurrent depression. Using purposeful sampling, a sample of 10 Pakistani women was recruited from the outpatient psychiatric clinics of AKUH who met the specified inclusion and exclusion criteria. Data were collected through semi-structured interviews using an interview guide. The study procedure and human subjects protection protocol was described in detail. Finally, a plan for data analysis was presented with exemplars where appropriate.

Chapter IV

Results

Sample Description

The sample consisted of ten Pakistani Muslim women who had experienced at least two episodes of depression and considered themselves to be recovering. The women did not have a clear idea about when they had their first experience of depression. Initially, when they experienced symptoms, they did not consider them to be symptoms of depression. Rather they focused on dealing with the physical manifestations of depression and the current stressors in their lives. They learnt over time that they were suffering from depression; consequently, no age of onset related data could be reported.

At the time of the interviews, they were living in Karachi, Pakistan and seeking treatment for depression from the psychiatric outpatient clinic at the Aga Khan University Hospital, a private tertiary care hospital in Karachi. They were between 30 and 55 years old, with a mean age of 40.4. Nine were married and one was single. Of those married, two had four children, four had two children, one had one child, and two did not have any children. Six were living in an extended family either with their own parents or with in-laws. Two had a graduate education, four had an undergraduate education, three had a middle to high school education, and one had no formal education. Three were from the upper middle socioeconomic class, four were from the lower middle socioeconomic class, and three were from the lower socioeconomic class. Women were from varied ethnic groups. Half were Urdu speaking; three were Punjabi; one was

Gujrati; and one was Memon. Only two were employed. One was self-employed at home, and the other had an office job. Only two had been admitted once to a hospital specifically for treating depression. The rest sought treatment from outpatient psychiatric clinics.

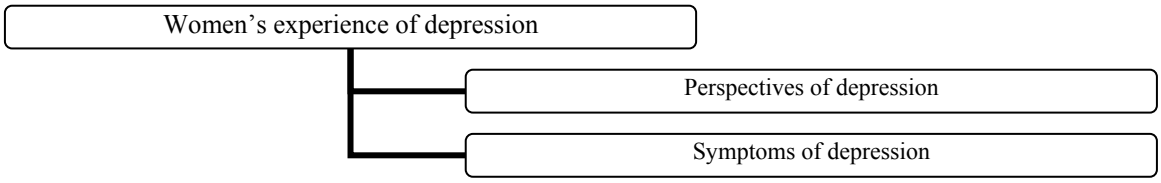
Findings

The findings of the study were organized under three major categories: (1) women's experience of depression, (2) factors influencing strategies, and (3) self-management strategies. Findings related to these categories were extracted from a total of 27 interviews with the 10 women and are described in this section.

Women's experience of depression.

The findings related to the experience of depression are grouped under two sub-categories. The first is perspectives of depression. The second sub-category is symptoms of depression (see Figure 2).

Figure 2: Women's Experience of Depression



Perspectives of depression.

All women shared varied perspectives about depression which were organized under the following four themes; (a) contributors to depression, (b) depression as an insidious and hidden illness, (c) depression impacted self and beyond, and (d) experience of depression created positive insights.

Contributors to depression.

Women shared that being a housewife (n=5), living in an extended family (n=3), marrying early (n=2) and early motherhood (n=2) contributed to their depression. Women shared negative views that being a housewife contributed to depression. For example, one stated, "…being a housewife definitely makes you mad." Similarly, being a housewife was viewed as an unpaid and thankless job; it bound them to home where they felt lonely and unhappy and were overpowered by negative thoughts. Hence, they recommended that a housewife should have a part or full time job which would create an opportunity to be with other people, feel happy and productive, and allow them to be out of the home for a good part of the day which might help prevent depression. However, they lacked knowledge that employed women could experience depression as well.

Living in an extended family was viewed as contributing to and worsening depression. For example one stated that it contributed "quite a lot" when living with abusive, disrespectful, suspicious, hypercritical, and uncaring husbands. Similarly, abusive mothers-in-law intruding in their personal matters created situations that resulted in abuse from their husbands. Living with parents who denied the presence of mental illness and did not allow or support their treatment for depression worsened and prolonged their suffering. However, women who lived with their siblings and siblings' extended family viewed them to be supportive in suggesting, implementing and following through on using self-management strategies.

Women viewed that early motherhood contributed to depression. For example one stated, "Yes quite a lot, thinking, meaning ability to think and understand, is lost because at 19, 20 years old having a child then having a second one, then the home situation was such that

taking care of both kids was very difficult for me… when they used to cry then nobody was there to help."

Depression as an insidious and hidden illness.

Women viewed depression as insidious and hidden in its course and representation. Depression was compared with other physical illnesses such as a cold, or cancer that people could see and sympathize with. In contrast, depression presented itself in a way which others might interpret as faking an illness. According to one, "In my view, it is a very bad illness; it is a very bad illness. This is an illness which a person can't see, and a person cannot tell anybody what my problem is." Similarly, another shared that "…if there is fever or God forbid there is cold so everyone can see it but this illness is such which I am feeling it but no one can see it. How can somebody think that I have this problem, someone may think I am doing an acting/faking it. That is why this illness is very serious/dangerous illness."

Depression impacted self and beyond.

All women shared that depression was a state of mind that affected all aspects of life. When one was overpowered by stressors, depression resulted in losing one's usual self, it changed one's lifestyle, and impacted one's ability to perform daily tasks which hampered meeting their roles, responsibilities and personal goals. Depression hit them suddenly when they were faced with stressors such as abuse, extreme and continuous financial issues, and loss of loved ones.

Experience of depression created positive insights.

Although the theme that depression created positive insights was infrequent, it created a unique and valuable understanding about the positive insights women experienced once they recovered from depression. For example, one viewed depression as a precious gift from God; she stated, "And I do feel like it is very God sent, and God's very precious gift." She realized that everyone had some problems, even those who were fortunate and well off could experience depression. In addition, her experience of depression provided her insight into what other people with depression experienced. Similarly, she became more mature in her thinking and analyzing which helped her be a better person by becoming empathetic toward those who were struggling with the illness. She also refuted there was a stigma attached to being mentally ill. For another, depression renewed her faith in God and Islam. She began performing rites and rituals including prayers, reciting the holy Qur'an, and viewing religious programs. She stated that her illness taught her to seek help from a doctor and use medication.

Symptoms of depression.

All women shared a variety of symptoms which were grouped under the following three themes: (a) physical symptoms, (b) emotional symptoms, and (c) cognitive symptoms. They experienced these symptoms over time which varied from episode to episode depending on the severity of the episode and the nature of their stressors or life's circumstances at a given point in time.

The nature of women's symptoms (physical, emotional or cognitive) and their understanding of them motivated their use of strategies. For example, one woman after the tragic loss of a loved one primarily experienced physical symptoms and spent three years seeking

treatment from a variety of health care providers before seeking help from mental health care providers. Women also shared that although symptoms motivated their using a desired strategy it was not always feasible for them to implement it at a given point in time. For example, two women shared that since their depression manifested physically, they were not physically fit to use strategies which were supposed to help them manage depression, "...like I go for a walk, I do it; if I have problem then I cannot even walk."

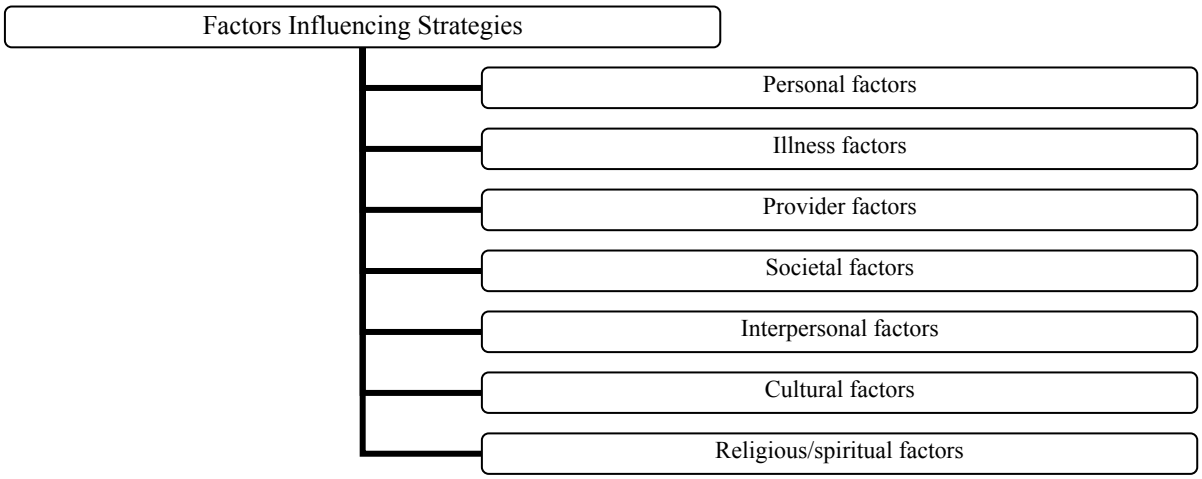
Findings related to the three themes indicated that compared to emotional and cognitive, physical symptoms were more commonly reported. The most common physical symptoms included functional disability (n=10); fatigue (n=7); loss of appetite (n=6) and diminished sleep (n=6). Least common symptoms included, headache (n=3); body aches (n=2), increased appetite (n=2) and increased sleep (n=1).

The most common emotional symptoms included anger at self and others (n=10); loss of interest (n=7); social disconnection (n=5); and loneliness (n=4). The least common symptoms included sadness (n=3); anxiety or restlessness (n=3); and stress reactions such as frustration, agitation, and mental tension (n=2). Cognitive symptoms were the least commonly reported; they included sense of insecurity (n=1), self-blaming (n=1), and feeling of worthlessness (n=1).

Factors influencing strategies.

The factors influencing strategies, the second category, consists of seven sub-categories: (1) personal, (2) illness, (3) provider, (4) societal, (5) interpersonal, (6) cultural, and (7) religious/spiritual (see Figure 3).

Figure 3: Factors Influencing Strategies



Personal factors.

Personal factors was grouped into two themes**,** demographic characteristics which included (a) gender (n=8), (b) socioeconomic status (n=10), (c) education (n=7), and (d) age (n=3); and personal goals (n=10). All were found to influence strategy selection or use.

Gender.

The majority of women thought that men's and women's use of strategies should not be viewed differently. For example, both genders could seek treatment, make sound treatment decisions, and go out for a walk. However, women viewed that being female was a privilege because they could stay home and not be expected to go out of the home to work. Staying at home allowed them to rest, sleep and watch TV.

Socioeconomic status.

Women were able to use desired and expensive strategies when they or their families were financially stable (n=7). For example, they could afford to go shopping for

themselves, stay in a hotel, or have a TV and enjoy it whenever they wanted. They could seek treatment from a good, expensive doctor and afford expensive treatments and medications. For example, according to one, “Finances influence in a way that if I want myself to be seen by a good doctor they are so expensive, consultation plus medication. If I am able or my family is able to support me or if I can afford the expenses….”

In contrast, women (n=3) who were financially unstable struggled to use the strategies they desired. For example, their lower socioeconomic status particularly influenced their seeking formal mental health treatment and getting expensive medications. After an initial consultation with a psychiatrist they missed or delayed going for follow-up appointments because they could not afford the treatments. In addition, they did not continue using the medication as prescribed, and either stopped using them without consultation or decreased the amount prescribed.

Education.

Women shared that education helped them develop self-awareness, independence and self-confidence, and an appreciation for the need for treatment. As one described, "...education helps because the more you are aware of yourself then you more effectively you are going to deal with it you know." In addition, it helped them change their attitude such as stigma associated with depression and its treatment. Being educated made it possible for them to read about and understand depression which helped them manage it.

Age.

Women viewed that age influenced their selection or use of strategies both physically and cognitively. For example, one described, “yes, aging affects everything.” They thought that the young could choose to fight the illness with strenuous physical activities such as

workouts, running, and walking. However, they did not think that they would be able to engage in strenuous physical activities because they might get tired more easily due to loss of stamina. Therefore with age, they considered modifying the effort and duration of their strategies,"...now I cannot workout as much as I did than you see, now I can probably run 4 miles, probably I used to run much more than that. I run for one hour and now for 20 minutes." Similarly they shared that if they were young they would be better able to think about what strategies to use.

Personal goals.

All women shared a strong conviction that their personal goals influenced the strategies they used to either manage and/or prevent depression. They reported some specific personal goals that motivated them to perform strategies. These goals were organized as a desire for a normal and contented life and a desire to regain and sustain a functional self.

Women had a desire for a normal and contented life in which they could be happy, peaceful, healthy, and could enjoy life as women. For example, one described the desire for a normal life by stating "Nothing would give me more happiness that I come out of it (depression)." "I do all the things/strategies so that I get happiness, I get peace." Similarly, another shared the influence that her personal goal had on her use of strategies by stating, "Whatever I do, I do for health… and to remain peaceful I do everything."

Women also had a desire to regain and sustain a functional self. To accomplish this, they continued seeking help from professional mental health care providers and followed up on treatment plans such as keeping their follow-up appointments. They wanted to meet their roles and responsibilities associated with the family so that the family was not affected. They wanted to get up early and do all the housework, take care of their children, be available for their

children, and prevent future episodes of depression.

Illness factors.

The sub-category of illness factors consists of two themes, (a) illness history, and (b) illness identity which influenced women's selection and use of strategies. Illness history included (a) impaired functional ability (n=10) and (b) number of previous episodes of depression (n=7). Illness identity included: (a) knowledge of, understanding of, and attitude towards depression (n=9), and (b) knowledge of medication (n=4).

Impaired functional ability.

All women agreed that impaired functional ability had a strong influence on their selection of strategies, their personal goals, interests, self-care, and fulfillment of job and religious obligations. For example, one described the extent of the impact of impaired functional ability by saying "it influences 100%". Similarly, another shared, "it influences almost everything. Obviously when the problem is beyond tolerance so I am not able to do any work, neither I am able to read, I am not able to help anybody, nothing…."

Number of previous episodes of depression.

Women shared that the number of previous episodes increased their understanding of depression and the circumstances involved in its relapse. It contributed to using a larger repertoire of strategies. Over time, new strategies were added and old ones, perceived to be effective, were also kept. For example, one woman shared that she did not recognize she was depressed for the first three episodes. She learned what depression was from the fourth episode. Likewise, women initially had no idea what illness they were suffering from

and did not use many strategies such as seeking professional mental health care services. For example, one shared this, "Over time I learnt that I should go to the doctor or have to do these things."

Knowledge of, understanding of, and attitude towards depression.

Women reported that their knowledge and understanding of depression assisted them in their use of strategies. For example, according to one:

> Meaning that now I know what kind of illness depression is, and what strategies help me, so when a person starts thinking this thing the problems go away, now that I have realized that depression has so much overpowered me, so it is a bad illness if I continue this, and let it overpower me so it will keep increasing and if I try, If I try to do something, try to get rid of it….

Women shared that when they lacked understanding they relied solely on the actual experience of depression and nothing more. One thing that contributed to lack of understanding was that the cluster of symptoms they experienced did not match their initial understanding of depression. For example, when they understood that depression was a feeling of hopelessness or loneliness, but did not experience them, they denied the existence of depression. For example, one described her lack of understanding of depression:

> In the past I didn't even understand what depression is.... I didn't know what has happened, why there is so much weakness. That's what I keep thinking. That was my thinking. I couldn't understand anything…. Yes now I understand this much that it's a tension, worry, thoughts come, thoughts. That's what I understand, earlier I didn't know that I worry due to which I get more sick.

Women, however, learnt and understood over time that depression was a recurrent yet manageable illness that required early diagnosis and treatment. One woman described the recurrent nature of depression, "It is imprinted in the mind it is an illness that once it is in you it doesn't leave." Understanding depression as a manageable illness needing early diagnosis and treatment was described as, "The understanding regarding depression is that it is a treatable illness and if you get it (treated) in the beginning that is better. There could be a great difference if you realize it in the beginning...."

Women also shared a variety of attitudes towards depression. First, the terms depression and mental illness were associated with crazy/mad. For example, one shared that because there was a stigma attached to depression she did not tell her husband prior to or even after marriage that she suffered from it. Her mother financially supported her treatment from professional mental health care providers and for medications. The second was that depression was an illness that occurred on its own, that never went away or could recur anytime. It, therefore, needed a fighting spirit to manage it by continuing to use strategies such as seeking treatment on an ongoing basis, taking medication regularly, and continuing life's daily routine. The third was that depression was from God. Contrary to the attitude that depression could recur, one woman shared that depression was an illness given by God so he would take it back, or that it was one's fate. Finally, depression was the worst of all illnesses, "... that people with cancer probably could be treated and can be seen as cured but this is something nobody can see it, nobody can understand it, unless you experience it yourself you don't even know its whereabouts." Similarly another shared:

> My attitude toward depression is that it's a very painful thing, and depression is what you call is a giant puzzle/twisty road, once you entered you have to make all the effort to get

> yourself out of it, you got successful then you are out of it but if it sucked you in then you keep spiraling down just like you are going in a ditch …. So you should make every effort to not go into it. But if you have gone into it then there should move your hand and legs (make effort) because if you leave (not make effort) which I have done it, it is a total flop.

Women with such attitudes were strongly convinced that to avoid recurrence they must make every effort to continue using strategies to deal with their depression regardless of whether they were depressed or not.

Knowledge of medication.

Women reported limited knowledge about antidepressants such as taking medications regularly, managing the side effects and adhering to prescribed use during acute depression and when not in depression. Limited knowledge of medications and their side effects worsened their health condition as women discontinued their use for a long time.

Provider factors.

The sub-category of provider factors consisted of a theme of professional providers performing limited versus comprehensive roles. Providers, psychiatrists (n=10), psychologists (n=3), and general practitioners, or specialists (n=7), played a role in the selection and implementation of strategies.

Professional providers performing limited versus comprehensive roles.

Women shared their perceptions regarding the variety of professional health care providers they sought help from in terms of whether or not the roles they performed were limited

or comprehensive in addressing their needs.

Women's perceptions regarding the roles psychiatrists played depended on their experiences of help from them. Seven shared that their psychiatrists strongly influenced their selection, use, and continuation of self-management strategies. In contrast, three women described that their psychiatrists played a very limited role. They expected that their psychiatrists would do more for them than simply prescribe medication, reinforce its use, and make medication adjustments. "I told you that the way he is fulfilling his responsibilities is that he prescribed medications, he should also be giving suggestions, advice, he should at least give suggestion that this is what you should do, that thing is not there/missing." In short, these women were not satisfied with their psychiatrists' roles and responsibilities. They did not think that their psychiatrists influenced their use of strategies other than their continued use of prescribed medications.

Perceptions regarding the roles psychologists played were similar to those of psychiatrists. Of three women, two were not satisfied with the help their psychologists offered. They shared that some of the recommended strategies they tried were not effective because they did not match their preferences, interests, and understanding of depression and its management. However, the third one thought that her therapy sessions with the psychologist influenced her quiet a lot and she continued seeking treatment. She described her experience, "Meaning the way they did it, exercise which I had left, or something not feeling interested in it, so they directed to it that goal, try it, try it, explained it very nicely, so once I leave after talking to them it made quite an impact."

Women's perceptions of the roles of general practitioners or specialists were similar to those of psychiatrists and psychologists, although with some nuances. Seven women approached

a general practitioner to seek relief from symptoms when they did not recognize their symptoms to be depression. However, once they learned that they were suffering from depression they did not go to a general practitioner to treat it.

Of seven women, four reported that a general practitioner played a variety of roles which assisted them to use self-management strategies such as identifying depression, prescribing antidepressants or antianxiety medications, and encouraging them to see a psychiatrist. On the other hand, three women reported that they were dissatisfied with their general practitioner or specialist due to their overemphasis on managing the symptoms with medications. They reported that these providers treated depression as though it were a physical health condition and overdosed them with intravenous fluids, injections or medications and made women endure a number of medical tests and hospitalization.

Societal factors.

The sub-category of societal factors comprised of the following two themes: (a) social hurdles affecting seeking treatment and (b) no or limited health insurance.

Social hurdles affecting seeking treatment.

Women shared various social hurdles that affected their seeking formal mental health care services. These were costly treatments (n=4), poverty (n=3), and unavailability of mental health care providers (n=1).

Expensive mental health care treatments were a burden on women to adhere to them. Women had to ask for financial support from others usually from those family members who already knew about depression and its treatment. In addition, women delayed seeking help or discontinued appointments for some time due to poverty. Financial concerns hampered their

ability to continue a treatment plan and limited their purchase and use of medications. A variety of situations in their lives contributed to their financial struggles and minimized the priority of seeking and continuing mental health treatment. For example, one was struggling to pay back a loan incurred for a son to go abroad as well as provide money for a daughter's marriage. While facing such situations, if they continued any treatment they self-regulated medication. On the other hand, one woman who was financially well off only approached a psychiatrist after 21 years of self-managing depression with her father's assistance. He introduced her to antidepressants as he was suffering from depression himself. The delay was due to living where a psychiatrist was not available.

No or limited health insurance.

Having health insurance was primarily viewed as a Western concept and eight women denied having it. Nonetheless they realized its value as it could support women's health seeking and health maintenance behaviors.

Of the two who shared their views about health insurance, only one had health insurance at the time of the interview through her son's job in a hospital. The other woman had health insurance at one time. However, she later cancelled the policy when she learnt that it earned interest which is prohibited in Islam.

Interpersonal factors.

The sub-category of interpersonal factors included three themes: **(**a) family living in the household played supportive versus non supportive roles, (b) family living outside the household played supportive versus non supportive roles, and (c) non-professional persons from outside the family played supportive versus non supportive roles.

Family living in the household played supportive versus non supportive roles.

Husbands (n=3), children (n=4), mothers-in-law (n=2), and father-in-law (n=1) played a supportive role in women's depression management. Some examples of the supportive roles husbands played included demonstrating interest in wives' wellbeing and spending more time with them when they were struggling with depression. They assisted in implementing strategies such as accompanying them on a walk; and encouraging them to continue seeking help from professional mental health care providers and to keep busy caring for self, children, and the family at large. They suggested ways to manage social relationships such as distancing themselves from friends when they were a source of stress. Finally, they verbalized the pivotal role women were playing as wives and mothers in sustaining the family. For example, one shared that she had a negative thought that all the wrong things that occurred in the family were her fault, "then again my husband said no this is wrong. When you will go out or run away everything will be messed up again, because your kids will miss you, we all will miss you so you should not run."

Similar to husbands, children played supportive roles in the use of self-management strategies. For example, they too suggested ways to manage stressors related to social relationships and discouraged their mothers from interacting with friends who were the source of stress. They also accompanied their mothers on walks. They were sensitive to their mothers' needs and would stay quiet so that their mothers could experience a peaceful environment and recuperate from their illness. Finally, they created hope, "…my son is a little bit mature we have told him, he would say, mom you would be alright."

Although both parents-in-law positively influenced use of self-management strategies, mothers-in-law played a more active and multiple roles compared to fathers-in-law living in a

household. For example, both encouraged seeking help from religious/spiritual healers. Mothers-in-law, moreover, encouraged them to care for themselves first by eating a proper diet to combat loss of appetite, followed by caring for their children and the rest of their families. They encouraged seeking help from a psychiatrist and following-up on treatments such as taking medication. For example, one shared that "… mother-in-law is the only one who says that this is the part of the body, and the brain is also a part of the body, as other organs get sick brain can also get sick so it is important to get it treated."

Besides supportive roles, women described the non-supportive roles their husbands (n=3), mothers-in-law (n=2), and sister-in-law (n=1) played in their use of strategies. For example, husbands demonstrated unsupportive and uncaring attitudes towards their wives' struggles with depression. For example, one shared, "And all of my worsening of my health condition, suicide I do because of my husband's attitude, when he doesn't support me meaning he doesn't listen to what I want…." Similarly, a woman shared that both mother-in-law and sister-law purposefully disturbed her rest and sleep to aggravate her health condition.

Family living outside the household played supportive versus non supportive roles.

Mothers (n=4), fathers (n=2), sisters (n=3), brothers (n=3), cousins (n=3), nephew and niece (n=1) played supportive roles that influenced women's selection and implementation of self-management strategies.

Fathers educated women about depression and assisted them to seek help from a psychiatrist and acquire medications when access to good mental health care services was not available. However, mothers played more active and supportive roles by suggesting and assisting in implementing strategies. For example, they suggested seeking help from

religious/spiritual healers, keeping busy, and going out and visiting family. Some fully or partially provided financial support for mental health treatment once they accepted the reality that their daughters like themselves had depression. They also prayed for their daughters' wellbeing.

Similarly, siblings played a pivotal role in supporting, encouraging, and ensuring that the treatment plans and associated strategies were implemented as prescribed. For example, they financially supported mental health treatment and provided opportunities to talk or socialize regardless of whether they were near or abroad. Besides seeking help from mental health care providers, brothers in particular assisted women to seek help from religious/spiritual healers. For example, the importance of a sister's role was described as, "They are the must part of the strategies…."

Like siblings, cousins, nephews and nieces provided opportunities for socialization. They encouraged women to get out of the house and pay visits. Those who had educational backgrounds in psychology guided women to seek help from a professional and engage in self-help activities. For example, one shared that, "My cousin also suggested that I should get admitted to a hospital to understand my feelings." Similarly, another shared that her niece suggested that she get involved in potentially helpful courses such as yoga and/or an art of living course which could lead her to voluntarily helping others through counseling. On the other hand, those who did not have such backgrounds guided women to seek help from religious/spiritual healers. For example one shared, "…she gave the address and the phone number…"

Besides supportive roles, they described the non-supportive roles their parents, siblings and mothers-in-law living outside the home played which made implementing strategies a struggle. Parents disregarded the need to seek treatment for depression, "My father still tells me

that it is useless to go to the doctor." Similarly mothers devalued the act of seeking mental health care treatments, including taking medication and adhering to treatment plans. For example, mothers discouraged women from taking their medications in front of them and communicated negative views that medications worsened health and caused side effects. With regards to siblings, they did not demonstrate a caring attitude and blamed them for being sick. Mothers-in-law who lived outside their households affected their strategies mostly when they came to visit and stayed in the household by creating more work, limiting time for rest and causing a strained relationship between their daughters-in-law and their sons.

Non-professional persons from outside the family played supportive versus non supportive roles.

Several non-professional people besides immediate family members supported women's use of self-management strategies. They were friends (n=7), neighbors (n=2), office colleagues (n=1), a maid (n=1), and a lady who taught Qur'an to kids (n=1). They all extended support in a variety of ways. Friends and office colleagues encouraged them to seek help from spiritual healers, use medication, and get involved in physically strenuous activities. For example, friends accompanied them on walks and provided them an opportunity to socialize. In addition, one family friend who was a physician recognized the psychological problem and extended support throughout the treatment process. Similarly neighbors, like friends, provided opportunities to socialize and accompanied women to the hospital when family members did not allow them to go alone. Finally, neighbors and a lady who taught Qur'an influenced the use of religious/spiritual strategies and guided a woman to recite the Qur'an. In addition to their supportive roles, friends were the only persons outside the home who played non supportive

roles when they fought and created stress. For example, one shared that "friends brought on an episode of depression".

Cultural factors.

The sub-category of cultural factors that influenced women's use of strategies was comprised of three themes: (a) stigma attached to mental illness (n=7), (b) stigma attached to seeking help from medical- (n=4) and non-medical health care providers (n=4), and (c) desire for a female psychiatrist (n=2).

Stigma attached to mental illness.

Personal and family attitudes of stigma attached to mental illness influenced the selection and use of strategies. Women shared that they and their families viewed that there was a stigma attached to mental illness. This attitude forced them to be very selective with whom they disclosed their diagnosis of and struggles with mental illness. Most often they chose to share their diagnosis only with their immediate families. They hid their struggles associated with mental illness as they believed it could be viewed as a personal weakness that could be used against them or to take advantage of them. For example, "....Can't share feelings that my state is becoming this, if you tell someone then everyone makes fun of you…. Husband is so good, the family is well off, so much money, she has a car, has kids, so what problems does she have…she has everything so what is her problem." Importantly, for some, over time, their attitude toward mental illness changed. For example, one shared that after almost three years of seeking treatment her attitude toward depression changed; she did not buy into the stigma anymore, accepted the fact that she was suffering from depression, and openly discussed her struggles with a psychiatrist.

Family members' attitude of stigma associated with mental illness influenced some but not all women's use of self-management strategies. When it influenced them, they did not take their medication in front of family members and sometimes they discontinued its use.

Stigma attached to seeking help from medical- and non-medical health care providers.

Stigma attached to seeking help from health care providers included seeking help from both formal mental health care providers and non-medical health care providers. They reported that one or more of their family members considered there was a stigma attached to seeking formal mental health care services or discouraged them from following a treatment plan such as taking medications. Family members included parents, sisters, husbands, and in-laws. One shared, "… no one knows that I go to the psychiatrist, I have one friend only she knows, if I tell them they would say she goes to a doctor who treats mad/crazy people, she is crazy/mad, what has happened, has depression, why it is, they make fun, so this is a very bad illness, a person cannot tell anyone, can't share." Similarly, another shared that her parents' thought that seeking treatment was "unnecessary/wasteful."

Of the seven who approached non-medical health care providers, i.e., religious/spiritual healers, four believed that there was stigma if the providers were people who were only interested in making money or who duped women out of money. They considered seeking help from such providers if their treatments involved using strategies that were cathartic or educational; or that diverted their attention to religious practices by talking to them, providing an educational lecture, inducing crying, and reciting holy Qur'anic verses. As one described, "So prayers and medication treatment should go hand in hand, both should be done, there are so many verses in God's Quran that if you read them your heart will be in peace.…" The fifth

women thought that if an amulet were given to her at her place of worship then it was acceptable. Of the five women who used religious/spiritual healers, two had opposite views related to integrating psychiatric and religious/spiritual approaches to manage their depression. One supported integrating strategies suggested by a religious/spiritual healer with using medication; whereas, the other did not consider such integration to be part of her treatment plan.

Desire for a female psychiatrist.

A less frequent theme was women's strong desire to have female psychiatrists for their mental health care providers. Although they had female residents doing their primary assessments, they wanted to have female psychiatrists because they believed that they would be more comfortable openly sharing their private struggles or stressors and get better guidance directly from them. According to one, "It is said that do not hide anything from the doctor. And the doctor I have. You are a female, I can't tell him right." Some examples they shared included a husband blaming his wife for having a sexual encounter with their eldest son, lacking interest in a romantic relationship and having an abusive relationship with husband.

Religious/spiritual factors.

The sub-category of religious/spiritual factors comprised of one theme: faith in God, an influence

Faith in God, an influence.

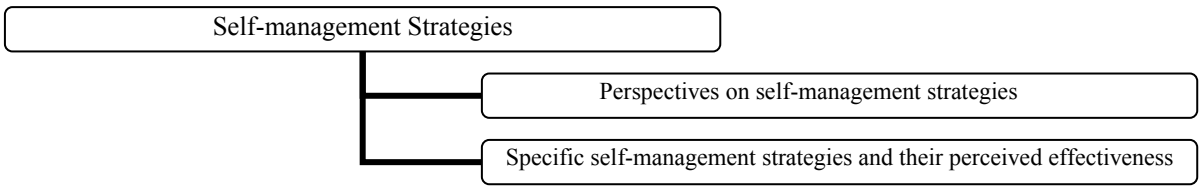
All the women viewed faith in God as the strongest influencing factor. For example, one woman affirmed that she has "too much" faith in God. Faith in God as an influencing factor was primarily based on the view that God had the power to solve all of their

problems, God was the only solution to all the problems in their lives, and God was the source of courage and strength.

Self-management strategies.

The category of self-management strategies was comprised of two sub-categories; perspectives on self-management strategies and specific self-management strategies and their perceived effectiveness (see Figure 4).

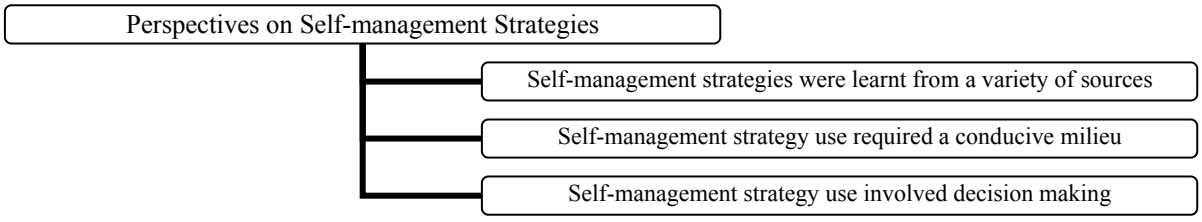
Figure 4: Self-management Strategies



Perspectives on self-management strategies.

All 10 women shared a variety of perspectives related to self-management strategies which were organized under three themes: (a) self-management strategies were learnt from a variety of sources, (b) self-management strategy use required a conducive milieu, and (c) self-management strategy use involved decision making (see Figure 5).

Figure 5: Perspectives on Self-management Strategies



Self-management strategies were learnt from a variety of sources.

Women learned self-management strategies from a variety of sources. They identified some; and family, friends, neighbors; and mental health care professionals identified some.

Women learned some strategies on their own and credited God for it. They learned them to help self, to be self-sufficient, and to meet personal goals. One shared, for example, "…I agree that I have depression, but my struggles and my loneliness have taught me too…. My circumstances have taught me. If in some ways I have to finish myself (suicide) but I have tried to live too." Some strategies were based on the desire to meet personal goals. For example, a desire to lose weight motivated a woman to think about joining a gym to exercise. Hence, personal goals and priorities seemed to dictate which strategies they would use. Some activities started prior to being diagnosed with depression were renewed to manage it. For example, reading a magazine was an activity before depression but after diagnosis one woman read magazines specifically looking for articles on depression. Another example which was started prior to having depression was practicing yoga to keep in shape. After diagnosis, it was practiced to manage and prevent depression as well.

Family, friends, or neighbors suggested some strategies. They played a pivotal role in not only identifying strategies but also in implementing them. For example, two women learnt some strategies while growing up and seeing their mothers struggling with depression. "My mother was experienced, she always used to tell me that dear don't let yourself get in to the phase of depression, if once you are in it then you, like I always give one example, it is a ditch in that you keep going in." Another one learnt about a good psychiatrist from her friend, and

neighbors accompanied her to appointments with a psychiatrist as she was not allowed to go to the hospital alone.

Psychiatrists and psychologists suggested some strategies and supported their implementation. Women usually recalled strategies once they recovered from depression but not always when depressed. Therefore, they suggested that someone, particularly a psychiatrist familiar with their history and medical file, should remind them about the strategies which helped them in an earlier episode(s) to manage and prevent depression because they found it hard to recall what strategies they used and whether or not they had helped. Similarly, psychologists could help them recall strategies that had been effective in the past. For example, one woman was able to continue yoga during severe depression as a result of her psychologist's encouragement and support. "For that I have to push myself quite hard but had to go. But I did go when I have had severe depression, then left for few days then when I went to Dr. ... she said to try to go, so again I went. I went during severe depression as well."

Self-management strategy use required a conducive milieu.

Using self-management strategy use required a conducive milieu. Women described presence of a supportive environment as the pre-requisite needed for them to use strategies to manage and prevent depression.

Women shared that in order to best perform strategies, they needed to have a supportive, non-stressful, and positive environment. One element of a supportive environment was not to have too many, equally competitive goals that were expected to be achieved regardless of whether they were depressed or not. For example, one shared that her husband expected her to lose weight. She was only able to focus and work on this goal when she left her husband's home

and went to her mother's after learning about her husband's involvement in extramarital affairs. When she returned to her husband's home she was criticized, not supported and expected to meet strict daily expectations of running a home and caring for children which caused her to struggle with losing weight.

A stigma-free environment was also conducive for using self-management strategies. But the presence of stigma towards seeking professional mental health care contributed to a milieu that was not supportive or conducive. According to one woman, "…so getting to the right counselor and a right therapy is one of the biggest solutions to this problem on which people of Pakistan don't believe. Even they believe it there is stigma, which is very wrong." Seeking mental health care for depression was viewed as a necessary step, and the belief against it was viewed as problematic.

Self-management strategy use involved decision making.

All 10 women shared a variety of personal views on the decisions they made regarding the strategies they used for depression. These views included: (a) symptom variation from episode to episode, (b) variation in the severity of depression, (c) feasibility of the strategies, (d) continuation of the strategies, and (e) individualized combination of strategies.

With regards to *symptoms variation from episode to episode*, women had to decide what strategy to use to address them. Such variation in symptoms, however, limited their ability to know what specific strategies to use. In addition, even if they knew which strategies to use they struggled to get the support to engage in them. For example, one decided to go for outings but no one allowed her to actualize her decision.

With regards to *variation in the severity of depression*, women's decisions to use strategies depended on it. For example, in severe depression women would use limited strategies even though they wanted to do more. In addition, they wanted to use the most helpful strategies but did not have the capacity to act on them when their depression was severe. Increasing levels of severity forced them to use sedentary strategies such as rest and sleep. They also kept taking prescribed medications. Women adjusted their strategies according to the severity of their depressive episode. For example, if the depression was mild then women used strategies like diverting their mind; whereas, if their depression increased they also took medications to avoid negative thinking. As one stated, "Or if the level is mild and is control by thoughts you do not need medicine. Yes, depends on the stage." Over time, when women experienced improvement, they became more motivated and involved in performing desired strategies so that depression did not overpower them again and impact their functioning.

With regards to *feasibility of the strategies*, decisions regarding the use of a strategy depended on its feasibility at a given point in time. For example, one shared that going out for a walk to keep busy may be a desirable but not feasible strategy to do in the middle of the night. Hence, alternative strategies were selected which were feasible such as watching TV or reciting the Quran. Similarly, another shared that going to a psychiatrist every time depression recurred, which could be frequent, was not feasible. Therefore, more feasible strategies were selected such as religious/spiritual ones e.g., reciting the Quran and/or socializing with others.

With regards to *continuation of the strategies*, women shared that when strategies were part of their daily routine they continued their use over time regardless of whether they were depressed or not. Not doing them on a regular basis was stressful. For example, a woman shared that she had been doing physically strenuous activities for around 20 years and if she did

not do them she would feel anxious. During her depression she struggled to continue them but for a shorter duration and realized that doing them even briefly had a positive impact. In short, during depression, the frequency and/or duration might change due to the struggle with the illness or the demand of the strategy such as how much energy and/or concentration was needed to perform it.

On the other hand, women decided to discontinue strategies once they recovered from depression and that did not complement their life styles, interests, preferences, and daily routine. In situations, where they decided to use them, they used them for only a short while. Women realized that discontinuing strategies was not a good decision yet they discontinued them when they could not keep up with them on a regular, daily basis.

With regards to *an individualized combination of multiple strategies*, each woman used more than one strategy at any given time and used them in their unique ways. Such unique combinations were due to each individual's unique perceptions and understanding about the cause of their depression, symptoms, and strategies learned over time. For example, one felt lonely during her depressive episode and believed that depression was due to the loss of her only child. Although she wanted to have another child she did not want to conceive while she was being treated for depression. Hence, based on her understanding about the cause of her depression and sense of loneliness, she began taking care of her brother-in-law's daughter as if she were her own. The multiple strategies selected could be quite varied. For example, one used physical activities such as yoga or swimming to keep busy, another used rest and sleep and took medication for depression.

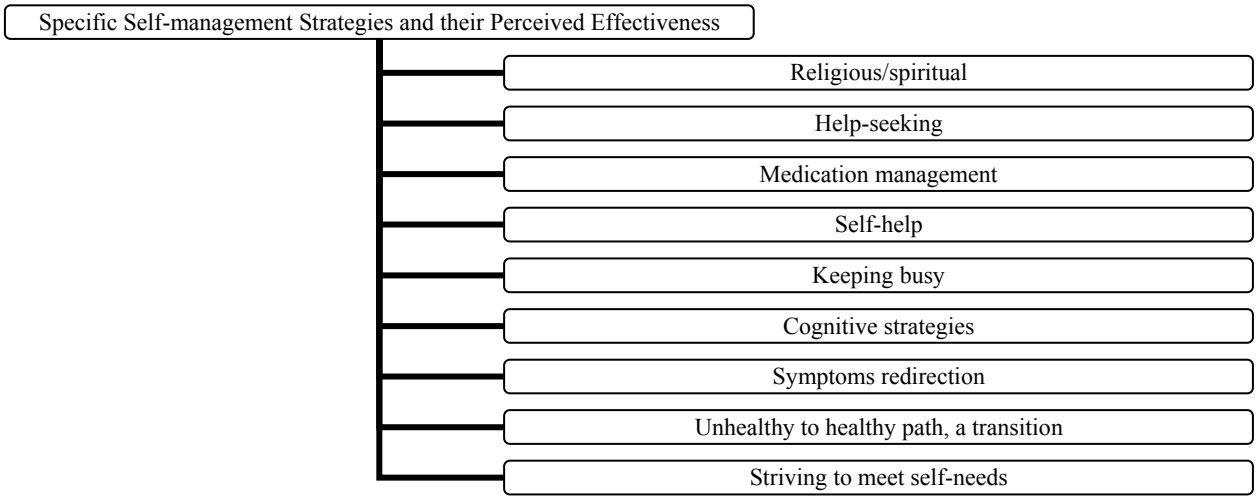
Specific self-management strategies and their perceived effectiveness.

The second sub-category, specific self-management strategies and their perceived effectiveness, is comprised of nine themes: (1) religious/spiritual, (2) help-seeking, (3) medication management, (4) self-help, (5) keeping busy, (6) cognitive strategies, (7) symptoms redirection, (8) unhealthy to healthy path, a transition, and (9) striving to meet self needs (see Figure 6).

Women reported that they used specific strategies to either manage and/or prevent recurrent depression. However, performing or getting involved in these strategies was not without a struggle particularly when they were acutely depressed. They were more able to initiate and continue their use of strategies when they were in their recovery phase of depression or as a way to prevent the recurrence of depression.

Since the frequency of the use of self-management strategies varied quite a lot among the women, extracting common frequency patterns or themes for each of the strategies was difficult.

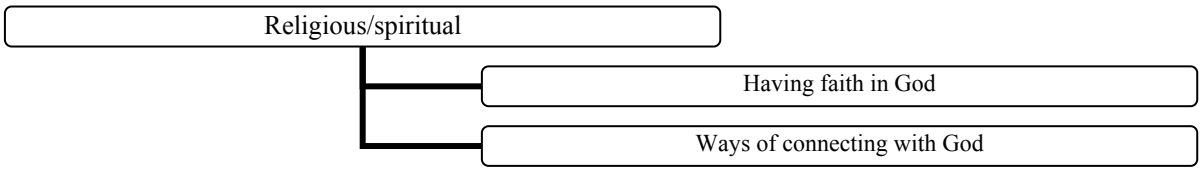
Figure 6: Specific Self-management Strategies and their Perceived Effectiveness



Religious/spiritual.

The religious/spiritual strategies included: having faith in God (n=3), and ways of connecting with God (n=10) (see Figure 7). All 10 women shared their ways on how they incorporated religious/spiritual strategies to either manage and/or prevent depression (see Figure 7).

Figure 7: Religious/Spiritual



With regards to *having faith in God*, women described that either they or their family identified that faith in God was a way to manage and prevent depression. Faith in God was viewed as a source of healing and a source of contentment, ease, help, and hope.

Faith in God as a source of contentment and ease guided them to be happy in God's willingness. For example one stated, "Everything is on him; if he gives then he takes it away. Illness, happiness everything is from him. I just have to try." Having faith in God brought a sense of contentment and ease as they realized that God only gave as much struggle as one could handle and would never give more than one could tolerate. Women noted that it was because of God's blessings that the condition was tolerable. Similarly, women's struggles and the consequences of implementing strategies to relieve depression were considered to be the will of God. Hence, there was a sense of relief from the stress associated with whether strategies would be helpful or not.

Faith in God as a source of help encompassed the idea that God had the power to solve all problems, therefore God was the one who helped and he would be the one who would help in the future as well. Hence, there was quite a lot of reliance on faith in God.

Faith in God created a sense of hope, "I am going to get better." In addition, when depression was viewed as hopelessness, having a sense of hope gave them courage, "God I can do it". Moreover, such a perspective prevented them from getting involved in self-harm activities such as suicide.

With regards to *ways of connecting with God*, women shared a variety of ways they connected with God: (a) performing prayers (n=10), (b) reciting the holy Qur'an (n=7), (c) talking to God (n=4), and (d) performing Pilgrimage (n=3).

Regarding *performing prayers*, all women shared views about performing obligated prayers. It was a way to connect to God; it assisted them to achieve goals such as preventing depression, stopping the need to take medication, and regaining usual functional self. Five key aspects related to prayers were reported: performing prayers is a therapy itself, performing prayers may or may not be continued during depression, performing prayers at certain times was more of a struggle compared to others, more prayers than the obligatory prayers were performed.

The first aspect was that praying was a therapy in itself. The process of praying from the cleaning ritual prior to performing prayers, particularly the posturing in prayers, resembled yoga and was a way of getting some daily exercise.

The second aspect was that praying may or may not be continued during depression. However, once in the recovery phase of depression, the routine of praying regularly was resumed. Many struggled to pray regularly during an acute phase of depression due to a lack of interest and ability to fully concentrate, physical discomfort, immobility, and fatigue. For

example, according to one, “Sometimes during depression I don’t feel like saying prayers at all. Okay if not today I will say it tomorrow. I feel scared as that there is such a sin of even missing one prayer.”

The third aspect was that for some women praying at certain times was more of a struggle compared to others. Performing morning and evening prayers was a struggle. For example, one clearly communicated her struggle to perform morning prayers:

> Performing early morning prayers was a struggle due to sleepless nights and the effects of medication which kept them sleeping in the morning. I would be so tired in the night 1:30 or 2:00am, I couldn’t read a book, like I said, at that time I would take this medicine and I think eight, nine o’clock in the morning I would like, you know, get up. But you know again during that time I would say that I don’t want to miss my early morning prayer. If I used to get up for my prayers I wouldn’t fall asleep after that because my mind used to be so active, and everything bad used to come to me, that was like a devil’s workshop you know and then for few days, like my husband said I should not get up for my prayer, get my sleep in a stretch you know and though I feel very guilty at that time but I had to do it because I was really not well.

Like morning prayers, performing evening prayers was a struggle because depression became severe in the evening. Performing all five prayers during depression was a struggle. One shared, that she could only pray in the recovery phase but then also, “Sometimes I say five times, sometimes the evening one is left why I should lie to you, I don’t do the evening one with great regularity.”

The fourth aspect was that some performed more prayers than the obligatory prayers as it provided a positive experience. For example, according to one, “Saying my prayers had made a

difference. My concentration has improved than before, before I could hardly concentrate." Examples of additional prayers included performing Nafils (non-obligatory prayers), and Istaikhara (when one intends to do something important one makes special prayers to seek goodness from Allah).

Regarding *reciting the holy Qur'an*, women described that they used the holy Quran in their daily lives by reciting or listening to the holy Qur'an and reciting Qur'anic verses as tasbih (repetitive utterances of Qur'anic verses frequently to glorify God). For some it was easy, for others it wasn't and they varied in their duration of recitation. They made every effort to use the holy Qur'an regardless of whether they were depressed or not. The motivation behind reciting or listening to the holy Qur'an was to remain busy and keep their mind occupied, to be spiritually enlightened, to redefine illness as a positive perspective, to seek help from God to manage life's struggles, to re-experience happiness and peace, and to heal.

The commonly preferred and recited words or Qur'anic verses were Durood Sharif (specific phrases in praise of Prophet Muhammad PBUM), the first and third Kalmas (words which talk about the fundamentals of Islam), Yaseen sharif (reading a Qur'anic chapter for blessings), asthaghfar (verse on forgiveness), and La Hawla Wala Quwata Illah Billah (an invocation, a treasure of paradise). They were recited whenever they were remembered, which usually was after each prayer, before the afternoon nap, and before bedtime.

Regarding *talking to God*, women shared that it was usually done at night and was a way to connect to and tell God what they desired. Women asked for help in the form of Dua (prayers) with the conviction that God would listen to them (prayers) if not immediately then later. Talking to God included topics such as seeking happiness and peace, seeking health and being free from struggles or suffering, punishing those who instigated sufferings, and

complaining to God for causing an illness which they later regretted. It helped them manage specific symptoms of depression such as loneliness, stress, frustration, lack of sleep and/or loss of interest. For example, for loss of interest, one woman shared, "I do do dua (prayers) that I get all my interests back."

Regarding *performing Pilgrimage*, of three women, one performed both Umrah and Hajj, the other two performed Hajj only. Umrah and Hajj are pilgrimages to Mecca. This strategy was not considered to be continued over time on an ongoing basis as Muslims were only expected, if they could afford it, to perform a Hajj at least once in a life time. Umrah on the other hand could be performed more than once if financial and travel related concerns could be addressed.

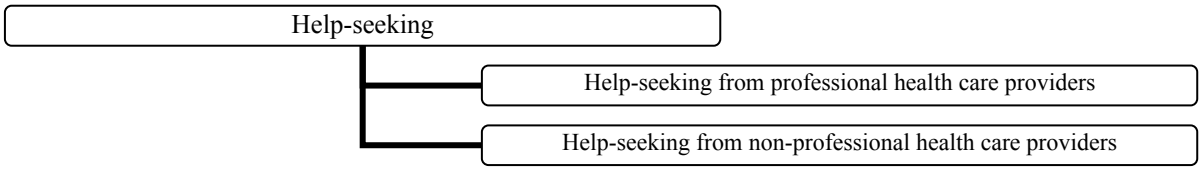
Women perceived that performing a pilgrimage was quite helpful as it was a way to connect to God and empower them to change their attitudes, outlooks, and priorities in life. God was viewed as the center of existence and the only priority in life. For example, one shared that:

> You start to think positively. Meaning is that, you would think positively then God would be by your side. First is God's will…try to learn to be happy in God's willing…your life will change quite a lot. Meaning in everything, if anyone asks me the questions that you have been married for five years and you don't have kids. I say God will give, in the past I used to say, started to fight, now I say God will give, if he gives then thank you God and if he doesn't then God's decision, and willingness, so on the day of judgment I would go to heaven, I would give positive response not like start crying; all of this I did it myself, I rather should say God gave me the guidance.

Help-seeking.

Help-seeking included: help-seeking from professional health care providers and help-seeking from non-professional health care providers. Professional health care providers were non-mental health care providers and mental health care providers. Non-mental health care providers were: general practitioners (n=8), and neurosurgeons (n=2). Mental health care providers were: psychiatrists (n=10), and psychologists (n=3). Help-seeking from non-professional included religious/spiritual healers (n=7) (see Figure 8).

Figure 8: Help-seeking



Help-seeking from professional health care providers included both non-mental health care providers (including general practitioners and neurosurgeons) and mental health care providers. There were two reasons for seeking help from non-mental health care providers. First was to get symptom relief and the second was to seek opinion or guidance. When women did not get relief from their symptoms or were diagnosed with depression by mental health care providers, they stopped seeking help from non-mental health care providers.

Some perceived seeking help from general practitioners to be helpful whereas others did not. When perceived helpful, general practitioners were able to identify depression, helped women manage symptoms through medications, and guided them towards seeking treatment from a psychiatrist. In contrast, general practitioners were perceived not to be helpful when they were unable to diagnose depression, ordered a variety of diagnostic procedures and

hospitalization, and overloaded them with medications. For example, one shared her frustration with general practitioners:

> Now how much medication should I keep taking, at the general practitioner every now and then I am getting I/V drips, every now and then I am getting injections, how long would it go. After every 15 days I am getting I/V drips, after every 15 days, it was temporary, the things which I had wasn't going away, then I thought my treatment is a waste I should do something my way.

Like general practitioners, neurosurgeons were perceived to be helpful when they were able to identify depression and made a referral to a psychiatrist. They were not helpful when they failed to do that and made women go through a series of diagnostic tests and treated them with intravenous medications. For example one expressed her discontentment with a neurosurgeon,

> I went to him; he did my MRI and so forth…. Yes, no problem was diagnosed. Approximately for a month or a month and a half I stayed under his treatment, and then left him as it didn't help in decreasing discomfort in the back and limbs.

Help-seeking from mental health care providers included psychiatrists and psychologists. Women's views about seeking help from psychiatrists are organized as follows: reasons for seeking help and its continuation, reasons for delaying, and reasons for interrupting and discontinuing treatment.

Women shared that they consulted a psychiatrist when they experienced extreme dissatisfaction with a general practitioner's mismanagement of their depression with IV medications and injections. For example, one stated that, "took a lot of medication but did not help. Then finally, since we knew him already, took Dr.'s appointment…" Similarly, another shared that her manifestation of depression did not match what she thought depression was.

They continued seeking help because their psychiatrists were able to diagnose depression, helped them manage their symptoms with minimal medications, and conducted individual and family therapy. For example, one stated that "These therapy sessions were really helpful." In these therapy sessions they learnt about depression, its recurrent nature, and learnt about the need for continuing treatment and the consequences of discontinuing treatment. They learnt to deal with personal problems and developed repertoires of strategies needed to deal with their personal struggles or stressors related to their illness such as getting involved in physically strenuous activities and engaging in religious/spiritual activities, and socializing with others. They were able to vent their feelings in a safe environment rather than sharing with a spouse which usually ended in an argument. They felt appreciated for continuing to use prescribed medications and other efforts made to manage depression. For example, "you will get better, you use medication; take it, you will get better". In addition, women valued seeking help from psychiatrists who helped them feel valued, "...that it is not that I am nothing, I am not this, I am not that, this makes a great difference." Similarly, women felt valued when psychiatrists monitored their progress in meeting their personal goals. They also learnt about family roles, particularly a husband's role, in implementing strategies.

In contrast, psychiatrists were perceived as not helpful when they over-emphasized using medications without explaining their role in treating depression; were not guided on how to live with depression or how to prevent it; and when they suggested strategies that did not match with women's life styles, preferences or possibilities. For example, one shared that, "No he did not explain it to me what the reason is, what the reasons are, how to prevent it, how to live with it, he only kept me on the medication."

Some women simultaneously sought help from psychologists and psychiatrists. Those who went to psychologists also shared a variety of reasons for seeking help and its continuation and discontinuation. Reasons for seeking help and continuation were that psychologists confirmed their psychiatrists' diagnosis of depression, provided therapy including discussion on women's self-selected topics and encouraged them to use previous effective strategies such as physical activities and keeping busy. For example one shared that, "Makes a difference in severe depression, therapy used to make a great difference, the way she used to do the therapy, used to help. Verbalized something whatever is in the heart used to feel that when I let it out, used to help, used to make a difference." In contrast, women discontinued seeking help when their treatment outcome did not meet their expectations. For example, one shared that she felt even more depressed the day after a therapy session and discontinued help after two to three sessions. In addition, suggested strategies were discontinued when they were not effective because they did not match women's preferences and interests.

Help-seeking from non-professional health care providers included religious/ spiritual healers. Primarily most women were personally not too motivated to seek help from religious/spiritual healers; it was usually family, friends, or colleagues who suggested their use. Seeking help from religious/spiritual healers was considered acceptable when they encouraged recitation of the holy Qur'anic verses, offered amulets to wear, provided sermons, heard them, and made them cry to accomplish catharsis.

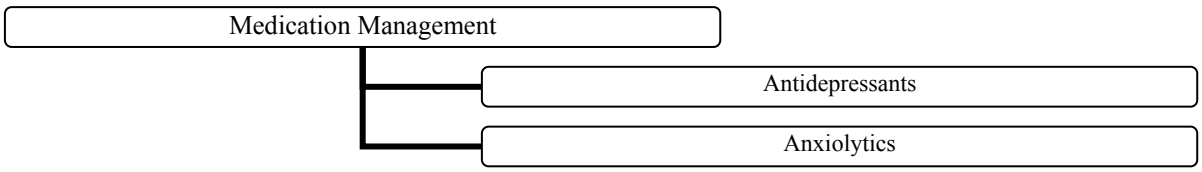
Religious/spiritual healers performed a variety of acts or rituals based on their interpretations of the cause of the women's health condition such as the evil-eye, black-magic or possession. However, women did not perceive the acts or rituals to be acceptable when they included sacrificing an animal such as a bull, burning an amulet for 21 days; or were offered

blessed water to drink. Except for a couple of women who continued seeking help over time, the rest discontinued seeking help from them. One woman stated that, "It was not helping me and it did not help at all."

Medication management.

All 10 women used one or more than one medication such as antidepressants, anxiolytics, analgesics, multivitamins, and Isabgol to manage depressive symptoms. The most common groups of medications were antidepressants (n=10) and anxiolytics (n=5) (see Figure 9). Analgesics, multivitamins and Isabgol were the least commonly used medications. One woman reported using these medications for physical symptoms she experienced in her depression. Medications were usually used in conjunction with other strategies to manage and prevent depression.

Figure 9: Medication Management



All women used *antidepressants*. Except for one, whose father recognized her depression and provided her antidepressants which she used for a short period, the others used them after they consulted with their psychiatrists. At the time of the research interview, all but one was taking them.

Women perceived that using antidepressants helped them manage their depression. For example, one reported "Medicine decreases its acuteness or its severity then I am able to watch or read." Women expressed four key reasons for taking antidepressants during an acute phase of

depression. First, psychiatrists emphasized the need to continue to take medications. Second, antidepressants assisted women to manage their overall depression and/or manage specific symptoms such as negative thinking, sadness, dullness, and loneliness. Over time, women learnt that medications temporarily resolved some of their symptoms such as sadness and dullness; and whenever they stopped them, their symptoms worsened. For example, one woman stopped treatment for six months which worsened her condition; she then recognized her need to continue taking medications. "Again I came to doctor; doctor told me that the faster the patient runs away from us, with the same speed come back. I told him you are right, and with God's blessings I won't do it." Third, medications assisted women to use other strategies, without which performing them was a struggle. Lastly, over time, women learnt that medications strengthened their mental capacity in depression and assisted them to meet their personal goals of becoming functional and getting back to a normal life routine without experiencing fatigue and tiredness both at home and outside the home. One said, "I got so down, I couldn't do any housework, not going anywhere and now obviously I am doing these." Similarly another shared, "food is cooked, food used to come from outside and now food is cooked." Therefore, although they may have been struggling financially, they made every effort to ensure that they did not run out of antidepressants during depressive and non-depressive phases.

The use of antidepressants was viewed as somewhat helpful in preventing depression but its use was not considered to be totally capable of preventing its recurrence. Women had no idea how it could prevent it if it did. Over time, women learned the value of continuing to use antidepressants regardless of whether they were depressed or not due to the consequences they faced when they stopped their use. Yet, such continuation of antidepressants was not without

struggle because some women experienced side effects and some struggled due to their attitude towards their continued use.

For half of the women, the experience of taking antidepressants was not pleasant as they reported a variety of side effects during acute depression. Side effects included an increase in appetite, weight gain, dizziness, and hypersomnia which made getting up early in the morning difficult. Therefore, performing morning prayers, performing family roles and responsibilities and doing exercises were affected. For example, one woman shared that,

> …so many people taunted me, in the village you know that getting up at 9am is a big issue, she got up at 9am, over there you have to get up by 6am, you should leave your bed, but I was sleeping till 9am then going back to sleep once kids leave for school, used to get up at around 10 or 11am so everyone used to criticize that she is sleeping till 11am, sleeping till 10am….so I was very stressed so then I told the doctor…then he reduced the tablet, so then he said take one, so what happened so then for two years I took this and then stopped them." The side effects of nausea and stomach upset disrupted taking medication for quite some time which led to more struggles with depression itself.

Besides side effects, there was general dissatisfaction and unhappiness about continuing medications for several reasons which also contributed to self-regulation of use and dosage. Women viewed that taking medication was not a normal part of living; therefore, they had a strong desire to discontinue it as soon as they recovered from depression. Similarly, there was a personal feeling of being different from others in their social network because they usually were the only young ones taking medication. For example, one shared that taking medication disrupted her life. She preferred to stay at her mom's home but since her mother and other

relatives were against medication use it interfered with her taking medications as prescribed. Similarly another woman struggled to make her parents accept her need to take medications.

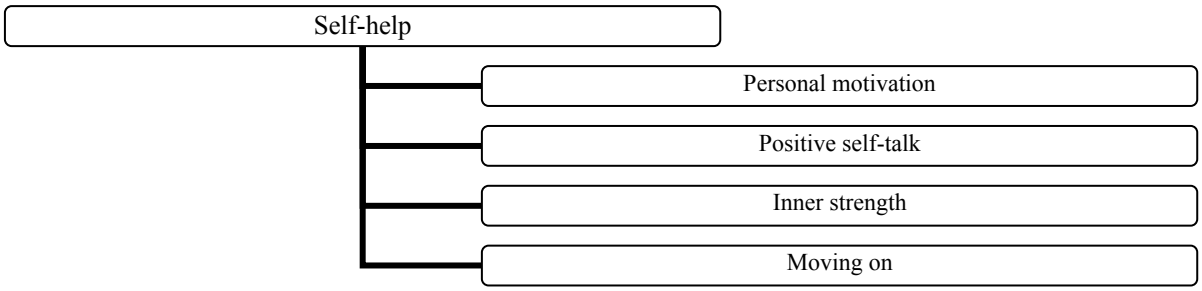
With regards to *Anxiolytics*, women shared that they initially treated some of their undiagnosed depressive symptoms by taking anxiolytics which family members and/or general practitioners offered for the symptoms of anxiety, insomnia, restlessness, and "a feeling of a sinking heart". Once they sought treatment from a psychiatrist, they sought guidance on whether or not to take medications and how much to use. Most did not understand exactly how anxiolytics worked but they helped them manage symptoms such as anxiety, restlessness, sinking heart, agitation and insomnia. In addition, they experienced satisfaction and peace of mind when they took medications and felt better. In relation to the role of anxiolytics to prevent depression, women stated that it had the potential to prevent depression as it took the edge off some situations that had potential to contribute to depression. However, one problem with anxiolytics was their short-term effectiveness which lasted only between 30 minutes to 5 hours.

In contrast, a few perceived that using anxiolytics was not helpful, particularly, when it did not help to completely manage restlessness. In fact, taking anxiolytics made it difficult for women to get up in the morning and to offer early morning prayers. In addition, due to their addictive nature, they developed a strong craving for them which made them very uncomfortable whenever they stopped taking them even after consulting with a psychiatrist. Due to their limitations, a few debated their use and preferred to turn to non-pharmacologic ways to manage symptoms such as reciting holy Qur'anic verses or God's names.

Self-help.

All women used some form of self-help related self-management strategies such as personal motivation (n=6), positive self-talk (n=3), inner strength, (n=2), and moving on (n=2) (Figure 10). These strategies primarily focused on using self to manage and prevent depression usually when there was little social support or when it was counter-productive. These self-help related strategies were either self-identified or identified by psychiatrists.

Figure 10: Self-help



Women described *personal motivation* as pushing self or using will power to manage and prevent depression. They used personal motivation primarily during the recovery phase of depression as they were able to motivate themselves to perform their roles and responsibilities such as doing housework, performing self-care, and seeking formal health care. However, when they were severely depressed, pushing themselves to work was extremely difficult. One shared her personal motivation to prevent recurrence by stating that "I try to finish it (depression) myself."

A few aspects prompted women to use personal motivation. The first was following God's guidance. According to one, her use of inner motivation to push herself or use her will power was influenced by God's direction for humans to make an effort as "there is a blessing in the move." Hence, when depressed she tried to follow God's direction:

This is what I said I used to get up and go to the kitchen to do dishes but were not able to, or used to go to do the work but couldn't do it, so I used to come back and sit down, I used to try and go, as it was said that keep trying, the effort at last become successful.

A second motivational factor was to regain previous interests or create new ones. For example, one shared, "Push self to create interest in everything such as in housework which was there before depression but is totally lost".

Women reported use of *positive self-talk* to manage a variety of symptoms of depression such as anger, frustration, sadness, and hopelessness. Although they were not always able to think positively and do positive self-talk in acute depression, they knew that it could help them even if they could not do it at any given moment. This strategy was considered possible when the depression was mild or when its severity was waning because then they were able to focus on the positive things in life such as having children and sacrificing for them, which was satisfying. Women believed that every effort should be made to do positive self-talk when not depressed to gain control over negative thoughts before they overpowered the mind.

This strategy when combined with other strategies such as seeking self-reassurance, professional mental health services, and medications was viewed as one of the most powerful strategies as it assisted women to perform a variety of other strategies. For example, positive self-talk assisted them to restart exercise or a job after a gap of a few days. Similarly, positive self-talk assisted them to seek treatments to manage their illness rather than use strategies which would upset God such as being angry at self or others (physical or verbal anger or screaming at others). For example, "I tell myself that if I wouldn't go then how the treatment would be done. Treatment is important...."

Women used *inner strength* both when depressed and not depressed. However, they struggled to use it in acute depression. The use of inner strength stems from the idea that these women considered themselves to be one of their most sincere buddies. One articulated, for example, “Dear doctor I don’t do much, I seek support from my heart (seek internal support/strength)….” The use of inner strength helped in self-care, and in making sound decisions related to personal health and wellbeing when depressed and when well.

The use of *moving on* was based on the understanding and the conclusion drawn over time that no one else, not even their immediate family members or maids would put up with a depressed loved one or boss. They shared that even husbands could only do so much for so long and would not help for long periods of time. Similarly, children would stop listening to the same depressive experience over and over again. With few exceptions, in-laws usually were frustrated with their daughters-in-law’s depression. For example, one shared, "They will say put her, put her into mental asylum, finish it why bother. Now even my mother can’t take it for long." Therefore, the need to use moving on was identified as living in the present, and not getting caught up in past incidences or worrying about the future which assisted them to regain normal self while in the recovery phase.

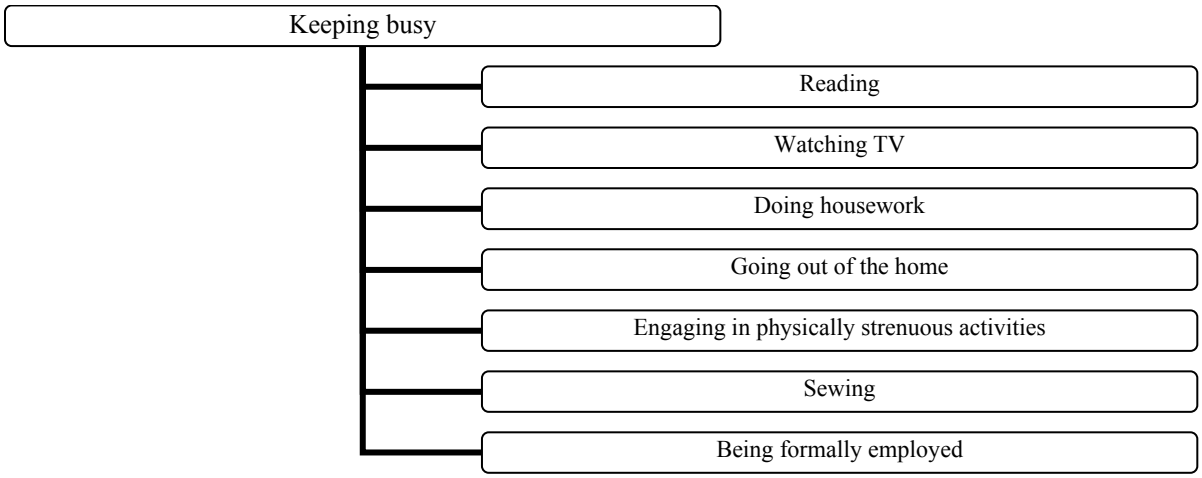
Keeping busy.

All women used one or more carefully selected keeping busy strategies to manage acute depression and prevent its recurrence. They struggled to keep busy when severely depressed but if they were able to keep busy they found it helped to divert them from distressing thoughts and circumstances. According to one, "since my condition got bad, since it got better slowly and gradually this is what I want to do keep myself busy." By keeping busy women

preoccupied themselves with tasks at hand which limited their time to ruminate about problems, struggles, and/or stressors which could contribute to depressive episodes.

Families, psychologists, and psychiatrists played a crucial role in identifying, motivating and assisting women to use ways to keep busy in their day to day tasks, roles, and responsibilities which they struggled with in depression. Some key activities they used to keep busy included: reading (n=7), watching TV(n=6), doing housework (n=5), going out of the home such as to visit relatives or friends (n=5), shopping (n=5), going to a totally new or strange place (n=3), going on outings (n=3), and going out with the husband (n=4), engaging in physically strenuous activities such as exercising/working out (n=4), walking (n=4), and practicing yoga (n=3), sewing (n=2), and being formally employed (n=2) (see Figure 11).

Figure 11: Keeping Busy



With regards to r*eading*, women who had a habit or passion for reading regularly continued reading although their ability to concentrate was affected. Women's reading materials to keep busy varied. They read about depression and focused on a variety of topics related to depression and stressors that contributed to it such as understanding marriage, commitment in marriage, anger, jealousy, depression, and medications for depression. They also chose reading

materials related to religion and its background such as the Qur'an, translations of the Qur'an, prayers, and Islamic history. Depression influenced women's choice of reading and its regularity. For example, some switched their reading from non-Islamic books or magazines to Islamic books. In terms of regularity, one woman who was a passionate reader put it this way, "I leave reading for two to four days when there is a lot of discomfort…. When I get quite better then I read."

With regards to *watching TV*, some women shared that their psychologists suggested and encouraged them to watch TV to keep busy; but not all who followed the suggestion found it to be a helpful way to keep busy. Others benefited from watching TV; it helped them manage depression as it engaged them and worked like a sleeping pill because they would fall asleep while watching it. Watching TV helped them to prevent depression because it kept their minds off of distressing thoughts which could contribute to a depressive episode. For example, one woman who was struggling with her husband's extramarital affairs found watching TV to be a diversion activity since, as a couple, they had nothing in common to do. According to this woman, "I watch TV, I get busy." The programs which they usually watched included religious programs, cooking shows, and/or health forums.

With regards to *doing housework*, women shared that housework, an expected female gender role, helped them to manage and prevent depression. Being occupied in housework, cooking, ironing, and organizing, diverted women's distressing thoughts from their illness. With their family's encouragement and expectations, women were able to get involved in household chores and fulfill their responsibilities when they were struggling in an acute depressive phase. Once they were not depressed, they willingly performed housework; and maintained a daily

routine. For example, “Initially I did it because it was compulsory. Yes, initially I did it because it was much needed/compulsory. But after that I got interested.”

With regards to *going out of the home*, women shared that they used it to manage and/or prevent depression. It was viewed to be a valuable strategy as it helped them to keep busy, provided them a feeling of self-worth and being functional and productive. For example, according to one:

> The purpose of getting out of home is that you get involved into something perhaps by being out and it does make a difference. Getting out of home is not for happiness, you do it for the depression. To decrease the overall depression. Getting out of home makes a difference.

Getting out during depression was very difficult. However, once they overcame this barrier and got out of their home, it helped them a great deal. They had no particular routine or frequency of activities that got them out of the house. Some of the places women went when they went out were visiting a relative’s home, shopping, going to a totally new or strange place, going on outings, and going out with their husband.

Going out to a relative’s home provided women an opportunity to vent their struggles, to socialize, to engage in conversation, and to attend family gatherings. The preference for going to their parents’ home over others was that women did not have to worry about dressing up, they could even go unkempt. In addition, their parents’ home was viewed as a refuge when the husband’s home became unbearable to live in.

Due to the financial implications of going shopping it was not always viewed as a feasible option. However, when women followed their psychologist’s suggestion of going shopping to get out of the house, they found it helpful. For example, one shared that, "I don't

know but maybe there is something in shopping, distraction, I don't know, when I go it makes a great difference. Buying for self creates the most satisfaction." Another shared:

> In the beginning I didn't know so doctor started saying that…when went for shopping, that made a difference. Going for shopping makes a great difference…. I don't know but maybe there is something in shopping, distraction, I don't know, when I go it makes a great difference.

Women shared that they went out to totally new, strange or public places to manage depression. They found it helpful as they became engrossed in a new environment, got a chance to see the outside world, were with the public, wandered around, and saw the current fashions and designs. This stimulation grabbed their attention and diverted their mind from focusing on stressors and illnesses, eventually helping them to relax and feel better. For example, one mentioned that:

> When I go out I see crowd, so being in crowd my pain meaning feeling of loneliness decreases. Then I get in to like what fashion people are doing? What garments, what is in nowadays, due to this loneliness decreases, of course if you go in a crowd your mind is diverted.

Psychologists also suggested going on outings to keep busy. When women did, it helped to divert their thoughts, decrease discomfort, bring happiness and improve health. Going on outings was viewed as having the potential to prevent depression. However, not everyone felt that going on outings was a feasible strategy due to family and cultural restrictions. They were usually allowed only to go out alone to shop for groceries and go to their parents' home if it were nearby. For example, one expressed:

> I want, but I can't do it…. With who should I go, how can I go alone, that is the whole problem,…. Can't do it. There is no one to take you or no one is there to say you go and no one is there who can give permission.

Going out with husbands was perceived to be helpful in managing some of their symptoms of depression such as increased or decreased appetite, loneliness, and crying as well as in preventing depression. For example, when husbands took them out to eat, it increased their appetite. Similarly, when they went out with a loving and friendly husband they did not feel lonely or cry; it provided them a chance to talk privately about their struggles with depression and to get some walking exercise. In contrast, they shared that going out with abusive and controlling husbands could worsen depression.

With regards to *engaging in physically strenuous activities*, women shared that they used physical activities such as exercising/working out, walking and yoga; they continued them whether they were depressed or not with the support of family members and friends. For example, husbands, children or friends accompanied them when they went out for a walk. Some women shared that their husbands also supported enrolling them in a gym or health club. However, women experienced difficulty in engaging in their usual strenuous physical activities when they were severely depressed. According to one the purpose of working out was "so that I don't remember. I should do so much of work that I don't think of that, I should keep myself so busy that my mind doesn't go there, I divert my mind."

With regards to *sewing*, women shared that it had the potential to manage and prevent depression. Psychiatrists suggested and encouraged them to sew as a way to keep busy. One shared that once her psychiatrist learned of her struggles with resuming sewing, he suggested starting with small projects such as a pillow case. Such support and guidance helped her to take

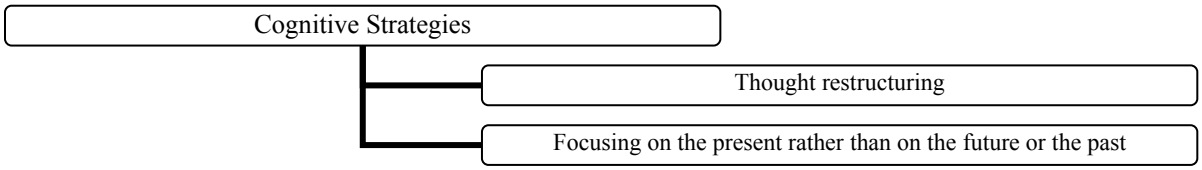
on more demanding projects such as completing a dress. Sewing began in depression and continued as the women emerged from it and in both situations they perceived it to be helpful in diverting their thoughts by keeping them busy.

With regards to *being formally employed*, women shared their desire to continue employment. They agreed that employment played a positive role in both managing and preventing depression. In depression, employment diverted their thoughts for several hours a day. Though doing a job when depressed was a struggle because they could not fully function, the work helped them feel productive. It assisted them to meet their personal goals of serving others and earning money to support the family. One described the value of formal employment in acute depression as it "absolutely" helped. Though they thought that a break from employment for a short while was helpful in acute depression, they preferred to continue to work because doing some work was better than taking a total break from the work routine. When not depressed, they continued to work at their full capacity and valued the role of employment in preventing depression as it kept them focused on constructive work and diverted their thoughts on matters which could contribute to their depression.

Cognitive strategies.

Though cognitive strategies were not the most common group of strategies used, when they were used they were reported to be helpful in managing and preventing depression. Cognitive strategies included: thought restructuring (n=2), and focusing on the present rather than on the future or the past (n=2) (see Figure 12).

Figure 12: Cognitive Strategies



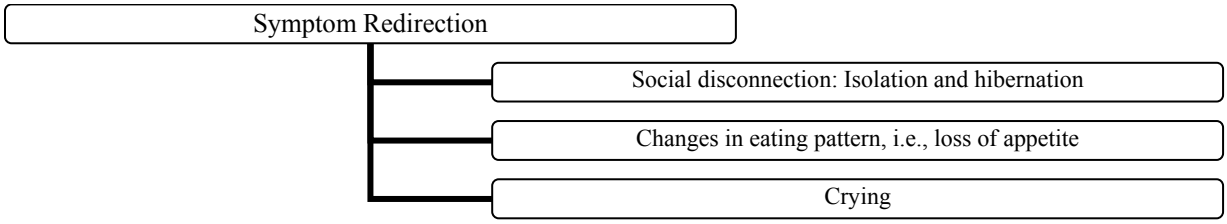
Thought restructuring was used mainly during depressive episodes. Over time, women learned to restructure their thoughts on their stressors and became more courageous and strong. For example, one who had difficulty with her in-laws stopped blaming herself for their negative behaviors. She learned to accept that this was how they were and would be, that she should not belittle herself in front of them but try to be quiet and if they talked nicely to her then she would talk nicely and respectfully to them and would do whatever she could for them. The women stated, "…I will not say that today I am set, nothing, though this condition is there but the way I think has changed…. This condition is there, pain is the same, but the way I think has changed." Another woman used to think of leaving home because of her husband's scolding and ongoing criticism. She restructured her thoughts after she reflected on her home situation and the suffering she would cause, particularly the suffering her kids would experience, and all the problems that would arise or activities disrupted if she left home.

Focusing on the present rather than on the future or the past combined with psychotropic medications and counseling was perceived to be helpful in managing negative thinking. For example, one stated, "…forget about future just think about present which helps a little…." Another one tried not to dwell on the past as thinking about it brought about her depression. Hence, she tried to focus on the present, particularly on her children.

Symptom redirection.

Symptom redirection occurred when a symptom was construed to be a positive component of illness and not a concern. These symptoms were: social disconnection: isolation and hibernation (n=6); changes in eating pattern, i.e., loss of appetite (n=3); and crying (n=3) (see Figure 13). Symptom redirection was relevant for managing depression but had nothing to do with preventing depression. Women redirected their symptoms in a unique way which assisted them to meet their personal goals.

Figure 13: Symptom Redirection



With regards to *social disconnection: isolation and hibernation*, women appreciated being alone during depression and consciously disconnected socially by isolating themselves for a short period of time as a way to manage depression. They were only able to isolate themselves for a few days because they were exclusively responsible for their family roles and responsibilities. In addition, they did not want to be alone for a long time as they would miss the attention their family gave them when they were sick. Using social disconnection required the availability of personal space. For them the best place to isolate themselves was at home (a familiar surrounding) and, if possible, in a rented room in a hotel. However, both of these options were not always feasible because of the presence of children or extended family and limited personal and family financial resources.

Social disconnection was perceived to be helpful in managing overall depression. For example, being alone limited the risk of feeling stress and frustration and straining personal, long-term marital and other social relationships. Women shared examples such as it helped them to avoid screaming at their children. In addition, it was their way of taking care of themselves, to experience quietness and relaxation, and to recuperate. For example, one woman stated:

> So, though I think, I think, but since I were alone so then it is not a problem so the thing is that if someone comes in front then I get angry, there is a lot of anger…. In order to avoid it I say that I get out somewhere, be alone, if I am lonely then my mind also relaxes, there is peace, … when I get relax then I come out.

With regards to *changes in eating pattern i.e., loss of appetite*, some women shared an interesting perspective of symptom redirection. Women viewed loss of appetite to be positive because it assisted them to meet their personal goal of losing weight. One stated, "Very happy with having loss of appetite as a symptom and wish that this symptom remains and the rest of the symptoms resolve."

With regards to *crying*, women shared that they viewed crying, a symptom of depression, as a therapy when women realized that over time it assisted them in dealing with stress, agitation, and irritation. For example, according to one:

> Crying helped to release pressure on the heart and helped feel relaxed. If crying is coming but I am not crying, my pressure increases. On my mind it is increasing, on my heart it is increasing, increasing on heart, because obviously it would increase, so once cry then heart is lighter.

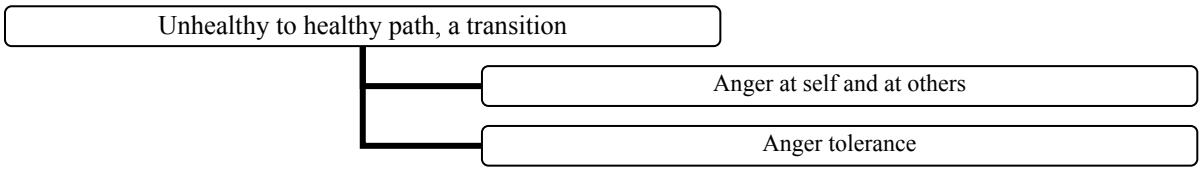
They desired to cry or wanted someone to make them cry. Crying to be a therapy involved a combination of activities. For example, when a woman was praying on a prayer mat and talking

to God for help, she experienced the presence of God around her and went into a state of transcendence which was followed by crying out loud, "I pray, I cry, I pray to God…." During this process women approached God and asked him to direct and guide them.

Unhealthy to healthy path, a transition.

Strategies used to manage or prevent depression were not always healthy, yet they were used as a last resort. However, such strategies were used with caution due to their possible negative consequences. Over time unhealthy strategies were somewhat replaced by more healthy ones. In short, a transition occurred from anger at self and at others (n=4) to anger tolerance (n=2) (see Figure 14).

Figure 14: Unhealthy to Healthy Path, a Transition



With regards to *anger at self and at others*, women shared that they used it as a strategy. Interestingly, although they recognized this strategy to be unhealthy, they used it in desperation, yet cautiously due to its possible negative consequences. Anger at self was expressed through screaming at self, beating self, banging their head against the wall and/or attempting to harm self (i.e., overdosing on medication). This strategy was acted on only in acute depression and discontinued when not depressed.

Anger at others included screaming at husband, in-laws, children, servants, and/or parents. However not everyone chose to use angry outbursts at husband or in-laws due to the possible serious repercussions. Therefore children, servants and parents were screamed at as

they were considered to be safe from negative consequences. Nonetheless, anger at self was perceived to be helpful in managing depression to a certain extent. According to one:

> Obviously it helped after punishing/hurting self. A person goes in the depth as to what to do, and comes into severity (becomes desperate) that I should do something, it decreases the depression quite a bit. When you hurt/punish yourself so it reduces, mine decreased.

In addition, they were able to get the attention of loved ones such as husbands and to get them to listen to their personal concerns and desires. Anger at others helped them gain control over and scare an uncaring or abusive husband. Such outbursts against others also provided an outlet to vent on whatever was causing their stress which eventually helped them relax. However, such venting and acting out resulted in negative consequences in terms of strained relationships, anger retaliation, and physical abuse. Hence, half of them chose to transition from anger at self and others to anger tolerance over time.

With regards to *anger tolerance*, women described that they changed from having anger outbursts to anger tolerance because of the angry reactions from others and loss of closeness with their spouses. They learnt over time that they did not achieve much from being angry at self and at others. For example, a woman shared her reasons for anger tolerance:

> One thing is that my home environment doesn't ruin, and the time is not wasted. Before going to work, in the morning time in the morning time I tolerate otherwise I am not the one who can tolerate. In the morning time the work hours/time is not wasted. The argument doesn't occur, the home environment is not ruined, my whole day is not ruined, and that's why I tolerate it…. so that the work is not affected and he goes to work.

Women dealt with anger at self and thoughts of self-harm or suicide mainly by getting involved in a variety of activities such as socializing with others and being busy at home performing

chores, "I got myself busy in the work I said don't do this crazy act. You would be the one who would suffer no one else would loss anything." In addition, their seeking guidance from the preaching of Islam and having been brought up in a religious family environment contributed to their not harming self and transitioning to anger tolerance. Self-harm was viewed as a prohibited act in Islam. One shared that she did not want to ruin her life after death. She would have committed suicide if she could have the assurance that there would be no repercussion of committing suicide after death. Similarly another shared:

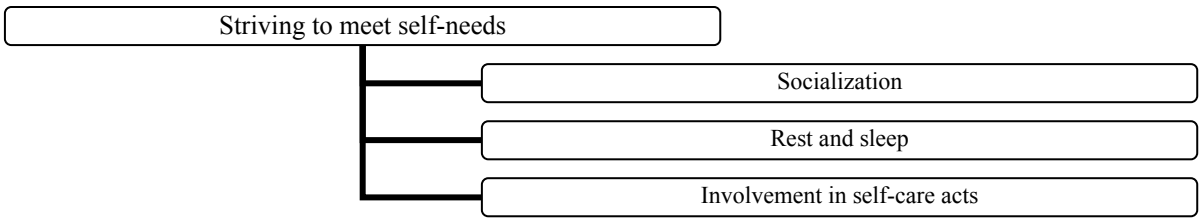
> God did not approve of self-harming activities, God gave humans a superior status amongst all his creation, and they also learnt from the Prophet's saying (Hadees) that those who commit suicide would not get a place in or not even be able to smell the scent of heaven.

Compared to angry outbursts, anger tolerance was perceived to be helpful as it was based on the preaching of faith and had fewer negative consequences for interpersonal relationships. The use of anger tolerance did not always have a positive outcome because when anger was suppressed or kept inside it sometimes contributed to women's depression. The motivation to use anger tolerance compared to anger expression was its fewer negative consequences on long-term relationships.

Striving to meet self-needs.

The theme striving to meet self-needs include: socialization (n=8), rest and sleep (n=7), and involvement in self-care acts (n=4) (see Figure 15).

Figure 15: Striving to Meet Self-needs



With regards to *socialization*, women who valued socialization used it regardless of whether they were depressed or not; however, some women doubted the benefits of socialization to manage and prevent depression when it did not suit their personality.

Women shared various viewpoints on socialization. They used socialization to talk to or interact with others they perceived to be truly supportive and trustworthy within or outside family and with mental health care providers and with God. Women were extra careful and thoughtful with whom they should talk to avoid strained relationships or elicit stigma. For example, one shared that her parents did not accept the presence and suffering of her depression; hence, talking to them was a source of frustration. Similarly, another shared that her husband scolded and abused her whenever she shared her personal struggles about her illness; therefore, she decided to stop sharing them with her husband.

Similarly socialization was used to attain peace and relaxation. For example, one shared, "…discussing my problems, sharing my problems with somebody who I think is confidential and sincere to me. It can be anyone outside, good friends, or my relatives, or my mother whatever. So after talking to them I feel little relax."

With regards to *rest and sleep*, women shared that they used it to meet their personal need of dealing with symptoms of fatigue, loss of interest in doing work, negative thinking,

sadness, increased sleep, and anger. For example, one shared, "At that time I used to feel that I should take rest, lie down."

The desire for quality, extended rest and sleep was heightened and used only during an acute episode of depression. Women reported that getting proper sleep was of prime importance during depression. Resting and getting several hours of good sleep (8-10 hours) by taking a tranquilizer was the only thing that helped them to feel physically and mentally rested. However, it was not always possible to get the desired rest and sleep due to family demands. In addition, family discouraged women from having extended periods of rest and sleep.

Involvement in self-care acts was a way to meet personal needs and was perceived to be an important strategy if it could be done. It included taking a shower, changing clothes, and putting on make-up. For example, one woman preferred to wear clothes made of the lightest material and could not tolerate heavily embroidered clothes.

In depression, women usually required a family member to encourage them to get involved in self-care acts. For example, husband's support and encouragement; or setting strict rules for them to join a health club, to go to school to pick up children or to go to a party required them to perform personal hygiene and dress up. Another woman shared:

> When I am depressed, my husband forces me to get up, take a shower, get out of the room etc. Sometimes I don't understand why he does all that. Most of the time I argue with him, what kind of a husband are you, that you don't let me sleep, don't let me walk; don't let me think when I want to. My husband insisted that I get up, take a shower and get out of the room. My husband does this a lot.

Self-care acts were perceived to be helpful because they felt fresh and emotionally better due to the change in their mood. They felt more sociable and went out partying, and had less desire to

sleep. For example, one shared that putting make-up helped her feel refreshed; it brightened her face and improved her appearance from a dull depressive look.

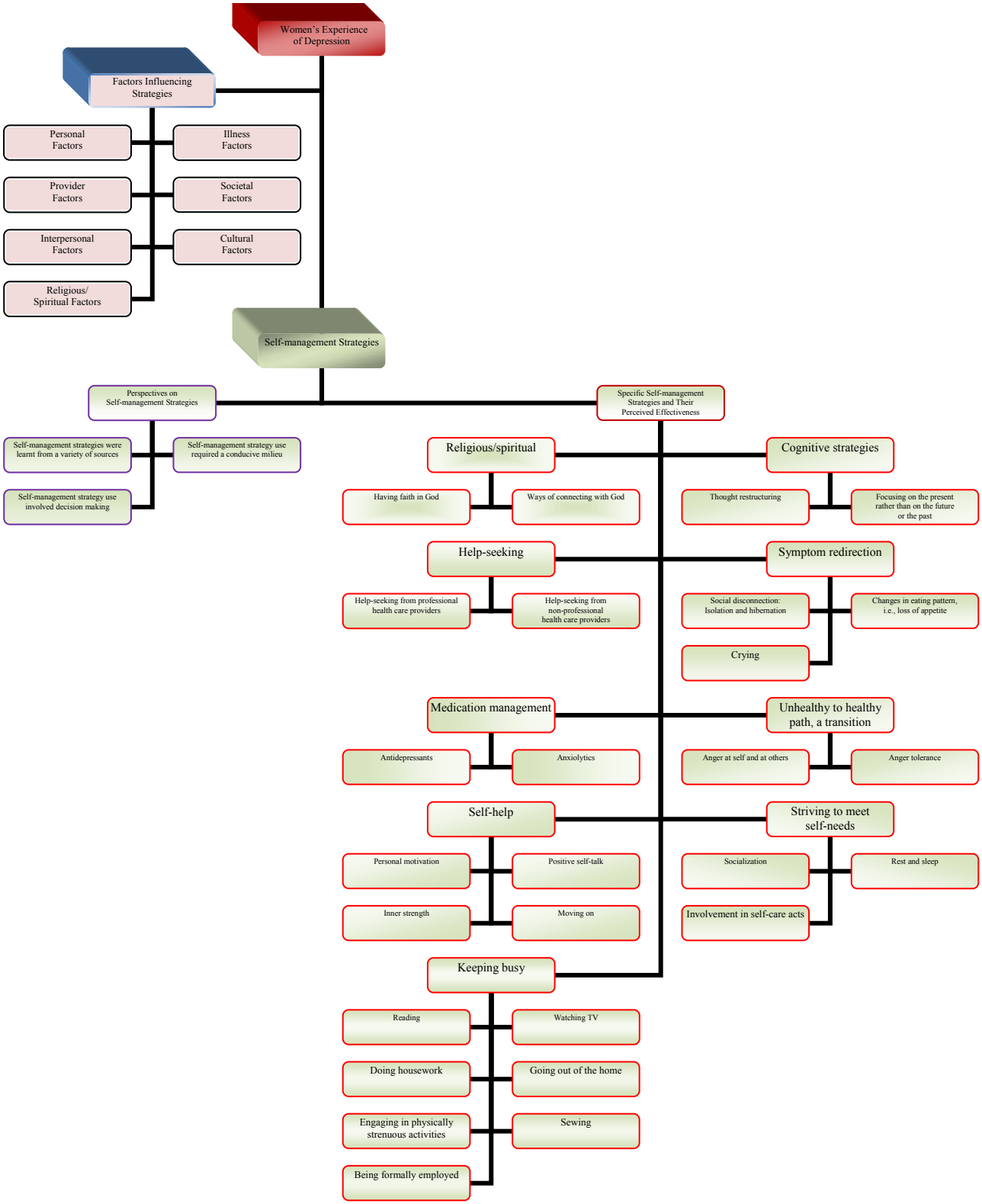
Summary

Ten Pakistani women described strategies they used to self-manage their recurrent depression. This study's findings enhance previous research on women's experience of depression, factors influencing strategies, and self-management strategies which are graphically presented in Figure 16.

In the findings related to the category of women's experience of depression, women's view on the perspectives and representation of depression were described. The findings related to the seven influencing factors including personal, illness, provider, societal, interpersonal, cultural, and religious/spiritual indicated how they influence women's selection and use of strategies. Finally, in the findings related to self-management strategies, women's various perspectives on self-management strategies and the nine groups of strategies with their perceived effectiveness in managing and preventing depression were described.

The nine groups of strategies were religious/spiritual, help-seeking, medication management, self-help, keeping busy, cognitive strategies, symptom redirection, unhealthy to healthy path, a transition, and striving to meet self needs. Some groups of strategies were more commonly used than others. However, although such strategies were not used by many, those who used them added interesting perspectives about their use.

Figure 16: Graphic Representation of Research Findings



Chapter V

Discussion

This qualitative study's purpose was to describe Pakistani women's perspectives on strategies in the self-management of their recurrent depression. The results of this study are organized under three categories: (1) women's experience of depression; (2) factors influencing strategies; and (3) self-management strategies. First, the unique findings related to each of these categories will be discussed. Second, the implications for research, practice, and education will be discussed. Finally, the strengths and limitations of the study will be highlighted.

Women's Experience of Depression

The findings related to the category of women's experience of depression **(**see Figure 16) are grouped under two sub-categories. The first sub-category, perspectives of depression, consisted of four themes: contributors to depression; depression as an insidious and hidden illness; depression impacted self and beyond; and experience of depression created positive insights. The second sub-category, symptoms of depression, consisted of three themes: physical symptoms, emotional symptoms, and cognitive symptoms.

Perspectives of depression.

In relation to perspectives of depression, women's many descriptions were typical of what is known about depression and the struggles with it such as the contributors to

depression, depression as an insidious and hidden illness, and depression impacted self-and beyond. However, their experience that depression created positive insights appeared to be unique and worth considering. For example, depression as a gift from God and a source of reviving faith in God and Islam created an opportunity to learn and grow from their adversity. This perspective promoted their feelings of closeness to God and their continued use of religious practices, help-seeking from doctors and use of medications. Nesse's (2000) paper "Is depression an adaptation?" presented the idea that one possible function of depression was a way to communicate a need for help. Connecting to God partly supports the idea that depression motivates women to connect and reach out to God and to continue their use of religious practices. Moreover, this positive perspective helped them become sensitive towards other women's struggle with depression because they understood that depression could occur to anyone, even to the most fortunate. This finding of depression creating positive insights definitely is an area that could be studied in future research. However, it is by no means intended to diminish the fact that depression is a nuisance for mankind (Murray & Lopez, 1996).

Symptoms of depression.

In relation to symptoms of depression, all women reported that their symptoms varied from one depressive episode to another. Women had to adjust the strategies they used based on the nature and severity of their symptoms as well as their understanding of their experience of depression at that point in time. Knowledge, understanding, and appreciating the severity of the symptoms guided women's use of strategies for depression. Lastly, overwhelming and multiple physical representations that did not match women's understanding of their psychological problems, combined with failing to recognize depression contributed to

their seeking help from other sources such as general health care providers or specialists, and religious/spiritual healers; and complicated and delayed their seeking mental health care services.

Factors Influencing Strategies

Prior to data collection seven influencing factors, personal, illness, provider, societal, interpersonal, cultural, and religious/spiritual, were outlined and graphically presented. They were derived mostly from the literature on depression and women in Pakistan, and drawn from clinical experience (see Figure 1). The findings supported their existence and influence on self-management strategies Pakistani women used for recurrent depression (see Figure 16).

Each of the seven influencing factors had its own thematic factors. It is important to mention that not all the specified thematic factors turned out to solely influence the use of strategies; rather, women perceived that some contributed to their depression as well. That thematic factors contribute and worsen depression is consistent with the literature related to depression in Pakistani women. For example, extended family members living in the household such husband, mother-in-law, and sister-in-law played non-supportive roles.

As graphed originally and suggested that each of the seven factors influencing strategies overlapped each adjacent factor and were interrelated and influenced Pakistani women's use of self-management strategies for recurrent depression held. Although this view held, Pakistani women described much deeper and more complex interrelationships amongst the influencing factors than the graphic representation depicted prior to data collection. All the factors were interrelated, and the interrelationships amongst them for each woman were unique depending on their unique life circumstances that contributed to the selection or use of self-management strategies. In this section, some of the unique findings related to the thematic factors associated

with personal, illness, provider, societal, interpersonal, cultural, and religious/spiritual influencing factors will be discussed.

Personal factors.

Personal factors was grouped into two themes**,** demographic characteristics and personal goals. Demographic characteristics included gender, socioeconomic status, education and age.

Female gender was not viewed by most women to be a factor hampering their use of strategies as long as they fulfilled their family roles and responsibilities and covered themselves properly and respectfully because family honor dictates women's role in society. Though there is no research to date that has systematically studied the influence of female gender on women's selection of strategies, one thing that can be said with some confidence is that regardless of what Pakistani women select to manage their depression, they must primarily fulfill their family roles and responsibilities to ensure family honor at all cost. Pakistani women's expectations of fulfilling traditional gender roles support the existing qualitative research that describes a "*good woman"* as one who does house work, looks after her family including husband, family and in-laws, and supports the family financially if necessary (T. S. Ali et al., 2011).

Socioeconomic status affected women's use of strategies regardless of whether a woman was financially stable or unstable. When financially stable, socioeconomic status assisted women to select strategies which were perceived to be helpful to relieve depression such as seeking help from an expensive doctor and affording expensive treatments and medications. When financially unstable, socioeconomic status limited or completely hampered women's use of strategies that required financial resources for help-seeking from professional mental health

care providers and managing medications. This finding supports the work of Knapp et al. (2006) that indicated that insufficient resources was an economic barrier that affected the availability, accessibility, efficiency and equity of mental health care amongst low- and middle-income countries. Another study with Pakistani women who sought help from health care providers for intimate partner violence found that they were financially dependent on financial support and transportation (Sebghati & Särnholm, 2010). Similarly, the qualitative study done by Jeon, Essue, Jan, Wells, and Whitworth (2009) with patients with varied chronic illnesses revealed that chronic illness self-management is seriously jeopardized when people struggle financially. No or limited financial resources affect prioritizing decisions related to selecting self-management activities.

Education contributed in a unique, two-fold way towards the selection and implementation of strategies. First, education assisted women to be self-efficacious in terms of educating themselves about depression through reading literature on depression and its management, including medical management. Second, women questioned and refuted the stigma associated with their depressive illness and sought professional mental health care services. These findings suggest that improving general literacy amongst Pakistani women has the potential to positively contribute towards their selection of strategies to manage their recurrent depression, and to combat the stigma associated with depression and seeking help from professional mental health care services. This notion is consistent with the argument that improved general literacy improves mental health literacy (Suhail, 2005).

Age with respect to use of strategies, although less frequently reported, turned out to be an area that would be worth exploring because findings demonstrated that women who were older compared themselves to younger women with respect to physically demanding and

cognitively challenging strategies. Women who perceived themselves older shared that they might experience limitations of intensity and duration if they performed physically strenuous activities even though they had been physically active most of their lives. A similar trend was reported regarding cognitively motivated strategies. Women who perceived themselves older compared themselves to younger women and reported that cognitively driven strategies were more challenging to perform. They reported that it was difficult to make appropriate decisions about selecting strategies. The change from getting involved in physically strenuous activities with the same intensity and duration as they did when they were young makes logical sense. However, it is difficult to comprehend why women perceived there to be a difference in getting involved in cognitively driven strategies with age. Maybe with age, interest in learning new strategies, adapting new strategies in daily life, or making decisions about what strategies to choose from a pool of learnt strategies over time might be difficult and frustrating. However, the exact impact of age on the use of cognitively driven strategies remains to be empirically elucidated.

Personal goals has been conceptualized as an important consideration in the self-management of other recurrent and chronic illnesses (Clark & Partridge, 2002). However, the motivating role of personal goals in the use of self-management strategies to manage and prevent depression is not fully understood. The emergence of personal goals in this research as a motivational force in selecting and implementing self-management strategies at any given time and over time in depression is extremely noteworthy. All women shared with quite certainty that their personal goals played a key role in their selection and use of strategies to manage and/or prevent depression. This finding supports Dickson et al. (2011) research that people with depression have and value personal goals. Considering the relevance of personal goals to

motivate using strategies to manage and prevent depression, this finding is worthy of further systematic exploration. Future research should focus on determining the nature of personal goals that motivate the use of strategies, whether the extent of the influence of personal goals is similar or different in the selection and implementation of strategies for managing depression verses preventing depression, and ways to apply the theoretical concept of personal goals in caring for clients with depression in a variety of cultures.

Illness factors.

Illness factors consists of two themes, illness history and illness identity. Illness history included impaired functional ability and number of previous episodes of depression. Illness identity included knowledge of, understanding of, and attitude towards depression, and knowledge of medication.

All women reported a pervasive impaired functional ability that affected various aspects of their lives and their use of self-management strategies. Disler, Gallagher, and Davidson (2012) did an integrative review of literature to determine factors that affect individual's self-management of chronic obstructive pulmonary disease and identified functional limitation as one of two key factors besides balancing disease management in day to day life that influence patients self-management. From a clinical practice perspective, this finding that women experience impaired functional ability in recurrent depression has valuable implications. In addition to other markers for diagnosing depression in Pakistani women with unexplained and excessive somatisation, the presence of pervasive impaired functional ability could be used to further evaluate Pakistani women for the presence of depression. Many women who sought treatment from general practitioners reported complaints of physical symptoms and were only

treated symptomatically. Munk-Jørgensen and colleagues (1997) reported that general practitioners were able to diagnose mental illness in people who struggled with employment related functional disability.

The findings related to the number of previous episodes of depression indicated that with an increasing number of episodes, many women developed a better understanding about the illness and its symptomatology. Over time, they developed a repertoire of strategies based on their perceived effectiveness to manage and prevent depression. These findings indicate how resourceful these Pakistani women became over time while living with recurrent depression. It demonstrated that they could be a great asset in a collaborative (Yeung et al., 2010) patient-provider partnership (Bachman, Swenson, Reardon, & Miller, 2006) within a framework of self-management strategies to achieve patient-based and clinical-based outcomes.

With regards to women's knowledge of, understanding of and attitude towards depression, the findings revealed some key perspectives that require serious attention and further empirical exploration. The expected negative attitudes reported were stigma; that women with depression are faking an illness, are crazy/mad, and once they have depression it never goes away. Similar negative attitudes towards depression were reported in a survey study to identify the attitudes that university students and teachers in Lahore, Pakistan had about a variety of mental illnesses including depression. These were that women with depression have themselves to blame, feel different, must pull themselves together, do not improve if treated, and never recover (Javed et al., 2006). It is disturbing to learn that Pakistani people including the educated community hold negative attitudes towards depression. This finding demonstrates the serious need for nation-wide actions to promote mental health literacy in Pakistan. Second, a unique finding with regard to understanding and attitudes towards depression was that some women

realized that depression was a recurrent, painful, complex, and a giant puzzle/twisty road. However, from such negative and painful insights and attitudes, women spun a positive attitude, i.e., the attitude of a fighting spirit, which led them to use appropriate strategies. They wanted to combat depression through their attitude of "fighting spirit" against depression that actually motivated them to make every effort to prevent or manage it by continuing to use a variety of strategies including seeking help from professional mental health care providers on an ongoing basis compared to a snap shot management of depression. There is no literature to support this finding of spinning a positive attitude of a fighting spirit from the cluster of negative attitudes towards depression. However, the idea that some Pakistani families sought help for mental illness holds true (Karim et al., 2004; Khan & Reza, 1998). In addition, Boardman et al. (2011) reported that some of their study participants talked about the value and significance of taking individual responsibility for their recovery from depression. This attitude of women needing a fighting spirit to combat depression seems to lend support to the Boardman et al. findings. This finding of fighting spirit remains to be further explored to determine its potential role in clinical practice. For example, could this attitude of fighting spirit be used to encourage Pakistani women to seek professional mental health care in a timely manner and to combat stigma towards seeking such help.

Knowledge of medication is worth discussing because women with recurrent depression who lacked knowledge about medications discontinued or self-regulated their use for quite some time. This finding was consistent with the evidence presented in the literature that lack of knowledge about the value of taking medications as prescribed, their side effects (Rafique, 2010) and ways to manage the side effects influenced the use of medications to a certain degree. These findings definitely should alert professional mental health care providers including nurses to give

special attention to educate women about the use of specific medications, their side effects and ways to address them, probable duration, and the value of continuing medications prescribed as part of a management plan to combat depression.

Provider factors.

Provider factors consists of one theme, professional providers performing limited versus comprehensive roles. Findings related to provider factors clearly indicated Pakistani women's expectations from their health care providers. They expected that their providers, general practitioners, psychiatrists, or psychologists, perform comprehensive and not limited roles. Limited roles mainly encompassed just managing symptoms and focused solely on prescribing, adjusting, and reinforcing the use of medications; or suggesting strategies without considering women's backgrounds and circumstances.

The finding that Pakistani women primarily sought help from primary care providers (Suhail, 2005) and from faith and religious healers (Mubbashar & Saeed, 2001; Syed et al., 2007) is consistent with existing literature that described such help-seeking behavior as primarily motivated by the somatization of depression (Naqvi & Khan, 2005) and belief that there is a stigma attached to having mental illness (Karim et al., 2004). It was apparent that many of the symptoms women experienced were physical compared to emotional and cognitive. This is consistent with the literature related to not only Pakistanis (Mallinson and Popay, 2007; Naqvi & Khan, 2005; Rack, 1980; Reza & Khan, 2003) but to Asians as well (Gada, 1982; Cheung et al., 1981). However, Rafique's findings indicated that Pakistani women were able to explain how depression impacted them psychologically such as their mood and cognition. This difference

was possibly due to the interview questions which aimed to understand the impact of depression on every aspect of their lives (Rafique, 2010).

This study supported previous findings that general practitioners and religious/spiritual healers are usually the first providers from whom women seek help (Mubbashar & Saeed, 2001; Suhail, 2005). This implies that these providers should be familiar with mental health related literature and be able to use simple diagnostic tools to recognize depression and direct women to mental health care services. Once women reach mental health care providers they also must be educated so that they are skilled in diagnosing and managing depression (Naqvi & Khan, 2005). However, providers should not simply rely on a symptoms checklist to determine whether a woman is depressed or not as she might not know that she is depressed and describes her experience differently (Epstein et al., 2010). Once diagnosed, mental health care providers' sole focus should not be on medically managing depression but rather should be on partnering with patients and learning what strategies they have used or would be amenable to use given their life circumstances, "…patients know their priorities and their limitations and what is feasible to implement given their personal and social environment" (Yeung et al., 2010, p. 7). If strategies, including medication, are simply suggested and women's interests and preferences, their feasibility of use, and understanding of depression and its management are not considered then it is highly likely that those strategies will not be used. If they are used, their use will be short lived and will have devastating consequences.

Societal factors.

Societal factors comprised of two themes: social hurdles affecting seeking treatment and no or limited health insurance. Social hurdles affecting seeking treatment included

costly treatments, poverty and unavailability of mental health care providers. Poverty was not a frequent theme in this study; however, those few who faced poverty struggled with accessing health care services. This is consistent with the literature (Tinker et al., 2000) because seeking help from professional mental health care services is quite costly. In Pakistan, 70% of the health care services are provided by the private sector (Khattak, 1996), and lack of health insurance requires people to pay for treatment themselves (Naqvi & Khan, 2005). Hence, this finding was not a surprise. Women who were struggling financially were stressed over expensive mental health care services. In their initial episodes after being diagnosed with depression, they either delayed or interrupted their seeking professional mental health care services for some time, and struggled to keep up with following an expected medication plan. According to Gadit (2012), the cost of mental health care services is a major deterrent to obtaining them.

Besides financial constraints, unavailability of mental health care providers to provide quality mental health care services complicates the situation. Although unavailability was not the major concern for most women in this study, it draws attention to the limited availability of current mental health care services in Pakistan. Approximately 20% of patients suffering from significant mental disorders (Olfson et al., 1997) including depression seek help from primary care physicians who are not able to properly diagnose it. Consequently, patients are not properly diagnosed, medically treated nor referred to mental health care services. In addition, not only are there limited and available mental health care services (Karim et al., 2004), but there is lack of an infra-structure conducive to referring patients from primary care to mental health care services (Ballester, Filippon, Braga, & Andereoli, 2005). The above generalizations found in developed countries are worse in Pakistan. Naqvi and Khan (2005) explicitly summarized the impact of poverty and the reasons for delaying to seek mental health care services:

> In Pakistan primary health is poorly developed with weak referral chain from primary-secondary-to-tertiary care services. Most patients' by-pass the primary care services and access services at secondary and tertiary care centers directly. The primary reason being poor quality of services offered at these centers. Additionally, in the absence of any kind of health insurance, most patients pay out of their own pockets. (p. 396)

From this study, it was learnt that over time these women understood the recurrent nature of depression and made every effort to ensure continuity of care and to regularly take medication. They sought financial help from a social support network and used health insurance if it were available as an option, though woman having private health insurance either through their own employers or through their family employers was rare. In Pakistan there is no formal health insurance system. This was confirmed in this study finding that the majority of women did not have health insurance. However, the prospects for developing a formal health insurance system for poor people in Pakistan have recently been discussed in professional publications (Abrejo & Shaikh, 2008; Jooma & Jalal, 2012).

Interpersonal factors.

Interpersonal factors included three themes: family living in the household played supportive versus non supportive roles, family living outside the household played supportive versus non supportive roles, and non-professional persons from outside the family played supportive versus non supportive roles.

Findings related to interpersonal factors demand that professional mental health care providers work on many fronts simultaneously to assist women in their struggle of living with depression in complex and influential socio-economic-culturally-politically driven environment.

Within Pakistan's cultural context, an immediate and extended social support network plays a central role in women's lives contributing negatively or positively to women's selection and de-selection and implementation of strategies. Hence, the findings could be captured in a phrase that *Pakistani women self-manage recurrent depression in a collective interpersonal milieu.* This has significant relevance for clinical practice within the overarching practice framework of self-management of chronic illness that it is not sufficient that the patient and provider simply identify strategies but more importantly that they identify strategies that the patient can feasibly implement in her daily life on an ongoing basis while living within their family structure. It is important for clinicians to consider the extended family's willingness to provide the support needed to implement effective strategies. Yeung et al. (2010) shared their views about the value of the role of family and friends in supporting the self-management of depression by stating "It is crucial that family and friends not be neglected in the self-management process" (p. 177).

Hence, it was not surprising to see that this study finding indicated the extensive involvement of women's immediate and extended families and others in social support networks in the selection, de-selection, continuation and discontinuation of strategies by suggesting, supporting, assisting and providing feedback on the effectiveness of self-management strategies to manage and prevent recurrent depression. Research by Clark et al. (2001) demonstrated the importance of significant others' contributions as role models and financial resource providers to an individual's ability to self-manage illness. In a recent study, Walker et al. (2012) found that social support factors such as their presence and absence, extent, numbers, and types were instrumental to epilepsy patients' use of self-management strategies to manage and/or prevent their episodes. They reported that usually parents and significant others were perceived as providing extensive emotional support which was instrumental for the use of self-management

strategies. In this study too, family members living inside and outside of the home which mainly included husbands, in-laws, and parents influenced strategies quite considerably. Similarly, Grey et al. (2006) emphasized that people self-manage their chronic illness within their family contexts; hence, family roles in managing chronic illness must be considered. In short, health care providers should involve the people in women's social support networks who they perceive to be influential to educate them about depression and develop a management plan that focuses on their expected roles to ensure their use of self-management strategies. Because when they are not considered the use and continuing use of strategies over time is hindered. This implies that people in Pakistani women's social support networks should be encouraged to become involved in supporting women to perform self-management strategies for depression.

Cultural factors.

Cultural factors consisted of three themes: stigma attached to mental illness, stigma attached to seeking help from medical- and non-medical health care providers, and desire for a female psychiatrist. Findings that stigma attached to mental illness and stigma attached to seeking formal mental health care services both resulted in not seeking mental health services or following a prescribed treatment plan. When stigma was associated with mental illness women or their families avoided discussing their illness and its struggles with others. Hence, seeking professional medical help would be impossible to consider. In addition, when women or their families viewed seeking mental health care services a stigma, it affected women's selection and continuing use of strategies such as seeking help from professional mental health care providers and following up on their suggested treatment plan including taking medication. In short, when stigma was linked to either depression or to seeking help from mental health care services, they

both negated the option of seeking help from professional mental health care services. This finding is consistent with what Van Hook (1999) reported in her study of women's help-seeking for depression. Stigma influences how women understand and experience depression and what they can or cannot do to manage it. Therefore these findings necessitate that health care providers' understand women's views about stigma attached to mental illness and seeking professional mental health help. It has been reported previously that the stigma of depression contributes to how people cope with illness (Boardman et al., 2011).

As far as the stigma attached to seeking health care from non-medical health care providers was concerned, the findings supported that some women sought help from religious/spiritual healers. However, women only viewed it a stigma if they were tricked out of money. However, if healers directed women towards using religious/spiritual strategies and performing educational and cathartic activities, then seeking help from them was not viewed as inappropriate. As a medical health care provider it is important to recognize and explore whether or not women are seeking help from a variety of providers including medical and non-medical health care providers as reported in this and a previous study conducted in Pakistan (Pirani, 2009). Although less frequent, this finding drew attention to an important point that women may or may not be willing to integrate strategies providers suggest. Hence, providers must not feel content to just plan care but they must follow-up on the treatment plan on an ongoing basis.

Another important aspect this study finding alluded to was that in Pakistan not only are more professional mental health care providers needed but there is a dire need for professional female mental health care providers. This is because Pakistani women generally do not feel comfortable sharing their personal and intimate struggles or stressors with male mental health care providers. As discussed earlier, there are too few psychiatrists available in Pakistan and

there are even fewer female psychiatrists. In fact, there are no female psychiatrists in Baluchistan, the largest province, by area, of Pakistan. According to Niaz (2010) there are approximately 12 female psychiatrists in Pakistan. Naqvi and Khan (2005) shared their views about the dire need for female psychiatrists in the mental health care services by relating it to the example of the initial failure of the program to control diarrhea in which women bringing children for treatment were hesitant to seek advice from male doctors.

Religious/spiritual.

Religious/spiritual factors consisted of one theme: faith in God, an influence. Faith in God was viewed as the strongest influencing factor affecting the selection and implementation of strategies and it was perceived to be a strategy that had the power to heal. In one study with Pakistani women with depression, faith in God was reported to be a factor which assisted women to recover from depression and/or anxiety by decreasing their tension (Naeem et al., 2004).

In summary, influencing factors turned out to have nuances which definitely require further systematic exploration. Furthermore, the influencing factors should be assessed for each woman for their roles in the selection and use of self-management strategies. They should make sense in the lives of each woman while they are depressed and trying to manage and/or prevent depression.

Self-management Strategies

This study created a wealth of knowledge and understanding regarding self-management strategies. Based on the findings, the concept of self-management strategies turned out to have two sub-categories (see Figure 16). The first sub-category, perspectives on self-management

strategies, consisted of three themes. The second sub-category, specific self-management strategies and their perceived effectiveness, had nine themes.

Perspectives on self-management strategies.

The findings revealed rich perspectives and increased understanding about the concept of self-management strategies within the context of Pakistani women living a life with recurrent and chronic depression.

Three perspectives identified included: self-management strategies were learnt from a variety of sources, self-management strategy use required a conducive milieu, and self-management strategy use involved decision making (see Figure 16).

Findings related to self-management strategies revealed that women learnt about various strategies over time from several sources. These included self, family, friends, neighbors, mental health care professionals; a variety of literature; and from watching educational, health, and religious TV programs. Since women learnt from varied resources, it is important for health care professionals to not only identify what strategies women used but also the sources and extent of their influence on the selection and implementation of strategies. They can either facilitate or deter an ongoing self-management effort to live a life with depression.

For women to use self-management strategies, they required a conducive milieu. The findings indicated that for women to select and implement valuable and desired strategies they needed them to be feasible to use at a given point in time. They required a supportive environment that consisted of family expectations that did not compete with the self-management of illness and were stigma-free. Pedan and Lichstein (1996) indicated that a treatment plan should consider a patient's perspectives about the circumstances including

barriers surrounding implementing strategies that minimize jeopardizing the use and continuity of strategies. It was interesting that findings hinted at a possible linkage between influencing factors and perspectives. For example, with respect to interpersonal factors women shared that supportive and non-supportive roles of family and others contributed towards their selection and de-selection of strategies respectively. Similarly, in the findings related to perspectives on self-management strategies, that women required a conducive milieu clearly indicated its influence on their selection and implementation of strategies. Furthermore, the findings discussed in cultural factors that women perceived stigma attached to seeking help from mental health care providers was reiterated in the perspectives on self-management. For them to use strategies, they needed a stigma-free environment. Interestingly, although women shared that they questioned and refuted stigma, they sought treatment which could have been due to the influence of their education, a personal factor. Hence, all these three examples indicate how influencing factors could shape an individual's perspectives on self-management strategies.

The findings related to final perspective of self-management strategy use involved decision making are quite encouraging as they showed that women with recurrent depression are capable of making decisions regarding their health maintenance or sustenance. Their decisions were based on several conditions such as: symptoms variation from episode to episode, variation in the severity of depression; feasibility of the strategies; continuation of strategies, and individualized combination of strategies. This perspective has clinical relevance in that it indicates the value of understanding the extent to which women's decision making involved identifying, selecting, and using specific self-management strategies to manage and prevent depression. Health care providers, particularly mental health care providers must understand that Pakistani women have been shown to be actively involved in making decisions regarding

managing their depressive episodes and preventing its recurrence. They need to also understand that women's use of strategies depended on a number of complex factors: the severity of depressive episodes, impaired functional ability, perceived effectiveness of given strategies, personal goals and priorities, feasibility, barriers such as stigma and an available supportive and conducive milieu. This discussion about Pakistani women making decisions regarding what strategies to use to live a life with recurrent and chronic depression through identifying, selecting, and utilizing self-management strategies extend support that women should be involved and be considered as partners in decision making. This model; is one in which the clinician shares what could be most helpful to manage depression and the patient shares that what is suggested is feasible to implement given her personal and social milieu and personal priorities (Yeung et al., 2010). Therefore, partnering with patients by viewing them to be experts of their illness experience and assisting them to implement appropriate strategies are keys to creating a successful self-management plan to combat depression and improve quality of life.

Specific self-management strategies and their perceived effectiveness.

The second sub-category, specific self-management strategies and their perceived effectiveness, is comprised of nine themes. These themes are: (1) religious/spiritual, (2) help-seeking, (3) medication management, (4) self-help, (5) keeping busy, (6) cognitive strategies, (7) symptoms redirection, (8) unhealthy to healthy path, a transition, and 9) striving to meet self needs (see Figure 16).

These themes will be discussed overall, highlighting their unique features with respect to the management and prevention of depression. But before discussing these themes, what was learnt about frequency and perceived effectives of strategies will be briefly discussed.

Frequency of using the same strategies varied quite a bit from woman to woman. Therefore, it was not possible to describe any set format or pattern regarding the use of identified strategies. Here is an example that demonstrates the importance of assessing each patient's frequency of use of self-management strategies. For example, as discussed in results related to religious/spiritual strategies that though all Muslims are expected to pray five times a day, variations existed. Some women were regular in prayers, others found it hard to perform morning prayers, others found it hard to perform evening prayers, and some just could not perform them at all in acute depression. Hence, women with depression might be using similar strategies, but the way they use and incorporate them in their daily life can be very individualized. Therefore there is a need to understand patient's perspectives about the facilitators and barriers that influence the desired frequency of the self-management strategies they have identified to manage or prevent depressive episode.

No other studies reporting the frequency of use of self-management strategies in Pakistani women with depression were found. However, studies conducted with patients self-managing other conditions such as dyspnea (Carrieri & Janson-Bjerklie, 1986; Christenbery, 2005; Nield, 2000) provided mixed results. Some studies demonstrated variations in the frequency of use of strategies amongst participants (Carrieri & Janson-Bjerklie, 1986; Nield, 2000) while others did not (Christenbery, 2005).

It was beyond the scope of the current study to identify specific factors involved in the variation of frequency of use of a variety of strategies. However, it would be worth exploring in future studies to develop a better understanding about the frequency of use of self-management strategies. The literature, however, indicated several factors involving the variation in the frequency of use of self-management strategies such as perceived effectiveness (Hammond,

1998), perceived burden associated with performing strategies (Weijman et al., 2005) better and formally educated about the strategies (Christenbery, 2005), and length of use and trying out multiple strategies (Keysor et al., 2003).

In this study, the variations of the frequency of use of strategies clearly indicates the need for health care providers to consider assessing each patient's frequency of using strategies, even for those strategies whose frequency of use is much more predictable.

Pakistani women described their *perceived effectiveness* of specific self-management strategies in terms of whether they were helpful or not to manage or prevent depression. A significant finding was that their perceived effectiveness changed over time. Hence, perceived effectiveness was not a constant; rather, it evolved over time and could change from being helpful to not helpful and vice versa. For example, some women discontinued taking medication(s) initially due to their side effects. However, over time they learnt the need and importance of continuing to take medication. Similarly, some women sought help from religious/spiritual healers hoping that it might help. However, over time most discontinued them as they did not perceive that the strategies religious/spiritual healers suggested were acceptable or helpful. Hence, this finding should alert health care providers to assess women's perceived effectiveness of strategies over time as their perceived effectiveness about the use of a particular strategy was not constant. Lastly, since perceived effectiveness was studied in terms of helpful and not helpful, future studies should consider exploring a range or continuum of the effectiveness (Eller et al., 2005) of strategies. The rest of this section is dedicated to discussing the nine themes and women's views about them.

The *religious/spiritual* strategies included having faith in God and ways of connecting with God. In the literature, religious/spiritual strategies have been studied within the context of a

variety of serious and chronic medical illnesses (Koenig, George, & Titus, 2004; Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011). The role of religious/spiritual strategies is increasingly recognized for its healing role in mental illnesses as well. This study's finding related to religious/spiritual strategies is one such example. The findings underscored the extensive, valuable, and pervasive contribution of religious/spiritual strategies for managing and preventing recurrent depression. Although performing religious/spiritual strategies was not without a struggle during acute depressive phases.

In this study, women's use of religious/spiritual strategies helped them in two ways. The first and most direct way was having faith in God. Faith in God helped women as it made them recognize God's power to solve their problems and created a sense of hope. The literature reported hope as a vital element in recovering from mental illness (Noh, Choe, & Yang, 2008). In this study the findings related to hope conveyed information that some nuances of it would be worth exploring in future research. For example, hope was viewed as a stand-alone strategy as well an extension of faith in God. In addition, the presence of hope was viewed as an absence of depression, since depression was conceived by some as feeling hopeless.

The notion of faith in God as a source of healing supported what Gadit (2007) discussed that, "The concept of God and faith in 'His' powers can help an individual in times of mental upheaval" (p. 522). The author raised questions regarding the need to incorporate a spiritual component in medical and post medical education curricula in Pakistan. Similarly, it would also be worth considering incorporating a spiritual component in Pakistan's nursing curriculum since nurses need to learn to provide holistic care and help patients learn to manage and prevent illnesses including mental illnesses.

The findings also alluded to a second, most reported, and an indirect path that is that women connected to God by getting involved in a variety of religious/spiritual activities. It was the influence of faith in God that promoted women's belief in their own abilities and directed them to select religious/spiritually driven strategies such as performing prayers, reciting the holy Quran, talking to God, and performing pilgrimage. Compared to other reported ways of connecting to God, only a few women shared that performing a Pilgrimage was a way to manage and prevent depression. This could possibly be due to the financial implications associated to with it.

All these religious/spiritual activities were women's way of connecting with God, although they were not without struggle. For example, some women struggled to keep up regularly performing specific time of day prayers such as performing early morning or evening prayers due to depression or depression related treatment effects. On the contrary, prayers were either performed regularly or more than the obligatory prayers due to their therapeutic effect. This finding of prayers having a therapeutic effect supported Hawley and Irurita's (1998) qualitative study of patients with coronary artery bypass graft surgery who engaged in praying and sought comfort in it. All the women in this study reported that praying was a way to connect with God. However, in clinical practice, praying is not usually discussed or recognized as a way to regain and sustain wellbeing. For example, McCaffrey, Eisenberg, Legedza, Davis, and Phillips (2004) conducted a national survey in the United States of America in 1998 and reported that of those who participated in the survey 35% used prayers for health related concerns, 75% used it for wellness, and 22% used it for a specific medical condition. Of all those who used prayers for specific medication conditions, 69% reported prayers to be very helpful. Yet most of the survey participants did not discuss prayers with their doctors. This overall discussion of

findings related to religious/spiritual strategies clearly indicates that health care professionals should take the initiative to explore religious/spiritual strategies and their effectiveness in dealing with recurrent depression. As Sims (2000) commented:

> In clinical practice psychiatrists are severely limited in their capacity to help patients unless they study their 'human cultural psychology ... world views, models of thought, interpretation of emotions, notions of personhood, and sense of cosmological spiritual placement in the universe that includes religion'. Until recently all aspects of culture have been relatively ignored by psychiatrists in the treatment of their patients, compared with the attention given at biochemical and pharmacological aspects of mental illness and to the psychodynamics of the individual in isolation from his family or microsociety. (p. 536)

Help-seeking strategies included help-seeking from professional health care providers which included both non-mental health care providers (including general practitioners and neurosurgeons) and mental health care providers; and help-seeking from non-professional health care providers which included religious/spiritual healers. The findings added some interesting perspectives about help-seeking behavior of Pakistani women with psychological health related problems.

More women approached general practitioners than other specialists. The reason of approaching either of them was that they lacked or had a limited understanding about their psychological concerns which was compounded by overwhelming physical symptoms (Naqvi & Khan, 2005; Schuyler, 2000). This was further compounded by other cultural factors discussed earlier such as stigma (Afridi, 2008; Schuyler, 2000) associated with depression (Naqvi & Khan, 2005; Schuyler, 2000; Suhail, 2005; Syed et al., 2007) and seeking mental health care services

(Cheung et al., 1981; Karim et al., 2004; Khan & Reza, 1998; Knapp et al., 2006; Weatherhead & Diaches, 2010). This situation became even more complex when general practitioners were not able to correctly diagnosis depression. Women reported that they found general practitioners not to be helpful when they were unable to diagnose depression. This finding is consistent with Pols and Battersby's (2008) most significant finding that general practitioners underdiagnose depression due to their prime focus on physical symptoms (Pols & Battersby, 2008). In addition, women viewed providers' roles as limited and not helpful when they overemphasized and prescribed excessive amounts of medications. This finding is consistent with Rüdell, Bhui, and Priebe's (2008) findings that participants viewed general practitioners as unhelpful when they focused too much on medication use. Hence, the value of training general practitioners and other specialists to recognize and identify depression (Naqvi & Khan, 2005) so they can refer women to professional mental health care providers cannot be overemphasized.

Once women started seeking help from professional mental health care providers and once they were diagnosed with depression, they stopped seeking help from general practitioners and other specialists for concerns associated with depression. This finding implies that if women's battle with depression is identified early and they are referred to mental health care professionals in a timely manner it would alleviate their struggles of continuing to seek help from multiple sources. It would also save time and money, and above all it would minimize their struggle of living with untreated depression and improve their quality of life.

With respect to help-seeking from non-professional health care providers, the findings revealed that women were personally not too motivated to seek help from religious/spiritual healers; it was usually family, friends, or colleagues who guided and motivated them to seek help from them. And even if they were, they were only comfortable seeking help if healers did not

intend to pocket their money. Women's lack of interest and motivation in seeking help from religious/spiritual healers was evidenced from the fact that those who sought help discontinued quite quickly and only a couple of women continued over time. In short, what is learned from the findings related to women seeking help from religious/spiritual healers is that their social network played an important role in motivating them to seek help from healers. Lack of women's personal motivation towards seeking help from healers needs further investigation to understand why this pattern existed and why their social network motivated them to seek help from healers. Was women's lack of motivation because they were from or currently residing in urban areas, were mostly educated and from an upper socioeconomic background, or seeking help and health education from other medically oriented health care providers. It is possible that these characteristics affected their perceptions, attitudes (Karim et al., 2004), understanding about the cause of mental illness and influenced their views about seeking help from healers.

The drawback of the societal preference for seeking help from religious/spiritual healers with respect to the early identification, diagnosis and management of depression is not only one of increased costs but more importantly one of wasted time on ineffective ways of managing psychological conditions thereby compounding the health condition of women and adding to their struggle of living with depression. However, as suggested in the literature that since there is a cultural preference towards seeking help from religious/spiritual healers (Mubbashar & Saeed, 2001; Suhail, 2005; Syed et al., 2007), they could be an asset if they were trained to recognize and identify depression and could contribute to the early recognition and timely referral to a mental health care facility for treatment which would minimize women's struggles and suffering associated with untreated and unmanaged depression. This suggestion of training religious/spiritual healers somewhat resonates with what Mubbashar and Saeed (2001) discussed

that Pakistani people generally approach faith and religious healers for their mental illness related concerns. Involving healers in providing mental health services could be beneficial.

An important finding in this study is that the women who participated sought help from a variety of sources at the same time. This is consistent with other recent qualitative research with Pakistani participants (Pirani, 2009). Similarly, this finding of seeking help from multiple sources was also reported as a norm in another study which aimed to understand help-seeking strategies for dealing with mentally distressing experiences (Rüdell et al., 2008). Nonetheless, that it is a norm in Pakistan across a variety of ethnic groups to seek help from multiple sources is yet to be determined.

Medication management comprised of antidepressants and anxiolytics. As expected, all women had or were using some type of medication to manage their symptoms; the most common types reported were antidepressants followed by anxiolytics. Besides taking antidepressants or anxiolytics to manage and prevent depressive episode, some women took analgesics, multivitamins, and Isabgol. This finding of using an array of non- psychotropic medications to manage physical symptoms supported the view that Pakistani women presented depression more through somatic symptoms than cognitive or psychological symptoms (Naqvi & Khan, 2005).

Using medication to manage depression (Rafique, 2010) is often reported in the literature. Antidepressants were the most common group of medications used to manage and prevent depressive symptoms. Women shared both positive and negative views regarding using antidepressants. This use is consistent with Rafique's (2010) findings in which Pakistani women with depression, residing in the UK, shared mixed views about using antidepressants. Rafique reported that women shared that antidepressants had a positive impact on their cognition and sleep but a negative impact in that they experienced a variety of side-effects.

Women's positive views were mainly related to the effectiveness of medications to manage and prevent depressive episodes. Negative views were mainly related to medications' side-effects, financial struggles to purchase costly medications, distorted view of living a normal life, and the disapproval of significant others towards the use of antidepressants. These negative views about medications discouraged them to continue their use. These findings have important implications for clinical practice. For example, patients must be encouraged and supported to use medications to manage and prevent depression. They must be informed about the value of continuing the use to prevent worsening symptoms and future episodes and to meet their personal goals. All of their concerns must be discussed and addressed to ensure they continue to use medications. Clinicians need to inform patients of the side effects (Lin et al., 2003), using medications in their daily schedule, the risks of self-regulating the dose, the importance of using medications regularly, and ways to address the negative personal and family attitudes towards taking medications (Lin et al., 2003).

Compared to using antidepressants, only half the women used anxiolytic agents which they continued only when they perceived them to be helpful in managing anxiety related symptoms during depressive episodes. When women perceived that using anxiolytics was not helpful, such as when they experienced their addictive nature, their short term effectiveness and that they interfered with their daily routine, they stopped using them. They then resorted to other strategies to manage their anxiety related symptoms such as reciting the holy Quran and God's names. In terms of implications for clinical practice, it is important to ask the patient about self-medicating with anxiolytics, evaluate their need to continue or discontinue them, and educate them about a variety of non-pharmacological ways to manage anxiety-related symptoms.

Self-help included: personal motivation, positive self-talk, inner strength, and moving on. Except for personal motivation which many of the women used, very few women used the others. However, it was impressive to learn that women who lacked or had limited social support used strategies that focused completely on self to heal in the midst of living a life with recurrent depression. Though some strategies were a struggle during acute phases of depression, in the recovery phases women used them to manage and prevent depression and to learn and grow from their experience of depression. For example, the findings related to moving on captures the essence of women's perceptions of their relationships and their family members' tolerance of their struggles with depression which left them no other choice than to get back to their usual routine life. Though women experienced moving on harshly, it eventually assisted them to re-develop interest in their house work and regain a sense of normalcy in their family's lives.

In this study, women discussed using a variety of self-help, self-driven strategies that did not require professional guidance (Morgan & Jorm, 2008). Morgan and Jorm (2008) systematically reviewed literature on randomized controlled trials aimed at examining self-help related interventions for depressive disorders or depressive symptoms. They concluded that a variety of self-help driven interventions lend convincing support for decreasing sub-threshold depressive symptoms.

It is important to note that women not only used self-help strategies but they also used multiple strategies that involved seeking help from external sources such as professional mental health care providers. Thus, the question remains for further investigation whether the use of self-help strategies alone could be equally or less effective in managing and preventing depression if they were used in combination with a variety of other non-self-help strategies. On

a similar note, there is a need for further empirical evidence to determine the difference in the effect of the use of none, single, and multiple self-help strategies (Rüdell et al., 2008).

Keeping busy strategies included: reading, watching TV, doing housework, going out of the home, engaging in physically strenuous activities, sewing, and being formally employed. Reading, watching TV, doing housework, going out of home and engaging in physically strenuous activities were more common reported strategies than sewing and being formally employed. Keeping busy aimed at diverting women's minds from distressing thoughts and circumstances which had contributed or could contribute to the recurrence of depressive episodes. Women shared that they struggled to use activities to keep them busy in acute depressive phases; however they perceived them to be helpful if they were able to do them. It is important to note that women's selection of activities to keep busy was primarily based on their personal preferences and what interested them, what they believed would capture their mind, and what would be feasible in terms of the support required to engage in them. These findings have clinical practice related implications in which clinicians could play an important role in not only helping women identify keeping busy related activities that would divert their minds, are recreational in nature and would assist them to recover and regain a prior level of functioning (Dade, 1947) but also encourage women to adhere to those activities, such as adhere to an exercise plan (Marcolina, 2007).

Many women read to manage an acute depressive episode, though they struggled during an acute depressive to keep up with their regular reading pattern. Women who were able to read during a depressive episode reported that it was a helpful strategy. These women, however, did not articulate the role of reading to prevent future episodes of depression even when it was a diversional activity. Reading as a strategy to manage and prevent depression remains to be

explored. Women read on a variety of topics including life stressors, depression and its management, and religion related readings such as the holy Quran and its translation and Islamic literature. Several studies have reported that people with affective disorders read as a strategy (Linden, Gehrke, & Geiselmann, 2009; Pedan, 1994). For example, Pedan's (1994) study on strategies women who were recovering from depression used reported that women used reading only to seek information about depression and its treatment. The interesting finding of this study was that some of the women switched their reading preferences altogether towards religion-related reading. This indicates how women incorporated faith and religion into various aspects of life and how much they valued recovery from an illness.

More than half of the women who participated in the study watched TV to divert their minds from distressing thoughts and to keep them busy in a passive activity. The increased use of this activity could be explained due to its feasibility to do any time of the day. It did not require external support or involvement and was effective in managing and preventing depression. This finding of TV watching is consistent with Linden et al. (2009) findings with patients with affective, anxiety and other neurotic and personality disorders. They reported that watching TV was the most frequently used passive recreational activity of subjects' lives. It would be interesting to make a comparative analysis between what makes women choose or prefer active versus passive recreational strategies and their effectiveness in managing and preventing depressive episodes. Such an understanding would assist health professionals to help and guide women to find their best active versus passive recreational activities to manage and prevent depressive episodes.

Involvement in physically strenuous activities such as exercise/workout, walking, yoga, and a sport was perceived to be helpful in managing depressive episodes and in preventing

depressive episodes. This finding is consistent with the literature (Teychenne, Ball, & Salmon, 2010; Sanchez-Villegas et al., 2008; Marcolina, 2007). Findings indicated the important role of a social network such as family members (Azar, Ball, Salmon, & Cleland, 2010) and friends in engaging women in physically strenuous exercises. Keeping busy was only possible with their support in creating a conducive milieu. Women's social network needed to be involved in physical activities such as accompanying them outside for a walk, financially supporting them or enrolling them in a gym or health club. Besides creating a conducive milieu, friends helped provide an opportunity for women to exchange their personal struggles and views and ways to deal with them. Besides family and friends, the role of psychologists, and psychiatrists in suggesting, motivating, monitoring and helping women to adhere to an exercise plan to meet their personal goals was also considered to be helpful. It is consistent with what Marcolina (2007) reported in her article about the role of professionals to encourage adherence to an exercise plan. Further empirical investigations are needed to explore the relationship between the role of a woman's social network and her engagement in exercise and physical activities.

Although being formally employed was one of the least frequent activities women considered to keep them busy, women's perspective provided important insights about the positive role of formal employment to manage and prevent depression. Women who were working shared a desire to continue their employment; however, they acknowledged they struggled to be employed while depressed. Some of the benefits they indicated were: keeping busy, mind diversion, change of environment for several hours each day, making them feel functional and productive, a morale boaster, meeting personal goal of serving others, and earning money to support the family. These findings are quite valuable and indicate the need to conduct future research on the cost-benefit of being employed to manage and prevent depression. The

literature discusses the costly impact of depression due to its limiting chances for or sustaining employment (Marcotte & Wilcox-Gök, 2001) versus the benefits people gain from being employed to manage and prevent depression. Research should be undertaken to determine if women are able to sustain their employment (Birnbaum, Leong, & Greenberg, 2003) while simultaneously leading a life with chronic and recurrent depression.

Cognitive strategies comprised of thought restructuring and focusing on the present rather than on the future or the past. Fava, Rafanelli, Grandi, Conti, and Belluardo (1998) reported cognitive restructuring to be effective in managing and preventing depression. In this study, however, very few women used thought restructuring to deal with stressful and troubling life situations such as spousal abuse and troubled relationships with in-laws. Does it mean that Pakistani women do not prefer to use cognitive strategies? Do Pakistani women prefer strategies that involved them physically and not cognitively? Why were cognitive strategies not used by most women when they used medications and were also seeking psychological help from psychiatrists and psychotherapists? These questions are yet to be systematically studied.

The findings related to focusing on the present rather than on the future or the past were reported to be effective when combined with medications and counseling. It would be helpful to study the use of cognitive strategies and their effectiveness when women are or are not using psychotropic medications and/or counseling. Nonetheless, the current findings are encouraging. Although many women did not use them, they provide some insight into their effectiveness in managing some of their symptoms of depression such as self-blaming, negative thinking or distressing thoughts.

Symptom redirection comprised of social disconnection: isolation and hibernation; changes in eating pattern, i.e., loss of appetite; and crying. These findings demonstrated that

some women were able to give a positive twist to some of their symptoms of depression. The findings related to symptom redirection are quite unique and striking.

Social disconnection was the most reported strategy of the three reported symptoms grouped under symptom redirection. Social disconnection was viewed as a way to save their significant relationships and a time to recuperate from depression. The most intriguing part of this strategy was that women used it cautiously and for a limited time due to their central role in fulfilling family roles and responsibilities. Otherwise social disconnection could potentially become non-therapeutic as it could cause women to be more depressed through isolation and loneliness.

The findings related to changes in eating pattern, i.e., loss of appetite, in depression were positively construed to be a way to meet women's personal goals of losing weight. Similarly, the symptom of crying was reframed as a therapy in itself. Of the three symptoms that were positively redirected, crying was the only one that was considerably reported on in the literature to positively contribute to wellbeing through its cathartic effect. Bylsma, Croon, Vingerhoets, and Rottenberg (2011) recently studied crying and its relation to improving mood. They reported that the affective outcome of crying depended on multiple factors such as the antecedent events that brought on crying, the crier's affective condition, and the response of others towards crying. It would be interesting to conduct similar research with Pakistani women to explore the cross-cultural differences associated with crying to manage and prevent depression. This new approach of looking at the symptoms of depression requires systematic inquiry to more fully understand the phenomenon of symptom redirection.

Unhealthy to healthy path, a transition comprised of anger at self and at others, and anger tolerance. This is the only group of specific strategies that indicated that women do not always

use healthy strategies to manage or prevent their illness. The most fascinating part of this finding was that half of the women who used anger at self and at others made a conscious effort to transit from using unhealthy strategies such as anger at self and at others to healthy ones such as anger tolerance. Because they learnt that such venting and acting out though helpful was not without serious negative consequences in terms of strained relationships, anger retaliation, and physical abuse.

The findings related to anger at self and at others and anger tolerance share some commonality with Jack's (1991) silencing of self-theory that incorporates anger expression and anger suppression. Jack's study found that some women who got angry at self and at others resorted to tolerating their anger over time to avoid further negative consequences of angry reactions from others and loss of closeness with their spouses. According to the self-silencing perspective (Jack, 1999), women have a higher tendency than their male counterparts to self-silence in intimate relationships to sustain relationships and to conform to traditional female gender roles. In Pakistan, a patriarchal society, women are brought up to be sub-ordinate to men and are discouraged to overtly express their anger. However, women in this study mentioned that during depression they experienced an increased likelihood of overtly expressing anger at self and at others. Women expressed anger at self through self-harming activities such as beating or hurting self or having thoughts of self-harm. They beat themselves, banged their head against the wall and or overdosed on medication. However, not everyone who expressed anger at others expressed it towards husbands and in-laws due to fear of strong retaliation and jeopardizing their relationships. Rather they expressed their anger by screaming at children, servants and parents who were regarded as safe. This response somewhat agrees with what Jack (1999) noted. According to Jack (1999), women generally have a tendency to self-silence and suppress anger.

If they sometimes express anger, it is either inappropriate or they express it towards innocent others.

The factors that contributed towards women's effort to transition from an unhealthy to a healthy response were based on their internal evaluation of the negative consequences of expressing anger at self and at others, their religious background, and seeking guidance from the preaching of Islam particularly that suicide is a sinful act.

This finding of transition provides evidence that women's selection of strategies changes over time. The idea of transitioning needs further investigation within Asian cultures to understand and clarify whether the expression of anger is later replaced by suppression of anger or vice versa. Jack (1999) argued that women's self-silence and anger suppression contributes towards their depression; however, sometimes they express anger, frustration, and rage. Similarly, this study finding that suggests that women express anger towards self and others more often while in a depressive episode needs further investigation. In addition, the role of anger tolerance and whether it contributes to the occurrence and recurrence of depression needs to be explicated. Lastly, further understanding of women's transitioning over time might have significant clinical implications. Providers can assess the existence of angry outbursts and anger tolerance and their role in the recurrence and worsening of depression and intervene accordingly.

Striving to meet self needs included socialization, rest and sleep, and involvement in self-care acts. The findings related to striving to meet self needs validated some behaviors that have been observed in clinical practice of Pakistani women with psychological health related problems and added some interesting perspectives as well.

Socialization was the most commonly reported strategy followed by rest and sleep and involvement in self-care acts. The findings related to socialization that included women talking

to someone (Vikan & Dias, 2009) to manage depression is consistent with the literature. In addition, the findings clearly indicated that women were selective with whom they talked to about their personal struggle with illness and who they felt supported them in their struggles with illness management. Interestingly, those who supported them in their personal struggles with illness were not always a family member; rather they included health care related personnel and God. Hence, while working with women with recurrent depression, it is important to understand who women view as their social network, from whom they seek support, and with whom they socialize beyond immediate family members or friends. The question is why family members or friends were not always viewed as part of women's network for social support but that interacting with health care providers and God were perceived as supportive. The literature provided insights that social relationships and their interactions do not always have a positive impact but rather sometimes have a negative impact (Ibarra-Rovillard & Kuiper, 2011; Vangelisti, 2009) on patients' management of chronic illnesses.

Disler et al. (2012) presented an extensive review of the literature that illustrated that healthcare professionals performed varied and extensive supportive roles within the framework self-managing illness. Similarly, in this research, most women shared about the comprehensive and positive roles of their professional mental health care providers and chose to interact or socialize with and continue to seek help from them. Finally, the finding that women chose to socialize with higher powers seems to have been a safe and private undertaking as there was no risk of negative consequences.

Rest and sleep, and involvement in self-care acts were usual struggles and management strategies for depression. With respect to self-care and sleep and rest, women revealed the strong contribution their families made in encouraging and expecting them to get involved in self-care

and did not allow them to sleep and rest for long periods. Though women perceived such acts as uncaring, mistreatment, and misunderstanding and sometimes caused tension in their relationships, they had a therapeutic effect by preventing women from becoming aloof, disconnected and distant from family and family responsibilities. In addition, it assisted them to have no choice than to regain interest in their lives. This finding of family supporting and encouraging women to get involved in self-care and discouraging their sleep and rest time lends support to the understanding that though individuals self-manage chronic illness it takes place within family and community contexts (Grey et al., 2006). This finding supports the influence of the interpersonal factor on the use of self-management strategies. Similarly, the other themes added expected and quite interesting perspectives regarding women's ways of protecting and saving self and significant personal relationships by their avoiding/escaping stressors and keeping quiet. Participants perceived that if given an opportunity to avoid/escape and to remain quiet even if it is for a short period of time, they could save long, invested relationships, they could get some time to recuperate from the effect of illness and could pull themselves together to reenter their usual life routine. The use of such strategies to save family relationships are in accordance with the values of the collectivistic culture of Pakistan where family or community needs are significantly valued and their goals have priority (Ahmad, Driver, McNally, & Stewart, 2009).

Implications for Research

Throughout this chapter, a variety of areas were identified that need further systematic investigation. There is compelling evidence to support the use of self-management strategies to manage and prevent a variety of chronic illnesses including depression. This pioneering,

qualitative research added new and valuable insights and understanding about the factors influencing Pakistani women's use of a variety of self-management strategies. Further systematic exploration is needed to develop evidence-based clinical practices in mental health care delivery that incorporate self-management strategies.

First, research should be conducted to determine clinicians' perspectives about the patient-provider partnership and the barriers to adapting such a framework of clinical practice within the constraints of current mental health care delivery systems.

Second, the aim of this study was to qualitatively describe the factors that influence self-management strategies. Now that a variety of thematic factors have been described in the study, what is needed is to examine the nature of the influence of each of them on each of the specific self-management strategies. In addition, as mentioned earlier, nuances were identified regarding the influencing factors. Some influencing factors influenced strategies and/or depression. This finding needs further systematic investigation to explain the role of influencing factors on strategies and on depression. Such an understanding is imperative to make sense of the complex interconnectedness amongst the variety of factors coming into play in the lives of patients with depression.

Third, there is a need to study self-management strategies across a variety of populations and genders to inform theory development on self-management strategies for recurrent depression.

Fourth, there is a need for clinical trials to test the comparative effectiveness of the common, established therapies for depression and the individually designed self-management strategies. Such research would inform both providers and patients about the relative benefits of using self-management strategies on an ongoing basis during and after a depressive episode.

Finally, there is a need to develop and test tools that could be clinically employed both within and beyond clinical settings to determine patients' use of self-management strategies, to monitor their progress in the use of self-management strategies including factors influencing those strategies, and that evaluate the effectiveness of strategies in terms of managing and preventing depressive episodes.

Implications for Practice

Current knowledge suggests that depression is more common in Pakistani women than in men (Ali et al., 2002). For many, depression is a recurrent and chronic disease (Greden, 2001). Learning and understanding strategies women use to self-manage their depression, what factors influence women's use of self-management strategies and their effectiveness have particular relevance for the mental health care delivery system including nursing practice aimed at managing and preventing depression.

The findings of this study, with future cross-cultural research across the globe regarding strategies, have the potential to change the role of mental health care professionals, particularly nurses, and the way the mental health care of women with depression could be packaged and delivered in Pakistan and beyond. The findings of this study illustrated a wide gamut of strategies that Pakistani women used, including religious/spiritual, help-seeking, medication management, self-help, keeping busy, cognitive redirection, symptom redirection, unhealthy to healthy path, a transition, socialization, and striving to meet self needs and beyond. These self-management strategies provide a perspective for holistic care for women with depression to help them accomplish their goal of recovery and sense of wellbeing. Moreover, each of these categories is broad and consists of a variety of strategies that may provide inroads to working

with women to effectively manage and prevent depression. For example, the knowledge generated from this study on strategies could be used to explore each woman's use of strategies for developing an individualized collaborative plan of self-management strategies to combat depression and/or to prevent it. Health care professionals need to spend time with their patients discussing each of the strategies identified in this research to assess their personal priorities and motivation; the feasibility of implementing and incorporating strategies in their daily routines; and the availability of needed social support, to name a few. Hence, if a woman agrees to take medication to manage and/or prevent depression, then simply prescribing and imparting knowledge about the medication itself is not enough; it is important to talk about the woman's perceptions, attitudes, motivations, and barriers (financial status, social support, stigma, or any other perceived barriers) that might come into play in implementing and sustaining the use of self-management strategies.

The findings of this study indicate the importance of involving, collaborating, and partnering with women to manage depression and to develop a feasible plan of holistic care that they can effectively execute in their daily life with minimum impact on meeting their personal goals and achieving functional ability to prevent recurrence of depressive episodes. In summary, providers should partner with individuals and groups living with chronic, recurrent depression to offer them tailored holistic care (Yeung et al., 2010). Health care providers partnering with patients to promote their self-management of depression is a shift from Pakistan's traditional health care delivery system of quickly fixing problems through professional treatment where the provider is on the giving end and patient is at the receiving end.

One finding in this study revealed that women heavily relied on and used a variety of religious/spiritual related self-management strategies. In the last decade or so there has been

growing evidence supporting the link between focusing on and meeting clients' religious/spiritual needs to improve their mental health and wellbeing (Koslander & Arvidsson, 2005, 2007; Koslander, da Silva, & Roxberg, 2009). Similarly, the knowledge generated from this study supports the recent trials of augmenting cognitive behavioral therapy by incorporating a spiritual dimension into it for clients with mental illness, including depression. For example, D'Souza and Rodrigo (2004) analyzed controlled studies in which spirituality was incorporated into cognitive behavioral therapy. They reported that incorporating spirituality in cognitive behavioral therapy over 16 therapy sessions benefitted study participants to manage their hopelessness and despair. In addition, improved participant collaboration in the treatment enhanced their functional recovery and decreased their rates of relapse of mental illness. Incorporating spirituality into cognitive behavioral therapy for Pakistani women would provide a culturally specific intervention for them to manage and prevent a relapse of depression.

Nonetheless, it is extremely important for health care professionals to be cognizant of a possible tendency to overindulge in a particular set of strategies to manage or prevent depression, for example focusing solely on religious/spiritual strategies. Hence, health care professionals have to not only understand and delineate strategies but also help women to create a more balanced set of strategies which includes a combination of a variety of strategies that are feasible for them to perform, addresses their personal goals, and that would keep their interest and motivation to continue their use during the struggled period of depression and when not depressed.

Pakistani nurses can also make a valuable contribution to prevent depression in women. In Pakistan, people in general and women in particular are struggling with poverty, limited opportunity to get educated, basic amenities not readily available that ensure safety and security.

In addition, there is limited access to quality health care in general and a dearth of professional mental health care services and professionally trained mental health care providers. Pakistani nurses practicing in a variety of clinical environments, particularly those working at the community health level, could play an integral role in preventing depression in women. They could promote mental health literacy for women and their families. They could share health education that focuses on the variety of factors that interplay in influencing depression and the gamut of relevant and feasible self-management strategies. In addition, health education could address ways to identify influencing factors such as information about the role and value of a supportive and healthy home and work environment, early identification and recognition of culturally specific representations of depression, ways to combat stigma associated with depression and seeking treatment for such psychological distress. This study provides nurses with information on a life style that incorporates the use of self-management strategies to prevent depression by communicating the importance of seeking formal professional mental health care in a timely and regular manner.

Similar recommendations are discussed in the literature that outlines ways to prevent depression. For example, in a consensus paper published by the European Communities, Walhbeck and Mäkinen (2008) emphasized the importance of mental health education, ways to address stigma, and implementing relevant and effective mental health policies, to name a few. The review of literature related to depression in Pakistan and ways to address this mental health concern as discussed earlier also endorsed the need for upgrading social living conditions, educating the public on depression through mass media, and training of primary care physicians to ensure early diagnosis and timely management.

Implication for Nursing Education

Based on this research's findings, and other research evidence, that people use self-management strategies to manage their illnesses supports the importance of integrating the concept of self-management strategies into the nursing curricula. The nursing curricula in general and the nursing curricula in Pakistan, in particular, needs to reflect on the inclusion and emphasis on the concept of self-management strategies in managing and preventing chronic illnesses across the various nursing practice specialties.

Nursing and medical education and practice requires a conceptual shift, especially with respect to self-management strategies, in the delivery of care from health care providers in prescriptive roles to health care providers in partnering roles with patients. This shift requires nurses to not only be taught about the concept theoretically but they need to be given opportunities to practice implementing self-management strategies in a variety of clinical settings with a wide range of chronic illnesses. This will expand their understanding that patients' use self-management strategies is unique to their milieu which is filled with a variety of factors that support or hinder their use of self-management strategies. This will also enhance their competency in working with patients on using of self-management strategies.

Study Strengths and Limitations

In this study, the credibility of the findings (i.e., the validity of the findings) was derived from the data collection process, from collecting rich data and from soliciting feedback from and discussion of the findings with an expert in self-management strategies throughout the data analysis.

Two independent reviewers with a nursing and education background reviewed the same one interview and coded it using the given code list. These were compared with the investigator's to ensure the reliability of the findings. In addition, throughout the analysis process, an effort was made to ensure logic, clarity, and the appropriateness of categories, sub-categories, and themes to reach the most plausible interpretations in relation to the study context. Special attention was paid to the reliability of the coding process such as ensuring that the emergent categories were separate, independent, and mutually exclusive.

It is important to report that the data collection and analysis methodologies used to address the research questions were appropriate. Data collected through repetitive semi-structured interviews using an interview guide and using open-ended questions allowed the investigator to respond to each individual woman's differences in the way they responded and assisted in obtaining detailed, complex, and interrelated descriptions of women' experiences of depression, factors influencing their self-management strategies and self-management strategies that were deemed relevant and appropriate to the aims of the study.

That the themes were not validated with women might be viewed as a limitation. However, having more than one interview to fully understand women' perspectives about the study aims and reaching saturation in the data collection strengthened the trustworthiness. Although the sample size was from a recognized private mental health care setting, the findings are still transferable and applicable to similar contexts.

Location from where the data was collected could be viewed as potentially limiting because women were selected from one of the most recognized mental health care services settings in the private sector, in an urban settlement, known for providing quality mental health care services. Therefore, the patients who had access and could afford to seek help from the

setting and their experience of seeking help from quality mental health care providers might have influenced their selection and use of self-management strategies and might not have captured the views of all women with depression who do not seek quality mental health care services.

Since the investigator who is bilingual was responsible and involved in transcribing all the interviews in Urdu and translating them into English and since there was only one randomly selected interview translated into English by an expert in both Urdu and English this might be viewed as a limitation. However, the investigator listened to each of the interviews several times and cross checked the English translations with the actual Urdu transcripts to ensure that the women' intent was captured besides back translating additional three randomly selected interviews.

Similarly, the huge data set of 27 qualitative interviews and thick descriptions risked the possibility of losing an important angle describing the themes and could be seen as a limitation. To minimize this loss, the investigator used ATLAS.ti, a qualitative analysis software, to aid in organizing, managing, and qualitatively and thematically coding and analyzing the transcribed interview data.

It is very likely that not all the thematic factors influencing strategies and the wide range of self-management strategies were captured. However, this study provides valuable and rich insights about the factors that influenced identified strategies, women' use of strategies and the management and prevention of recurrent depression.

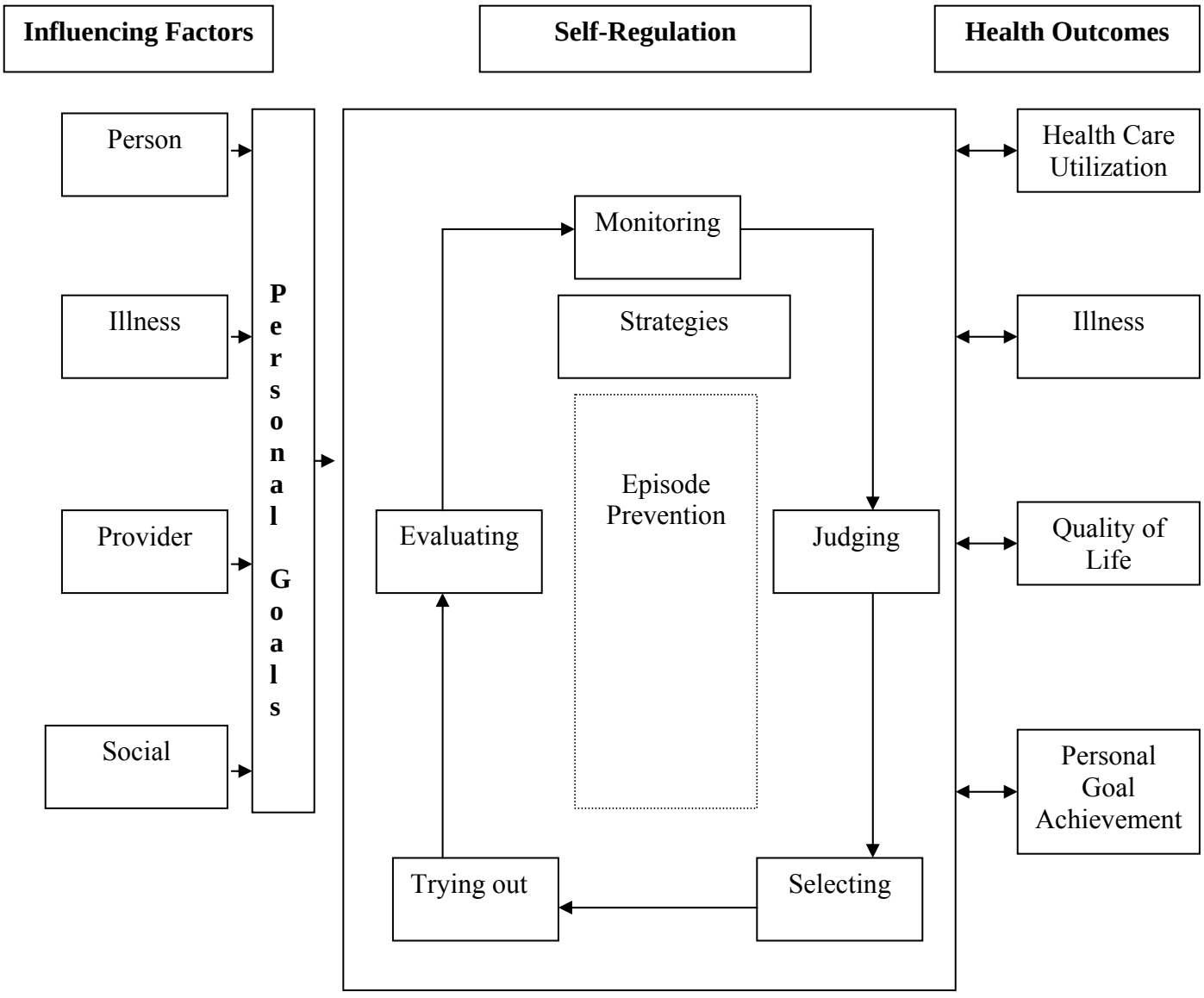
Summary

This novel and pioneering qualitative research of Pakistani women's use of self-management strategies for recurrent depression is a valuable addition to the literature on

Pakistani women with depression and self-management strategies. The findings covered areas related to three categories, women's experience of depression, factors influencing self-management strategies, and self-management strategies, which require further empirical scrutiny. The findings have opened new avenues for research including cross-cultural research to further understand the role of self-management strategies to manage recurrent depression across populations. The findings have great potential to revolutionize mental health practice in general and nursing practice in particular because what is needed to work within the realm of self-management strategies is what nursing has always aimed for and that is to provide holistic care within a provider-client partnership framework.

Appendix A

Self-management model for recurrent depression of Hagerty, Williams, Greden, and Lynch Sauer, 2002.



Taken from: Hagerty, Williams, Greden, and Lynch-Sauer (R21 Proposal, 2002)

Appendix B

Participant Information Sheet (Handout p.1)

Interview Guide: The English-Urdu Version of Participant Information Sheet

Date: _____

Participant code #: _____

Participant interview #: _____

Gender: _____

Direction: I will ask you some questions that will help me better understand the results of this research study:

1. What is your place of birth?
2. What is your age?
3. How many years of formal schooling did you have? _____
4. What is the highest level of school you have completed? _____
5. Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
   If married, for how long? _____

6. What is the total number of people who live in your household? _____
7. Who do you live with?

   ☐ Live alone ☐ Live with parents' family

   ☐ Live with spouse ☐ Live with spouse's family

   ☐ Live with your children ☐ Live with a relative

   ☐ Live with a roommate ☐ Other (please identify) _____

Specify who lives in your household

☐ Yourself ☐ Your parents ☐ Your siblings

☐ Your spouse ☐ Your children ☐ Your in-laws

☐ Your relatives ☐ Other (please specify) _____

8. How many children do you have? _____
9. How many children are living at home? _____
10. What is your ethnicity? _____
11. What is your religion? _____
12. What is your employment status?

☐ Not employed ☐ Employed full-time

☐ Employed part-time ☐ Other (please specify) _____

If employed, what is your occupation? _____

13. Your household income is approximately _____ Pakistani Rupees/month
14. Age of onset of initial major depressive episode: _____
15. Number of previous major depressive episodes: _____

Appendix B

Interview Questions (Handout p.2)

Interview Guide: The English-Urdu Version of Interview Questions

Instruction for the investigator:

Here is the list of broad and specific interview questions. These questions will help to ascertain self-management strategies, factors influencing self-management strategies, and perceived effectiveness of strategies used by Pakistani women with depression.

It is not necessary that all the questions should be asked in the same sequence using the same words; rather these questions should be used as a guide to ensure that all aspects of the research questions are covered. Hence, the word and sequence of these questions can be changed to respond to individual differences.

#	Key areas	Research questions	Interview questions
A	Experience of Depression		Broad overarching question: • Let us talk about your experience of depression Specific question: • What is a depressive episode like for you? • How many depressive episodes have you had so far • What are your symptoms of depression
B	Self-management strategies	1. What types of strategies do Pakistani women use to self-manage their recurrent depression?	• What kinds of things do you do for your symptoms of depression? • Tell me what do you do for each specific symptom (name of the symptom) of depression?
		2. How often do Pakistani women use strategies to self-manage their recurrent depression	• Tell me how often do you use (name of the strategy) to deal with the symptom (name of the specific symptom) of depression?
		3. Do Pakistani women use different strategies to manage different symptoms	• Do you use it (name of the strategy) to deal with any particular symptom of depression or to deal with all the symptoms

		of depression?	
		4. What are the similarities and differences in the types of strategies Pakistani women use for managing acute depressive episodes and preventing future depressive episodes?	• What do you do to prevent the occurrence of symptoms (name) of depression? • What similarities do you find between the things (name of strategies) you do for symptoms when you have them and when you do not have them? • Similarly what differences do you find between the things (name of strategies) you do for symptoms when you have them and when you do not have them?
		5. How do they make decisions as to which strategy they can or cannot use to self-manage their recurrent depression?	• Help me understand how you make decisions about what you can do to deal with symptoms of depression? • Similarly help me understand how you make decisions about what you cannot do to deal with symptoms of depression?
C	Influencing Factors	1. What factors (such as personal, illness, provider, social, interpersonal, cultural, and religious/spiritual related) influence Pakistani women's selection of self-management strategies?	• What makes you use (name of the particular strategy) it? • How did you know about (name of the particular strategy) to be used for symptom (name of the symptom) of depression • Who identifies or select it (name of the strategy) for you? • Help me understand what role your family plays in what you do (name of the strategy) for depression • What does your family do for your depression • What do you think about how your family affects what you do for depression? (N.B: Similar questions will be used for understanding the influence of ***personal*** (demographic characteristics and personal attributes), ***illness*** (illness history and illness identity), ***provider*** (types of health care providers, roles performed by various health care providers), ***social*** (poverty, unemployment, overcrowding, poor civic amenities, unavailability of mental health care services, expensive mental health care services, and health insurance), ***cultural*** (early marriage, housewife, living in extended family, early motherhood, repeated pregnancy, high number of

			children, stigma attached with mental illness and seeking formal mental health care services, and seeking health care from non-medical health care providers for depression), and ***religious/spiritual*** (faith in Allah, prayers, use of Taweez, and use of religious and faith healer) factors in the selection of strategies, once the participant indicates any of these factors in their reports)
D	Perceived Effectiveness	1. What strategies do Pakistani women find helpful or not helpful to manage their acute depressive episodes?	• How does it (name of the particular strategy) work for you? • What makes you continue to use (name of the strategy) for your depression? • How does it (name of the strategy) help you manage your depression • Are there any things that you have done in the past and do not do anymore for dealing with depression? • What makes you discontinue the use (name of the strategy) for depression?
		2. What strategies do Pakistani women find helpful or not helpful to prevent future depressive episodes	• How does it (name of the strategy) help you to prevent the occurrence of depression • Are there any things that you have done in the past and do not do anymore for preventing the occurrence of depression • How does it (name of the strategy) not help you to prevent the occurrence of depression

Probing

Definition of probing	Types of probes	Descriptions and examples
Probing is an interviewing technique used "to stimulate an informant to produce more information without injecting yourself so much into the interaction that you get only a reflection of yourself in the data." (Bernard, 1988, p.	1. Silent probe	• It consists of remaining quiet and waiting for a participant to talk (p. 211) • May be accompanied by: o Nod o Mumbled (e.g., "un-huh")
	2. Repeat probe	• It consists of repeating what the participants said last and asking them to carry on talking. • Examples of encouraging informant to continue are:

211)		○ Un-huh ○ Yes, I see ○ Right, un-huh
	3. Phrased assertion or baiting	• In this type of probing the investigators act as if they already know something in order for the participants to open up. This technique is helpful as it makes participants feel that they are not divulging secrets. In addition, some participants may correct researchers' understanding about the phenomenon under study.

Taken from: Bernard, H. R. (1988). *Research methods in cultural anthropology*. Newbury Park, CA: Sage Publications.

Clarifying Questions

The investigator will ask questions to clarify what the participant stated to understand what they really mean. Examples of clarifying questions includes, for example:

1. What do you mean by (description of the content that needs clarification) ….
2. Did you mean (share your own understanding of the data shared by the participant)….
3. Help me understand (description of the content that needs clarification)….
4. Give me an example of what you just said about (description of the content that needs clarification) ….

Appendix C

The English-Urdu Version of Flyer Describing the Study

Currently Ms. Nadia Charania, a Ph.D. student at the University of Michigan and an Assistant Professor at the Aga Khan University School of Nursing is conducting a study in this psychiatric clinic titled "strategies Pakistani women use to self-manage their recurrent depression". You can be a part of this study if you: (a) are a Pakistani woman, (b) are 18 years of age or older, (c) are aware that you have depression, (d) had at least two episodes of depression (e) are a follow-up patient in the outpatient psychiatric clinics of the Aga Khan University Hospital (AKUH), (f) can speak Urdu and/or English, (g) give permission to access your medical file, (h) do not have any other mental illness besides depression, (i) are not abusing any substance, (j) are not admitted to the in-patient psychiatric unit of the AKUH, and (k) are willing to be interviewed.

If you are interested in participating in this study, please fill out necessary information in the forms kept in the attached envelop and submit it to Ms. Nadia Charania, if available in the clinic, or place it in the box provided at the clinic reception/information desk.

By participating in this study you can make a major contribution in the life of other Pakistani women with depression. You will also be paid 300 Pakistani rupees for your contribution and time in the study.

Thank you,

Nadia Ali Muhammad Ali Charania
Telephone #: 2259150
Email: charania@umich.edu

Appendix D

Checklist of Inclusion and Exclusion Criteria (Handout p.1)

Direction: The following are the inclusion and exclusion criteria for the study, "self-management strategies Pakistani women use for recurrent depression". Please assess each criterion and check (√) the boxes that apply.

Patient's Name: _____
Telephone #: _____
Medical Record #: _____

Inclusion Criteria: The potential participant:

☐ Was born in Pakistan
☐ Is 18 years of age or older
☐ Has had at least two episodes of depression
☐ Is currently a follow-up patient in the outpatient psychiatric clinics of the AKUH
☐ Is aware that she has depression
☐ Can speak Urdu and/or English
☐ Gives permission to access her medical file

Exclusion Criteria: The potential participant

☐ Does not have a bipolar disorder
☐ Is not currently abusing any substance
☐ Is not currently admitted to the psychiatric unit of the AKUH

***Steps to follow prior to submitting this handout to the potential participant who meets all the inclusion and exclusion criteria specified above*:**

If the potential participant can write her name and telephone # on page 2 of this handout then just verbally explain to her that if she is willing to participate she will need to fill out her name and telephone # and put a check mark in the space provided on page #2 and place the completed handout (pages 1 and 2) in the box provided at the reception/information desk of the psychiatric clinic. She can also meet the investigator, Nadia Charania, if available in the clinic, and submit it directly to her.

If the potential participant cannot write her name and telephone # on page 2, please write her name and telephone # on page 2 and verbally explain her that she needs to put a check mark on the space provided on page # 2 and place the completed handout (page 1 and 2) in the box provided at the reception/information desk. She can also meet the investigator, Nadia Charania, if available in the clinic, and submit it directly to her. Thank you

Signature of the Psychiatric Clinician: _____ Date: _____

Appendix D

The English-Urdu Written Proof of Interest in Participating in the Study (Handout p.2)

By signing my name (name of the potential participant) _____, providing a telephone #_____, and making a check mark (√) in the box provided below I show an interest in participating in the study, "strategies Pakistani women use to self-manage their depression" conducted by Nadia Charania, Ph.D. candidate at the University of Michigan, USA.

☐ I am interested in participating in the study so please contact me.

Date: _____

Appendix E

Proof of Payment Form

Direction: Please write your name in the space provided (or the investigator will write your name if you cannot write) and make a check mark (√) yourself in the box provided below:

I (name of the participant) _____ agree that I have received 300 Pakistani Rupees ☐ for participating in the research titled "Strategies Pakistani Women Use to Self-manage their Recurrent Depression".

Name of the investigator: _____

Date: _____

Appendix F

Confidentiality Form for Translator

By signing this form, I (name of the translator) _____ agree that I will not disclose to anyone the research data for the study "strategies Pakistani women use to self-manage their recurrent depression" provided by Ms. Nadia Ali Muhammad Ali Charania for translation.

Signature of the translator: _____

Signature of the investigator: _____

Date: _____

Appendix G

Consent Form

Title of the research project:

"Strategies Pakistani Women Use to Self-manage their Recurrent Depression"

Name of the researcher

Nadia Ali Muhammad Ali Charania, MS, BScN, RN
Ph.D. candidate, University of Michigan, United States of America
Assistant Professor, Aga Khan University School of Nursing

Description of the research

You are asked to participate in a study on what Pakistani women do for their depression, what makes them do what they do, and whether or not they find doing what they do helpful in managing their depression.

This study is important because:

(1) The findings from this study are expected to generate knowledge which will help Pakistani nurses and doctors:
   a. to better understand how Pakistani women manage their depression,
   b. to provide better care for depressed Pakistani women, and
   c. to prevent depression in Pakistani women.

(2) The findings will assist nurses and doctors to develop new and individualized treatment options for women with depression

(3) Other Pakistani women with depression who have and do not have access to health care services are expected to benefit by recognizing and learning various ways of managing depression

Description of human subject involvement

You have a choice to select an interview date from any week-day or at your next clinic appointment date at the Aga Khan University Hospital (AKUH). The interviews will be done in the clinic at the AKUH. If you choose to be interviewed on the day you have an appointment with your doctor the interview time will be set so that it does not interfere with your doctor's appointment time.

On the day of the interview, I will explain to you the study purpose and the study procedure. The study procedures include:

1. Each interview will be about 1-1 1/2 hours so that you and I do not feel rushed to complete the interview.

2. I will ask you questions to meet the study purpose which I have prepared prior to the interview.
3. I will explain to you my role as a researcher compared to a psychiatric nurse. As a researcher, I am interested in understanding your views of what do they do to manage your depression. Any information you will provide in response to interview questions will not be recorded in your medical file; hence, it will not be used for your treatment purposes. In addition, I am not responsible for changing or modifying any of your treatment plans such as prescribing medications or changing the dose of current medications if any.
4. Each interview will be audio taped.
5. I will take some notes during the interview.
6. You have a choice to speak in Urdu or English or both and to take a break at any time during the interview.
7. You can stop before and during the interview(s) and ask me any questions you may have about the study or procedures related to the study.
8. At the end of the first interview you will be thanked and paid 300 Pakistani Rupees for your contribution and time. You will be requested to acknowledge receipt of money by signing the proof of payment form and/or making a check mark on a proof of payment form which I will immediately sign and date.
9. Depending how much is accomplished in the first interview; you may be selected for second or third follow-up interviews. At the end of follow-up interviews you will be verbally thanked for your time and contribution. There is no monetary compensation for participating in follow-up interviews. You will sign this consent form before we start the interview, if for any reason you cannot or do not want to sign your name but you say that you want to participate in the study then your verbal acceptance to participate in the study will be considered your permission to participate in this research. In this situation, I will write your name, sign my name and date of the interview on this form and you will make a check mark next to your name on the consent form.

Length of human subject participation

Each interview will be about 1-11/2 hours. Depending on how much is accomplished in the first interview, the participants may be asked to perhaps participate in the second interview for completion of data collection. The third interview may be arranged if the investigator would like to seek clarification and understanding of the data so far provided by the study participant. Hence, the total time commitment will range between 3 to 41/2 hours. Since the data collection is done during August, September, October, November, and December, 2005, the interviews are expected to be done during these months.

Risks and discomforts of participation

There are no identified risks or harms for participating in this study; however, the discussion of your experience of depression and its management may result in some emotional response.

Measures to be taken to minimize risks and discomforts

I am an experienced psychiatric nurse, have worked with women with depression, and will make clinical judgments about whether or not it is appropriate to continue the interview. If I make a judgment that we can continue the interview, I will offer you a choice to take a short break prior to restarting the interview.

Expected benefits to subjects and to others

The study may not have any specific, direct benefit to you; except that there might be a chance for you to reflect on how you manage your depression. In addition, you have a choice to ask for a one-page summary of the research findings either in Urdu or English which I will provide to you after the completion of writing of the research findings. For this you will have to provide your complete home or work mailing address.

Your participation in the study will make a major contribution in generating important information to help health care providers in Pakistan better understand what the depression experience is for some Pakistani women. Moreover, knowledge generated on what Pakistani women do for their depression will help health care providers to incorporate the information in the care of other Pakistani women with depression and help some Pakistani women to self-manage their depression. This would assist Pakistani women with depression to improve their day to day functioning, minimize the effects of depression in their lives, and reduce the risks of future episodes of depression.

Cost to subject resulting from participation in the study

There is no cost involved in participating in the study. You have a choice to participate on the day of your clinic appointment at the AKUH. However, if you choose to be interviewed on any other day and not on your clinic appointment day, you will bear the cost of travel to AKUH.

Payments to subject for participation in the study

You will be paid 300 Pakistani Rupees for your contribution and time at the end of the first interview. If you withdraw from participation before the first interview, you will not be paid 300 Pakistani Rupees.

Confidentiality

The following steps will be taken to ensure confidentiality.

1. Your doctor will not be informed of whether you opted or opted out from participating in the study.
2. A code number and not your name will be used on the information sheets used during the interview
3. You have a choice to use an alias or your real name during the interview.
4. The notes taken during the interview will also be given the same code number as the information sheet.
5. The interview data will be coded so that data are not linked to your name.
6. All study data will be stored in a secure place (i.e., locked cupboard in the investigator's home). Only I will have access to the locked cupboard. For example, audio tapes will only be used for transcriptions and then kept in the locked cupboard. These audio tapes

will be destroyed after the completion of writing of this research study report. Similarly, transcripts files on computers will not have any identifiers and will be password protected.

7. The study data will be shared only with the translator(s) for translating the interviews into English, and with the faculty on the investigator's dissertation committee. The translator(s) will sign a confidentiality form prior to translating the interviews into English. However, any records or data obtained as a result of your participation in this study may be inspected by the financial sponsor, Aga Khan University School of Nursing, by the University of Michigan Institutional Review Board, Health, or by the Aga Khan University Ethical Review Committee members.
8. Both audio taped and written materials collected will be destroyed once the study is completed.
9. You will not be identified in any reports on this study.

Situations in which confidentiality will not be maintained

1. If you are at risk of harming yourself or others, confidentiality will not be maintained.
2. If you show behavior that indicates suicidal ideation or increased suicidal ideation, or suicide planning, I, an experienced psychiatric nurse, will conduct a suicide assessment. If there is:
    a. Increased frequency, duration or severity of suicidal ideation with no plan or imminent intent, you will be asked to contact your doctor at the clinic of AKUH before leaving for home.
    b. Indication of suicidal planning, intent, and substance use, you and I will contact your doctor at the AKUH clinic, family member, or friend.
    c. An imminent suicide intent, I will make sure that the doctor at AKUH clinic be informed immediately for your complete psychiatric evaluation, including suicide intent. You will bear the cost of psychiatric evaluation.

Management of physical injury

In the unlikely event of physical injury resulting from research procedures, the Aga Khan University Hospital, Karachi, Pakistan, will provide first aid medical treatment or emergency care. Additional medical care will be provided if the Aga Khan University Hospital determines that it is responsible to provide such treatment. By signing form, you do not give up your right to seek additional compensation if you are harmed as a result of participation in this study.

Availability of further information

If significant new knowledge obtained during the course of this research which may relate to your willingness to continue participation you will be informed of this knowledge.

Contact information

Researcher Name: Nadia Ali Muhammad Ali Charania, MS, BScN, RN
Pakistan Home Telephone #: 2259150
Email: charania@umich.edu
Faculty Advisor Name: Dr. Bonnie M. Hagerty, Associate Professor, School of Nursing, University of Michigan
Office Telephone # in USA: (734) 764 2866

Email: bmkh@umich.edu

Required IRB contact information

Should you have any questions regarding your rights as a research participant, please contact:

1. Institutional Review Board, Kate Keever, 540 East Liberty Street, Suite 202, Ann Arbor, MI 48104-2210
   Telephone #: (734) 936-0933
   Fax: (734) 998-9171
   Email: irbhsbs@umich.edu
2. Aga Khan University Ethical Review Committee
   Dr. Rumina Hasan, Chair, Ethical Review Committee
   Email: rumina.hasan@aku.edu
   Stadium Road, P.O. Box 3500, Karachi 74800, Pakistan.
   Telephone #: 92-21-4930051
   Fax: 92-21-4934294, 4932095
   Email: aku@aku.edu

Voluntary nature of participation

Your participation in this project is voluntary. Even after you sign the informed consent document, you may decide to leave the study at any time without penalty or loss of benefits to which you may otherwise be entitled.

Documentation of the consent

One copy of this document will be kept together with the research records of this study. Also you will be given a copy to keep.

Audio Recording of subjects

An audio-recoding device (tape-recorder) will be used during the interviews. Audio taped materials collected during the interview will be destroyed once the study is completed.

Please sign below if you are willing to have the interview(s) audio taped. You will not be able to participate in this study if you are not willing to have the interview recorded.

Signature/Check mark (√) **Date**

Consent of the subject

"I have read or been informed of the information given above. Nadia Ali Muhammad Ali Charania has offered to answer any questions I may have concerning the study. I hereby voluntarily consent to participate in the study. I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable Federal, state, or local laws."

Printed Name	**Consenting signature/Check mark (√)**	**Date**
Researcher Name	**Signature**	**Date**

Appendix H

Set of Borrowed Categories and Sub-categories

#	Categories	Sub-categories
1.	Depression	Personal experience
2.	Influencing Factors	Personal factors
		Illness factors
		Provider factors
		Social factors
		Interpersonal factors
		Cultural factors
		Religious/spiritual factors

3.	Self-management Strategies	Types
		• Similarities in types of strategies used for depression
		  o Management
		  o Prevention
		• Differences in types of strategies used for depression
		  o Management
		  o Prevention

		Frequency
		Strategies for specific symptoms
		Decision making • Use strategies • Do not use strategies
4.	Perceived effectiveness	Helpful strategies for depression • Management • Prevention
		Not helpful strategies for depression • Management • Prevention

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