

Evaluation and Development of a Self-help Resource for Muslim Patients with Depression

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Abstract

Background: National guidelines in the UK and US promote attention to variations in patients' cultural background in choice of treatment for depression as these significantly affect outcomes. People from Muslim backgrounds are more likely to use religious coping techniques for mental health problems than other social groups. There is evidence that faith-sensitive therapies can achieve earlier results than secular treatments for this population. However, little guidance is available on the form and content of culturally appropriate interventions.

Method: Behavioral Activation, an effective therapy for depression, was culturally adapted to meet the needs of Muslim patients. A self-help resource was developed as part of this process, drawing on MRC guidelines for development of complex interventions. The resource was piloted with patients attending primary care therapy services in Bradford, an ethnically diverse city in the UK. Feedback was obtained from patients, therapists, supervisors and managers through evaluation of pre-pilot training and semi-structured interviews at the end of the study. Analysis of results informed further refinement of the self-help booklet.

Conclusion: Most practitioners and participants felt the intervention was acceptable and feasible within NHS settings. Whilst recognizing the need for and value of the self-help resource, however, practitioners often struggled to engage with their patients' religious identity or support the use of 'positive religious coping' within a therapy setting. Findings suggest a need for implementation support at sites wishing to use this culturally adapted intervention.

Keywords: Mental health problems; Behavioral activation; Effective therapy; Depression; Physical illnesses

Introduction

A number of policy statements and guidelines promote the use of culturally appropriate treatment for service users from minority ethnic and faith groups [1-3]. Reviews of clinical trials and interventions provide little evidence about minority religious groups, however and detailed descriptions of interventions for Muslim patients are rarely available [4,5]. More evidence is therefore needed about culture-sensitive models of therapy and specific resources that practitioners might utilize [6].

There is evidence that some people within Muslim communities experience higher levels of depression which are more chronic in nature than in the general population. Muslim patients are also more likely to use religious coping techniques than individuals from most other religious groups in the UK [7]; this is therefore a potentially important focus for culturally appropriate mental health treatments. There is a significant body of literature which shows that religion may influence wellbeing through pathways that are behavioural, psychological, social and physiological [8]. This literature identifies a distinction between 'negative religious coping' i.e., feeling abandoned or punished by God or unsupported by one's religious community and 'positive religious coping'. The former can increase depression and anxiety and pain severity for people with physical illnesses [9,10]. 'Positive religious coping', on the other hand, is associated with reduced levels of depression and the use of an internalized spiritual belief system to provide strategies that promote hope and resilience [8,11]. Religious beliefs and practices that encourage a proactive approach to dealing with problems, rather than relying on divine intervention, are also more likely to help people overcome depression [12].

Reviews of therapies incorporating religious components have

shown that these can have positive results and that adapted therapies can be at least as effective as secular interventions [8,9,13]. For Muslim patients such therapies have also shown earlier improvements in depressive symptom [6].

Psychotherapy and religious teachings can therefore be seen as complementary rather than competing approaches to overcoming depression [14,15]. It is suggested that the effectiveness of spiritually focused therapy is achieved through its ability to provide meaning, a sense of wellbeing, social support and the use of positive self-talk as well as to the act of surrendering control to a higher power [10,16-18].

Given that practitioners without religious beliefs are overrepresented in the NHS, approaches that can potentially be delivered by therapists from a range of religious and non-religious backgrounds are desirable [19]. In this context, a secular therapy with the capacity to incorporate spirituality – a concept understood in both secular and religious contexts – may provide an important bridging model [20]. There is evidence that therapies adapted in this way can be effectively delivered by non-religious therapists [6,13].

Behavioural Activation (BA), an effective therapy for depression was selected as an appropriate therapy for adaptation because of its

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focus on client values [21]. Behavioral therapy also supports religious teachings that certain types of activity can increase a sense of meaning in life, the loss of which may be a cause of depression [22].

Methods

The study broadly followed Medical Research Council guidelines for development of complex interventions [23]. Existing evidence was explored to determine the components of culturally appropriate therapy; search strategies were developed in collaboration with an Information Specialist and three Project Advisory Groups made up of mental health practitioners, service users and academics [24]. The review included grey literature such as work undertaken by community-based organisations and from outside the UK, where Islamic perspectives may be more predominant [25].

Themes developed from the literature review were used to develop a topic guide for semi-structured interviews with 30 Key Informants (key informants), individuals with experience of mental health in Muslim communities. These included five clinical psychologists, four service users, three psychiatrists, two service managers, a mental health support worker, GP and BA expert. Interviews were transcribed, translated where necessary and coded using NV Ivo 8 software.

Data from key informant interviews was organised into themes adapted from a previous cultural adaptation of BA and analysed using the Framework approach [26]. These were: social context; spiritual understandings of health, illness and depression; client values; client-therapist matching; therapeutic tools; support and resources available. Analysis brought together supporting and disproving evidence for interpretive propositions; deviant cases were used to enhance validity and develop explanations encompassing diverse viewpoints [27]. Reliability and objectivity were achieved through the systematic and documented collection of data and reflexive approaches during all stages of research [26]. Findings from analysis were validated by the project advisory groups and synthesised to influence production of a culturally adapted treatment, comprising a therapy manual and self-help booklet [14,28]. This paper focuses on findings related to the self-help booklet [29].

The self-help intervention was piloted with 19 Muslim service users aged 23-56, along with 9 primary care therapists and 5 supervisors who were trained to deliver the intervention. Training covered the content and anticipated use of the self-help booklet alongside basic theory of Behavioral Activation, adaptations to the BA manual, recruitment, and supervision arrangements. Therapist adherence to the manual was assessed by two researchers for 25% of therapy sessions, using a checklist adapted to include "appropriate focus on religion" [30].

Semi structured interviews with 29 study respondents (13 patients, 9 therapists, 5 supervisors and 2 team managers), included 14 respondents who had withdrawn during the course of the study and explored acceptability and feasibility of the intervention [31]. Qualitative Framework Analysis used processes and themes developed previously to explore participants views about the experience and impact of the therapy and views on the self-help booklet [26]. Ethical approval was obtained from the Yorkshire and Humber Research Ethics Committee.

Results

Intervention development

Feedback from Key Informants was that widely divergent practices were used to discuss issues relating to religious identity with patients.

These ranged from perceiving such discussions as 'unprofessional' to deliberately making space within therapy to discuss the importance or otherwise of patients' religious identity and relevance to depression. A number of Key informants felt that therapists should explicitly express an openness to talk about patients' religious identity and explore solutions from within patients' cultural systems:

"I think it helps if they know a little bit about the religion or at least be curious about the religion and ultimately it's kind of a little like an attitude thing. And I when I work with anyone from any kind of culture I believe that ultimately within their own cultural system there will be ways of dealing with those difficulties."

Intercultural therapist

Findings from the synthesis indicated that this latter approach was most helpful to patients and should be more consistent in practice. To support this process, a self-help booklet was developed in both English and Urdu, modelled on an existing resource for psychosis recovery in Muslim communities [32]. The booklet brought together various Islamic teachings that could help patients develop 'positive religious coping' and that reinforced the effective components of Behavioural Activation [11].

Development involved input and feedback on initial drafts from service user advisory group members and a Muslim clinical psychologist. The booklet specifically avoided sectarian differences to support its relevance to as many patients as possible, and also avoided religious teachings that might support negative interpretations of depression.

Therapists were advised to assess the importance of religion to patients and, for those to whom this was important, to offer the resource as a way of highlighting parallels between BA and Islamic teachings and of placing the adapted BA therapy within a framework that patients valued and were already likely to understand. Some key informants, for example, had used a similar approach to promote the idea of hope, or drawn on religious teachings about how to behave when angry to promote understanding of the link between emotions and behaviour. As such the self-help booklet was intended to enhance BA approaches, rather than act as a substitute for these.

Table 1 demonstrates how teachings included in the booklet related to the underlying concepts of BA and the idea of 'positive religious coping'.

An anticipated benefit of the booklet was that it would equip therapists with a level of religious knowledge that could facilitate helpful engagement with Muslim patients. Knowledge of Islam was also considered helpful for sensitising therapists to issues that might cause difficulties or discomfort for patients, such as appointments that clashed with Friday prayers or mixed gender activities. The evidence synthesis confirmed that evidence of interest in Islam, such as having a copy of the Qur'an and referring to this during therapy sessions, also gave an important message of social acceptance to patients found that Muslim service users in Pakistan valued being treated by health professionals who expressed religious sentiments and an inclination towards God [33]. Some key informants from Muslim backgrounds felt that such expressions could also be appropriate in the UK context, once they had developed a relationship of trust with a patient.

At the same time, key informants warned that an interest in religion should not be assumed, given the diversity in religious practice amongst Muslim patients. Therapists were therefore advised that the booklet

Section of Self-Help Booklet	Parallels With ba/Psychological Benefit
Dealing with difficulties	As in BA, sadness and grief are seen as normal responses to difficult life events from an Islamic perspective. This section can be used to help patients feel they are not abnormal or 'mad' and that any stigma they have encountered is unjustified.
Staying Active: Mercy to yourself Hope Core beliefs	These sections support 'positive religious coping' by encouraging patients to think positively about themselves and discouraging them from being too self-critical or harsh on themselves. The teachings can help patients reframe their relationship with God, give them hope, and help them feel less alone.
Practical steps to wellbeing	These sections can again be used to show that the BA approach is similar to an Islamic framework. They highlight that being active is key to following Islam and is encouraged through small daily acts of worship that are likely to be achievable for most people. For example, it may be helpful to discuss how much activity is involved in observing the five pillars of Islam. For patients who say religion is important to them, these small actions will contribute towards developing congruence between their beliefs and their daily actions. They can also support patients to spend time on themselves rather than focusing only on others and to begin to look after themselves physically.
Tie your camel	This teaching similarly highlights a parallel with BA, encouraging patients to take action themselves and not just rely on God to provide a solution.
One step at a time:	This teaching conveys to the patient that being active is encouraged in Islam and highlights parallels between Islamic teachings and therapy that focuses on action (Valiente). From both perspectives even small changes in behaviour can have a major influence on one's situation, no matter how complex and difficult this may be. The Hadith also discourages extremism which may be useful to counter obsessive behaviour.
Remembering God	All these sections support 'positive religious coping' by encouraging patients to think positively about themselves and discouraging them from being too self-critical or harsh on themselves. The teachings can help patients reframe their relationship with God, give them hope, and help them feel less alone. They can also help patients reframe their understanding of their experience and develop a sense of meaning in their lives. This in turn can promote a positive outlook and the resilience to deal with difficult situations.
Connecting with the Qur'an	The teachings can help counter feelings of helplessness, for example the therapist could ask whether the patient believes God has the power to help and if so what the patient can do to receive that help. For example, the therapist can introduce a discussion about some of the Names of Allah (e.g. Most Merciful and Most Compassionate) to help patients who think they are beyond forgiveness or who have a concept of God as punishing to consider more positive ways of thinking about God. Patients who may feel guilty about past actions could be asked what Islam teaches them to do when they have done something wrong. Where patients have an ambivalent attitude towards God or think of Him in ways that increase hopelessness or guilt, it may be helpful to suggest they reflect on the Names of Allah and explore whether they have any experience relating to the positive ways in which God describes Himself in the Qur'an.
Calling on Allah	Certain ways of remembering God, such as the 'Remembrance for Morning and Evening' prayers can also be helpful for patients who may feel fearful or exposed to harm from others. For example if a patient feels threatened by supernatural forces, these teachings provide an Islamic response to the risk of harm.
Names of Allah	
Dealing with unhelpful thoughts:	As above these teachings can support an active approach and positive religious coping linked to an improved relationship with God. The therapist may also explore with the patient their response to key concepts in the Qur'an that can help positive religious coping: for example, that illness is a test that has meaning and that times of difficulty are followed by times of ease.
God's mercy/ forgiveness <i>Sabr</i> Developing <i>Ihsan</i>	Islamic teachings about <i>Ihsan</i> describe this state as the highest level of faith, achieved by focusing intensely on God during acts of worship. This is similar to the concept of mindfulness, in which a person's focus and perception is altered by intense concentration. For patients who constantly ruminate, an activation experiment to develop <i>Ihsan</i> , for example during their daily prayers or during other acts of worship, may be helpful in refocusing thoughts.
Be part of your community	These teachings support BA approaches by encouraging interaction with others in ways that can reduce a patient's sense of isolation. A number of social activities are recommended by Islamic teachings that can be drawn on for activation assignments

Table 1: Relationship of self-help booklet to adapted BA therapy.

should not be offered immediately to patients but could be suggested to those who had referred positively to religion in relation to their values, beliefs or activities. However, patients should be specifically asked how/how much they would like to include attention to religion in their therapy; it should not be assumed that patients with strong religious values, for example, would necessarily feel religious activity was relevant to their therapy, particularly if they were already active in drawing on religious teachings for support. Similarly patients for whom religion was not a central value could nevertheless appreciate assignments that helped them increase their practice of Islam, particularly if the absence of religious activity was a consequence of feeling depressed.

For patients identified as using 'negative religious coping', or with ambivalent or hostile views of God, evidence from Key Informants suggested that the Booklet could be introduced as an alternative way of drawing on religious beliefs through activation assignments, depending on whether the therapist thought this would be useful.

Matching religious activation to the patient's level of religiosity was also considered important to avoid inducing guilt in patients who were not able to fulfill religious activation assignments. The synthesis indicated that feelings of guilt about not fulfilling religious practice

could be discussed in terms of helpful behaviors that would address this feeling [22].

Therapists were advised to follow up patients' reaction to the booklet and any teachings they found helpful during therapy. The standard techniques and tools of BA, such as activation assignments, were recommended to help patients integrate any teachings from the self-help booklet they had found helpful with their treatment for depression.

Pilot findings

Evaluation of training on use of the booklet indicated that this had helped therapists develop understanding of the need to include a discussion around religion in assessment and not rely on patients to volunteer information that this was important. The parallels between psychological and religious coping concepts and techniques and how to differentiate between cultural and religious influences on patients were also felt to be important aspects of training.

General feedback on the self-help booklet itself was overwhelmingly positive, particularly from service users. However, therapists appeared to have handed out the resource with little or no explanation about

its function. Service users who received it said that, whilst they had often found it useful and interesting, they lacked the guidance that was required on how to use it as a therapeutic resource. Whilst the adapted therapy was generally perceived as helpful, the self-help booklet remained largely separated from therapy sessions and underutilised, despite evidence suggesting many patients found it beneficial:

“every time I read, it was more of a common sense to me. I wasn’t practicing but when I was reading, you know ‘This is me, this is me, this is me’, this is how I feel and this is what I should be doing. But then I didn’t even entertain it, I just left it, so I’m not quite sure how you are going to bring the religion in ...”

Service User

Service user

Therapists had more mixed opinions about the self-help booklet than patients, with some “struggling” with its use within therapy. A recurrent theme from therapists who had dropped out of the pilot was self-doubt about their knowledge of Islam and perceptions that this was a barrier to delivery of the intervention:

“with things that you’re presenting to patients in sessions, you would want to sort of feel comfortable with it yourself, in terms of understanding before you presented it, like you were saying about any kind of interventions and things, whereas I think I might feel a bit uncertain about some of the things that we were looking at, that I didn’t have an equal knowledge to the patient about what we were looking at.”

Therapist

Therapists did not usually think that the self-help booklet was aimed at promoting religion or pressurising patients to become more religious. Most understood that the resource was an “extra resource” (Therapist). For those Muslims who felt they had drifted away from Islamic practice, it provided a helpful and appropriate means of reconnecting to their faith, which had previously held an important place in their life:

“And I think if people have come away from Islam it’s kind of nice and easy to flick through, isn’t it and just, kind of, to dip in and out and remember why, you know, the religion was important in the first place.”

Therapist

With practice, therapists actually delivering the intervention felt more confident to discuss religious issues with patients. For example, one drew on teachings about showing mercy to oneself with a patient who was overly self-critical, reinforcing therapeutic goals through the culturally relevant examples that were in line with the patient’s values.

However, a number of practitioners felt uncomfortable about introducing or using the booklet and suggested that script be provided to support their engagement with discussions about religion in ways that avoided ‘imposing’ religion on patients, ‘patronising’ them or ‘preaching’. Table 2 gives some examples of the kind of script that was

provided in response to concerns about the self-help booklet.

An important response to pilot findings was adapting the Self-help Booklet to include more information to patients about the therapy and what they should expect. An explanation of the BA model was included in the resource along with the Values Assessment and other tools provided for therapists in the manual. Increasing patient access to the process and model of therapy was intended to raise patient expectations and control of the therapeutic process in relation to religious activation and to reduce the gatekeeping role of therapists. The text created links between the two resources and provided information about how the Booklet should be used directly to patients. We suggest that more informed patients, who are less reliant on therapists to raise issues of relevance to them, improve the potential for co-production of therapy to take place.

Discussion

This study responds to calls in current mental health policy for culturally appropriate therapies that meet the needs of minority groups in the UK, using a robust methodology [23]. Findings suggest the resulting intervention is considered acceptable and helpful by patients, therapists and referral agencies.

Results of the study indicate that the self-help resource improves ‘positive religious coping’ in Muslim patients with depression [11]. Findings demonstrate the feasibility of using the booklet in clinical settings and its acceptability, particularly to patients from the minority group in question. However, results also indicate some tensions in delivery of the culturally adapted resource developed for this study.

Specific discussion of the importance of religion to patients with depression is necessary in the approach outlined in this study. For some therapists, such discussions are novel and may feel uncomfortable, particularly if their knowledge of patients’ religious background is limited. Cultural influences on the legitimacy of discussing religion in clinical settings may contribute to this discomfort and to the lack of therapist training in this area: within the European cultural context, religious teachings are most often confined to the sphere of private life as ‘beliefs’ and excluded from public or scientific discourse [34,35]. Furthermore, barriers to such discussions may be increased by the dominance of practitioners without religious belief in UK and US health services and, in the UK, increasing secularity amongst the general population [19,36,37].

Our evidence suggests the resource was perceived as validating by patients and this itself may have contributed to therapist discomfort. Such validation directly contradicts a long history of Islamophobia in Europe and media representation of Muslim populations globally as morally inferior and to be feared and controlled [38-42].

Conclusion

In the current climate of high-profile, predominantly negative, international attention to Muslim communities, evidence from the

“The people who developed this therapy have produced a self-help booklet for clients which contains Islamic teachings that you might find helpful. I wondered if you would be interested in looking at this for your homework this week?”

“How helpful do you think the self-help book is?”

“Were there any parts of it that you thought could support the goals you want to achieve?”

“How would you feel about my supporting you to work through the booklet when we meet and think about how it could help you become more active?”

“Do you think it would be helpful to involve someone with in-depth knowledge of Islamic teachings to advise you or motivate you to achieve the goals you have identified?”

Table 2: Therapist script for discussing the resource.

research is particularly topical and important. Our results show that within clinical settings dynamics reflecting current social tensions affect mental health practitioners of all backgrounds as well as Muslim patients. Study results go some way towards improving understanding of these dynamics and potential ways forward for mental health professionals.

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