

## ASHA: Using Participatory Methods to Develop an Asset-building Mental Health Intervention for Bangladeshi Immigrant Women



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### Abstract

**Background.** Common mental disorder (CMD) is highly prevalent among low-income immigrant women, yet few receive effective treatment. This underutilization is partly owing to a lack of conceptual synchrony between biopsychiatric theories underlying conventional mental treatments and explanatory models in community settings. The Action to Improve Self-esteem and Health through Asset building (ASHA) program is a depression intervention designed by and for South Asian women immigrants. ASHA helps women to build psychological, social, and financial assets.

**Objectives.** This paper describes the development and a preliminary pilot evaluation of the ASHA intervention.

**Methods.** Researchers, clinicians, activists, and women from the Bronx Bangladeshi community collaboratively designed a depression intervention that would synchronize with local concepts of distress. In addition to providing mental health treatment, ASHA addresses social isolation and financial dependence. ASHA was evaluated in a pilot study described in this paper. Participants were assigned to intervention or

delayed intervention (control) groups. Data collection at baseline and time 2 (6 months) included the Physicians Health Questionnaire–9 (PHQ–9) and an indigenous measure of psychological and somatic distress.

**Results.** Eighty percent of intervention participants completed the 6-month program. After treatment, mean PHQ–9 scores in the intervention group decreased from 9.90 to 4.26 ( $p < .001$ ). Participants saved an average of \$10 per week. To date, participants have applied their skills and savings toward such activities as starting small businesses and enrolling in community college.

**Conclusions.** **ASHA was effective in improving depression and increasing financial independence.** Using a culturally synchronous approach to psychological treatment may be effective in ameliorating distress in immigrant populations.

### Keywords

Community-based participatory research, community health partnerships, health disparities, health services, indigenous, mental health services

South Asian immigrants from India, Pakistan and Bangladesh are the fastest growing immigrant group in the United States.<sup>1</sup> Although their population numbers nearly 3 million, they have received little attention from health researchers. This may be owing in part to their reputation as a “model minority.”<sup>2</sup> Earlier waves of South Asian immigrants consisted largely of educated professionals who assimilated

rapidly and dispersed into suburban communities. But this pattern has altered sharply in recent years, during which many working class South Asians have made their way to the United States and settled in low-income urban neighborhoods. One of newest, fastest growing South Asian groups is the Bangladeshi community in the Bronx, New York.

Rates of CMD—distress, depression, and anxiety—are

high in immigrant communities. Many new immigrants face a range of economic and social stressors, including financial strain, inadequate housing, discrimination, and linguistic isolation. South Asian women face additional strains. Married women in some families face many difficulties, including a heavy burden of work, exclusion from family decision making, and confinement to the home. These practices contribute to high rates of depression.<sup>3-5</sup> Young married South Asian women in the UK are three times more likely to attempt suicide than their White counterparts.<sup>6</sup> Despite their high risk for CMD, South Asian women immigrants are much less likely than White women to receive effective mental health treatment.<sup>7-10</sup>

Across low-income, ethnic minority, and immigrant communities, in general, the utilization of mental health treatment is very low.<sup>11,12</sup> Low utilization is related in part to explanatory models of distress. Standard mental health treatments available in Western societies are predicated on a biopsychiatric model of depressive illness in which depression is conceptualized as a pathology of the individual. This model reflects themes prevalent in Western middle-class culture, including an emphasis on individual agency and the medicalization of suffering.<sup>13-15</sup> Yet in ethnic minority and immigrant communities, depression and anxiety are often characterized quite differently in social or situational terms.<sup>16,17</sup> Explanatory models of distress affect willingness to seek treatment. Individuals who conceptualize their distress as a situational problem are dubious about the efficacy of conventional biopsychiatric treatments.<sup>7,18,19</sup>

The clash between biomedical models of distress and the situational models of depression common in community settings is often labeled pejoratively as a problem of “mental health literacy” that needs to be corrected through education.<sup>20,21</sup> Yet these apparently “unscientific” situational models are strongly supported by current evidence. Epidemiological studies show robust associations between depression and poverty; marital problems; and loneliness, humiliation, and loss.<sup>22-24</sup>

We conceptualize the problem as a lack of conceptual synchrony between community models of CMD and the biopsychiatric treatment models currently available. Ethnic minority communities need innovative mental health approaches that achieve conceptual synchrony with local models of mental illness<sup>25</sup> and address the social and structural antecedents of CMDs. Community-based participatory research (CBPR) emphasizes the values, beliefs, and knowledge of the com-

munity and is typically oriented toward a social–structural perspective of suffering and disease. CBPR approaches are thus ideally suited to the development of culturally sensitive treatment models of mental disorder that address underlying social and economic realities. Yet, as noted in a recent review, the vast majority of CBPR mental health projects conceptualize the problem in biopsychiatric terms and make only minor adaptations in applying conventional models.<sup>25-27</sup>

In contrast, the research program described herein took a more innovative, even radical approach. An academic–community partnership worked together to create a novel, multilevel intervention model for CMD. The intervention was designed with two goals in mind: first, to achieve conceptual synchrony with social, situational models of distress and, second, to address social and economic cause’s depression.

## DEVELOPMENT OF THE PROGRAM

### The Bondhu Project

ASHA is an outgrowth of a National Institute of Mental Health–funded partnership development project, the “Bondhu Project,” conducted in a Bangladeshi immigrant community in 2007 and 2008. The goal of Bondhu was to develop a community research partnership among researchers at Albert Einstein College of Medicine and women members of the local Bronx Bangladeshi immigrant community, explore the problem of women’s emotional distress and depression, analyze the causes or antecedents of this problem, and develop a culturally appropriate intervention to address distress and depression. In the original Request for Application (RFA), the intervention developed during this planning grant was to be tested in a larger study funded in a second grant. The Bondhu project was approved by the Institutional Review Board of the Albert Einstein College of Medicine.

### Step 1: Forming the Partnership

The first step, the development of the planning team, occurred during the writing of the grant proposal. The planning team included a physician in the local community, a health advocate, and several researchers from Albert Einstein College of Medicine.

The project location was a medical clinic in the eastern Bronx, home to a new Bangladeshi immigrant community. One

of the planning group members was the medical director of the clinic. To recruit community member partners, we approached patients at her clinic and distributed flyers throughout the community. There was an overwhelming response. Within a few weeks, 16 women were recruited. There were no selection criteria; participants were recruited on a first come-first serve basis. Forty women remained on the waiting list.

The Bondhu group met twice a month for about 12 months in the waiting room of the clinic. Each woman was compensated \$25 for her participation in the 2-hour meeting. For the first few meetings, we explained the purpose of the project and focused on building cohesion and trust within the group. We actively sought to create a comfortable, relaxed environment in which each participant's voice was valued equally. We engaged in a variety of activities to encourage bonds in the group, including regular icebreakers and other games.

To help empower participants, the group made a set of written rules, such as "no interruptions," "no criticizing others," and "give others a chance to be heard." One of the most important rules had to do with confidentiality. Group members decided that anything said in the group could not be shared outside the group without the speakers' permission. These rules were written on a large sheet of paper that was hung on the wall at each meeting.

### Step 2: Conceptualizing the Problem

Once the group had been formed, we moved on to the second step: conceptualizing the problem to be studied. One of the planning group members, a skilled group facilitator, led the group through a series of guided discussions focusing on the nature of women's distress in the local Bangladeshi community. Our inquiry a broad conceptual framework derived in part from Leventhal's "illness representational model."<sup>28</sup> The illness representational model has been used in previous studies to explore South Asian women's conceptual representations of emotional distress.<sup>17,29-31</sup> Categories explored by the group included the labels used to describe women's distress and emotional illness (what you call it), symptoms (what it looks like), causes (What causes it? What makes it better or worse? Why are women vulnerable?) impact or consequences (How harmful is it? Why does it matter?), and treatment or management (What you can do about it; what makes it better). Each discussion was transcribed in detailed

notes by a bilingual translator on poster paper. Notes from the previous meeting were reviewed by the group before each meeting. Below are summaries of the conceptual categories that emerged in group discussions.

*Label.* As we saw it, the identification of a shared illness category was a key step in the development of a culturally synchronous intervention. The Bondhu group discussed a variety of potential syndromes or symptoms commonly experienced by women. The term "depression" was discussed, and dismissed as a rare, severe disorder in which people acted *pagal* (the Bengali word for crazy). The syndrome the group chose to work with was "tension," a common illness category in South Asia.<sup>32</sup>

*Symptoms.* The syndrome of tension includes psychological symptoms overlapping with depression, anxiety, and other forms of CMD found in western society. Sadness, anger, anxiety, and exhaustion are common symptoms associated with the syndrome. A detailed description of "tension" has been published elsewhere.<sup>32</sup>

*Causes.* Causes of tension identified by the group included isolation in the home, financial problems, lack of immigration status, marital conflict, and abuse. Bondhu participants emphasized women's low status, lack financial independence, and loneliness. Extended family tensions, common in traditional South Asian families, were common.<sup>33</sup> Worry over poverty or illness in one's own relatives was another common problem.

*Impact.* Participants explored the impact of severe tension on a woman's health and well-being. A common perspective was that women's emotional distress and illness were not only common, but "normal." Through discussion, this perspective shifted as women explored the consequences of tension, such overeating and obesity, isolation and loneliness, and inadequacy in important social roles.

*Management of Tension.* Common ways of addressing and alleviating tension were discussed. Advice and support from close family and friends was the most common source of strength and comfort. Many women also sought help from husbands and older children. Prayer and reading the Quran were also frequently mentioned. Other self-help strategies included distraction—getting out of the house, watching television, or "resting." As expected,<sup>17,31</sup> women almost never mentioned formal medical or psychological treatment as appropriate for "tension."

### Step 3: Designing an Intervention

An important goal of the Bondhu project involved the design of a culturally appropriate intervention to address tension. As expected, Bondhu community partners were dubious about the value of Western psychiatric medications and therapies. Somewhat to the surprise of researchers, many were familiar with Zoloft and other antidepressants because they saw the nightly television advertisements on television. The notion that emotional distress, embedded as women saw it in social discord, would be responsive to medication was quite mystifying to participants. Some wondered if Western “depression” was a completely different disorder from what they recognized in their own community. In discussions about interventions, women asked us to develop strategies that would address the environmental antecedents of depression, including immigration problems, isolation, the lack of English language competence, and unemployment/poverty.\*

As discussed, few efforts to develop mental health interventions that address social and economic antecedents of CMD have been reported in the literature. Members of the planning team, including the first and fourth author, conducted a literature search and a review of National Institute of Health–funded research projects addressing health through poverty alleviation. Through this process, we discovered a promising theoretical approach called asset theory.

*Asset Theory.* According to asset theory, what most distinguishes the poor from the wealthy is not income, but wealth. Accumulated assets allow individuals to set goals, plan for the future, and enjoy security. Assets give individuals a stake in the future. Helping low-income individuals build financial assets can have a powerful effect, even when the amounts accumulated are small. Asset building programs affect health behaviors such as sexual risk taking,<sup>34,35</sup> enhance hope, confidence, self-esteem, future orientation, and social connectedness.<sup>36,37</sup> Some asset-building programs involve matched

savings accounts. In these programs, participants open bank accounts and put aside savings every week while receiving financial literacy training and other support. Matched savings funders such as the federal Assets for Independence program augment individual savings with matching grants.<sup>38</sup>

Through our literature review, we identified an asset building intervention developed by HopeWorks, an academic–community partnership at the University of North Carolina, Chapel Hill. HopeWorks was implementing a program that used matched savings accounts in combination with a lifestyle and nutrition program to address obesity in low-income women. In January 2010, we formed an “intervention group” of six members of the larger Bondhu partnership. The intervention group, including the principal investigator and two other members of the planning group, along with three Bangladeshi community partners, made a fact-finding trip to visit HopeWorks to learn more about their asset building approach.<sup>39–41</sup> Our meetings with HopeWorks community and research partners encouraged us to pursue this approach in developing our depression treatment intervention.

Back in New York, the intervention group again reviewed the literature on asset building and health. No studies in the United States to date have examined the effects of asset building programs on depression. However, two research studies of asset interventions for orphans struggling with acquired immunodeficiency syndrome (AIDS) in Uganda examined the mental health outcomes of these programs, finding that matched savings accounts increased well-being and decreased depressive symptoms in this vulnerable population.<sup>36,42,43</sup> The intervention group decided to adopt the matched savings account model. The program was designed through several meetings of the group. The design for the intervention was presented to the larger Bondhu partnership during several final meetings in 2009.

Eighteen months later, the principal investigator secured support from a local New York City foundation to enroll an

\* The group described many unmet service needs. Women on the waiting list of the project also frequently visited the clinic director and other members of the partnership, requesting programs and services. As these discussions continued, some members of the planning group decided to start a nonprofit organization that would address directly the needs of the community. The Westchester Square Partnership (WSP) was founded in 2008. An initial Board of Directors was formed that included several members of the Bondhu project. Other Bondhu members formed the Mothers’ Club, an independent group that generated its own programs, including a Bengali weekend school for children, and served in an advisory capacity to WSP’s board of directors. Foundation funding from the New York Women’s Foundation was received almost immediately. WSP began offering English as a Second Language (ESL) classes in the clinic waiting room, and four Bondhu participants were hired as community health workers to start offering health education and patient navigation. The organization continues today under the name Sapna NYC ([www.sapnanyc.org](http://www.sapnanyc.org)).

initial cohort (two groups) into a pilot/feasibility study of the program. “Action to improve Self-esteem and Health through Asset building” (ASHA; “hope”) was implemented in 2012 in the offices of a local community-based organization, Sapna NYC. The program and evaluation are described herein.

### The ASHA Program

The first phase of ASHA is a 26-week treatment intervention for women experiencing symptoms of tension/depression, and this phase is the focus of the current review.

During phase I, the treatment phase, participants meet twice a month for 12 sessions, in a group led by a peer health worker. Biweekly, 2-hour sessions are conducted in a private meeting space. Participants complete the PHQ-9 at the beginning of each session and chart their scores in a notebook. The facilitator keeps track of the scores and follows up with participants who are failing to improve or getting worse. All sessions and program materials are provided in Bengali.

The phase I curriculum emphasizes three types of assets: psychological skills, social networks, and financial assets. Each session is structured similarly, with a combination of social activities, review of homework, an educational module, and a discussion (Table 1). Subsequent sections below provide further detail on the topics covered in each aspect of the curriculum.

*Psychological Skills.* During the psychological skills-building sessions, participants learn to identify symptoms of tension and the thoughts and feelings associated with them.

Participants learn basic cognitive strategies for addressing depressogenic thoughts (catastrophizing, self-criticism, “all or nothing thinking,” and perseverative worry). Additional sessions focus on understanding the relationship between inactivity and depression/tension, and the importance of increasing pleasant activities to improve mood (Table 2).

*Social Networks.* ASHA’s curriculum helps to strengthen social networks and build friendships among women. Each woman in the group is assigned a partner/friend—another member of the group—who acts as a source of social support. Partners receive training in supportive listening and are required to make at least one phone or in-person contact per week. They reported on these contacts during ASHA sessions. We noticed that even very shy, isolated women found it quite easy to develop ties with their partners. As the pairs became closer, they reached out to form ties with other group members. Program staff made efforts to encourage social ties through group activities such as exercising together or visiting the bank. As another way of building group ties, the partici-

**Table 1. A Typical ASHA Session**

Time (min)	Topic
15	Icebreaker
15	Report on goal setting
40	Educational component
10	Report on group savings, plan for next session
10	Relaxation and snack

**Table 2. ASHA Circle Session Topics**

Introduction to the program: Getting to know your Group Members
Getting to know our Bondhus
Our Hopes, Our ASHA: Psychoeducation; the importance of goals, and hope for the future; understanding women’s goals
Self Help 1: Getting Active—Behavioral activation—the importance of being active and accomplishing goals/tasks to improve mood
You and your money—financial literacy education—basic information on budgeting, saving, banking
Healthy Relationships—understanding how negative relationships and conflict affect mood; figuring out how to increase positive relationships and decrease negative ones
Self Help 2: Worrying and Negative Thoughts—Psychoeducation—how to recognize and address negative thinking
Financial Independence—The role of money in women’s independence—thinking about a financial future, beginning to goal set
Improving Relationships through Assertiveness—Basic assertiveness training. Learning to say No—in a positive way
Self Help 3: Improving Physical Health—importance of exercise and physical activity in mental health
Building Healthy Communities—understanding depression among South Asian women. Importance of bringing community messages
Wrap up and next steps—goal setting for our financial future

participants create an outreach project. Each ASHA group creates a community conference to which friends and neighbors are invited. Between 20 and 40 community members attend the conferences. Topics chosen by the group to present include assertiveness and its role in mental and emotional well-being, the importance of supportive listening, or the role of physical activity in mental health. Some participants create videos, an example of which may be viewed online ([www.youtube.com/watch?v=P1nh3yf7GfM](http://www.youtube.com/watch?v=P1nh3yf7GfM)).

*Financial Asset Building.* Phase I of the ASHA program includes two sessions providing basic financial literacy education and information on household budgeting. Each participant opens a bank account and saves up to \$10 per week. The financial asset building component of ASHA is supported by a matched savings grant from the U.S. Department of Health and Human Services. A participant may withdraw her funds at any time before the end of the program, but she must replenish her account promptly if she wishes to receive a match. At the

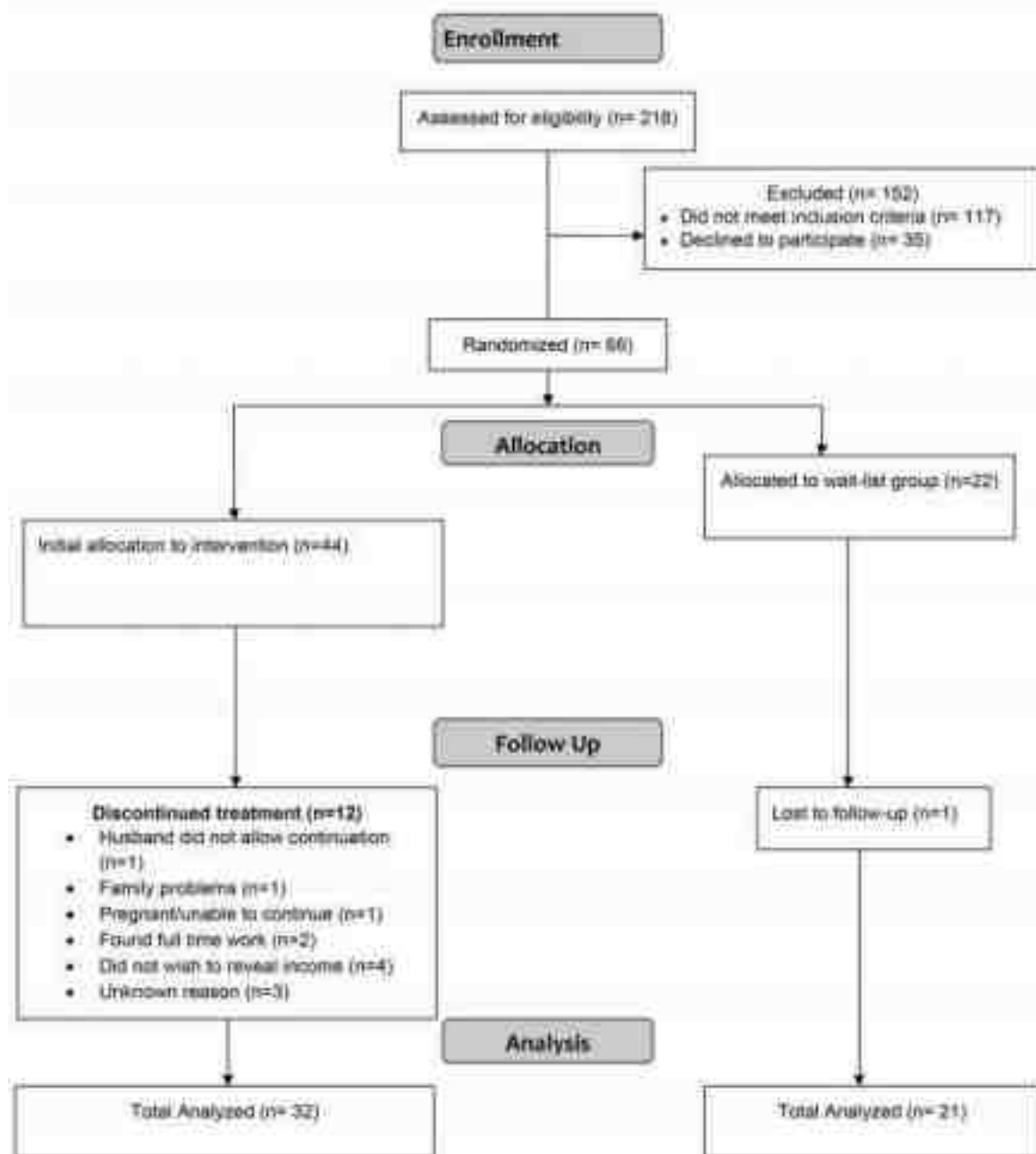


Figure 1. Study Flow Diagram.

end of the 26-week treatment phase, participants in the intervention group may elect to receive a match. At this point, the participant's assets are "frozen" and may be withdrawn only to purchase assets that can contribute to financial independence. Acceptable asset purchases include training programs, higher education, and small business capitalization.

## PRELIMINARY EVALUATION OF ASHA

### Methods

*Participants.* Participants were recruited program participants at SAPNA-NYC, a community-based organization located in the new rapidly growing Bangladeshi community in the Bronx (Figure 1). Forty-four participants were randomized to the intervention group. Twenty-two participants were randomized into a wait list control group. Control group participants were eligible to participate in later cohorts of the program; eight eventually joined the intervention group after completing their T2 data collection, for a total of 52 intervention participants. Two groups were recruited in 2012 and three groups in 2013. Eligibility criteria included age 18 to 70; a score of 8 or above on the PHQ-9 (44,45); family income if less than 200% of the federal poverty level (\$47,000 for a family of four). Families below this threshold are eligible for the federal Assets For Independence matched savings program. Exclusion criteria included inability to provide informed consent owing to cognitive impairment or evidence of psychotic symptoms. One woman who was recruited could not read or write; she believed that she would not be able to manage the program and withdrew.

*Data collection.* Participants were interviewed at two different time points: T1 (baseline) and T2 (26 weeks). All data were collected in Bengali by trained bilingual interviewers. Individual instruments were translated and adapted using standard techniques. The baseline interview included the following instruments.

*Demographics.* These data were collected through a standard demographic questionnaire administered at Baseline.

*Depression.* The PHQ-9 is a nine-item depression questionnaire that has been widely used and validated in primary care and community samples. The PHQ has been found to be valid<sup>44,45</sup> in a variety of settings.

*Indigenous Distress.* The South Asian Tension Scale is a

new instrument, designed using participatory research strategies during the Bondhu project.<sup>32</sup> The Tension Scale consists of 23 questions where respondents are asked to rate on a scale of 0 to 4 the frequency with which they have been bothered by symptoms reflecting the indigenous construct of "tension" described earlier in this review.

The T2 interview assessed depression and indigenous distress, as well as perceptions and experiences of the program. Qualitative data regarding experiences, perceptions, of the program, changes in outlook, and plans for the future was collected in an in-depth qualitative interview administered at T2 with eight randomly selected participants.

### Data Analysis

*Clinical Outcomes.* Differences in PHQ-9 and Tension Scale scores were assessed using analysis of variance to compare the scores between T1 and T2, as well as to contrast T2 follow-up scores between treatment and control groups. We examined whether scores changed between time points within groups as well as across groups.

*Perceptions and Experiences.* Qualitative data were assessed using standard qualitative analysis techniques. The first and second authors developed a simple coding scheme, applied it to the data, and revised in an iterative process. The first and second authors then coded passages of the data together, discussed discrepancies in coding decisions, and revised coding definitions until consistent coding outcomes was achieved. At that point, the second author coded the complete dataset. The data were entered into NVIVO, a qualitative analysis computer program that facilitates the rapid categorization and retrieval of thematically linked material. Relevant categories related to the perceptions, experiences, and life changes associated with the ASHA program were then summarized.

## RESULTS

### Retention

The overall retention rate was 80%. Twelve participants withdrew from the intervention group. Four withdrew before starting the intervention because they did not want to provide the income data required for the matched savings grant from the U.S. Department of Health and Human Services.

Other reasons for discontinuation included pregnancy, family problems, and a husband's withdrawal of permission to participate. One participant withdrew from the control-only group. The final sample included 32 intervention participants and 21 control participants.

### Demographics

There were no demographic differences between intervention and control groups (Table 3). Participants were all native Bengali speakers and a majority (55.38%) reported speaking only Bengali at home. All participants were married and reported having at least three children. The eight participants who also completed the in-depth qualitative interviews were an average of 44.50 years old ( $SD = 7.69$ ) and they had been in the United States an average of 9.63 years ( $SD = 7.22$ ).

### Treatment Outcomes

The primary outcome was PHQ-9 scores. When assessed at T1 (baseline), the mean PHQ-9 score for participants in the control group was 10.1, and in the intervention group, the mean score was 9.9. This difference between groups at T1 was not significant ( $p = .33$ ), suggested that all participants were reporting similar levels of depression during their baseline evaluation.

At the end of the 26-week program, we again reviewed follow up PHQ-9 scores and found that scores in the intervention group decreased substantially from 9.90 to 4.26 ( $p < .001$ ). Scores in the control group displayed a small, nonsignificant decline, from 10.10 to 7.95 ( $p = .21$ ). The difference in mean PHQ-9 follow-up scores between the intervention and control groups was significant ( $p = .02$ ). Scores on the Tension Scale yielded a similar pattern: participants in the experimental

group experienced a decrease in scores from 42.90 to 34.70 ( $p = .004$ ) over the 26-week period while those in the control group had their scores increase from 38.80 to 45.10 ( $p = .29$ ). Differences between group scores on the Tension Scale were also significant ( $p = .005$ ).

### Asset Acquisition

Regarding financial outcomes, intervention participants saved an average of \$10 per week. At week 26, the end of phase I, women in the intervention group received a triple match of their savings and worked together in groups to plan their asset purchases. Only one woman to date declined to make the match. To date, of the women finishing the program, 10 have started small businesses through workers' cooperatives, 9 have enrolled in ongoing English language learning courses, 4 have obtained drivers' licenses, and 2 have enrolled in pre-college courses. Many other women have applied their assets toward entrepreneurial pursuits such as obtaining a license to work in childcare, beauty, or food service professions. Detailed outcomes of the phase II of the program are currently being evaluated and plan to be described in a future publication.

### Perceptions and Experiences of the Program

A key benefit of the ASHA program was that it helped with loneliness.

When you come out, you mingle with people with different ideas, different ways of doing things, then you feel brave. When you see others do things, then you feel the courage to do things yourself. . . . none of us looked down on one another. We shared what was in our hearts and it felt good . . . we became a family.

**Table 3. Demographic Characteristics of Final Sample ( $N = 53$ )**

Characteristic	Control ( $n = 21$ )	Intervention ( $n = 32$ )	$p$
Mean age ( $SD$ )	42.10 (2.49)	40.4 (6.41)	.691
Years in United States ( $SD$ )	5.10 (2.45)	5.2 (5.38)	.911
Employed outside the home, % ( $n$ )	19.04 ( 4)	15.6 ( 5)	.701
Primarily speaks Bengali at home, % ( $n$ )	38.10 ( 8)	50.0 (16)	.365
Comfortable speaking English, % ( $n$ )	100.00 (21)	100.0 (32)	1.000
Married, % ( $n$ )	100.00 (21)	100.0 (32)	1.000



The ASHA curriculum includes several sessions that focus on cognitive-behavioral therapy (CBT) skills. Because CBT is a standard Western psychotherapy technique, we were particularly interested to find out whether participants felt they had benefited from learning some of the skills during the CBT sessions. Several participants had clearly absorbed the basic message the CBT sessions. They described being able to “hear” their own thoughts and understand the relationship between thoughts and feelings.

I don't try to do things emotionally (now). It is my emotions taking control when I think I don't like it in this country. It is again my emotions when I think I don't want to stay here.

For most women, the savings and asset purchase aspect of the program was viewed in a highly positive light. As intended, the experience of saving money in one's own bank account contributed to feelings of confidence, which in turn led to hope for the future.

Saving money in the bank is happiness for everyone. By saving money in the bank you feel strong.

After finishing the program, many women described feeling prepared to move forward with their lives.

Because of kids and family, it never occurred in my head to study or find time for myself. During these times I used to think is my job only to do house chores and take care of the children? Do I not have anything else to do? . . . After going outside and joining this program, it opened a path for us. . . . After knowing this, now I feel I can do something.

### Need for Improvement

Most participants described weaknesses in the program and need for improvement. The most common theme was the need for more—a longer program, longer sessions, and larger savings goals. Participants proposed additions to the program that would involve job training and more extensive job placement assistance. Half of the participants felt that the program should have included an ESL component, because their lack of English abilities made entry into the job market difficult.

## DISCUSSION

This article describes the development of an innovative treatment model to address CMD in a highly vulnerable

immigrant community. In our view, the approach described in the article incorporates two key innovations. The first innovation relates to our participatory process. Unlike other CBPR mental health projects published in the literature, we incorporated community participatory methods throughout the entire project. Instead of “educating” community members on the effectiveness and appropriateness of conventional biopsychiatric models of mental disorder and treatment, we worked collaboratively to define a common understanding of the illness problem, its causes, and its treatment. The second innovation relates to our intervention design. An important barrier to effective treatment among low-income persons of color is the fact that many such patients do not believe that standard mental health treatments will be effective in relieving their suffering. A key focus of the ASHA model is its focus on “conceptual synchrony” with local models of illness and treatment. Our high acceptance and low attrition rates suggest that the ASHA model made sense conceptually to women we approached.

Another important component of the model is its financial asset building. Evidence suggests that depressed patients experiencing financial hardship receive less benefit from treatment treatment.<sup>12,46,47</sup> To many mental health researchers and practitioners, the task of altering the social or financial landscape of a patient's life may seem far beyond the scope of mental health treatment. Yet the ASHA program, despite its small budget and modest scope, seemed to do this successfully for many participants.

The results of this intervention are promising in light of recent research. A recent review of studies of psychotherapy attrition reports an average rate of attrition of 47% across studies, with rates consistently higher for ethnic minority and low-income patients.<sup>48</sup> An often cited randomized controlled trial of CBT and medication in culturally adapted treatment for low-income ethnic minority women found an attrition rate of 67%. The authors suggest that many of the participants may have been ambivalent about treatment and chose to withdraw owing in part to a lack of interest.<sup>49</sup> Beyond attrition rates, the observed declines in depressive symptomology in our sample are comparable to or better than those observed in treatment research with similar samples. A recent review examining the effectiveness of culturally tailored psychotherapy interventions<sup>50</sup> found significant improvement in only 8 of 15 participants.

The pilot evaluation reported in this article has a number of important weaknesses. We were limited by real-life economic constraints in rolling out our program. Policy and funding changes at the National Institute of Mental Health meant that the scale up and formal trial of the intervention has not, to date, been possible. Instead, we have had to implement and test our program model through small, incremental steps, funding each new cohort of ASHA through small local foundation grants. However, the daunting ideological and pragmatic barriers we have faced have been partially overcome through this piece meal approach. Over time we have tested the model on 51 patients, and our results have been remarkably consistent across cohorts, showing marked declines in symptomology and improved life circumstances.

Ultimately, the most important test of the ASHA approach lies in a comparative effectiveness study in which retention and symptom outcomes are compared with high-quality conventional mental health treatments. Until that evaluation is possible, we propose that the results described in this article do suggest the promise of our approach.

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